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

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

APRIL-JUNE 1998

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CITE AS

50 Van Natta ____ (1998)

In the Matter of the Compensation of
PINKNEY S. JOHNSON, Claimant
Own Motion No. 97-0526M
SECOND OWN MOTION ORDER DENYING RECONSIDERATION
Lundeen, et al., Defense Attorneys

On January 28, 1998, we denied the insurer's request for reconsideration of our November 14, 1997 Own Motion Order. Finding that more than 30 days had elapsed since the issuance of our November 14, 1997 order, we concluded that we were not authorized to reconsider our decision. We have now received from the insurer another request for reconsideration of our November 14, 1998 order. The insurer argues that we have authority to reconsider our order, "notwithstanding the appeal deadlines, where extraordinary circumstances exist. OAR 438-012-0065(2)." The insurer further directs us to consider our decision in Joseph E. Bailey, 1993 WL 194001 (1993), in reviewing our decision.

"Extraordinary circumstances" are determined on a case by case basis. There are no predetermined events or actions which would automatically qualify as "extraordinary circumstances." The insurer asserts that, because we found extraordinary circumstances existed in our decision in Joseph E. Bailey, where both parties agreed that temporary disability benefits were awarded in error because claimant was retired, extraordinary circumstances exist in this case. We disagree.

The facts surrounding our decision in Joseph E. Bailey, do not parallel the facts in this instant case. In the Bailey case, the carrier recommended denying temporary disability benefits because claimant was retired. Claimant did not respond to the carrier's contention that he had withdrawn from the work force. However, based on a medical report which stated that claimant ran an antique store and "would probably be off work about a month," we concluded that claimant had remained in the work force. The carrier did not request reconsideration of that order until five months later, after it had received correspondence from the claimant, which was in response to the carrier's request for earnings information. In the claimant's letter, he asserted that "I [claimant] have not asked anyone for any time-loss benefits and I do not want any." Since the parties agreed that the claimant had withdrawn from the work force and the claimant expressly represented that he was not seeking temporary disability benefits, we concluded that extraordinary circumstances existed to reconsider our previous decision and to deny temporary disability benefits.

Here, the insurer submitted its recommendation form wherein it contends that claimant was not in the work force at the time of the current disability, but nevertheless recommended reopening the claim to provide temporary disability benefits. We issued our own motion order reopening the claim and awarding temporary disability benefits on November 14, 1997. Our order contained a statement explaining the parties' rights of reconsideration and appeal. Notwithstanding that statement, the insurer did not request reconsideration of the November 14, 1997 order until January 20, 1998, more than 60 days after our order issued. Moreover, the insurer did not offer an explanation for its untimely filing. We denied the January 20, 1998 request for reconsideration because it was untimely. In its most recent request for reconsideration, the insurer now relies on the "extraordinary circumstances" clause of OAR 438-012-0065 in support of its position. We do not find extraordinary circumstances exist in this present case.

First, the insurer recommended reopening the claim.[1] Further, unlike our decision in Bailey, which took into consideration the fact that both parties concurred that the claimant had withdrawn from the work force; in this case, only the insurer asserts that "extraordinary circumstances" exist to reconsider our decision. Moreover, claimant has neither joined in the insurer's request, nor has he stated that he has not sought temporary disability benefits. Finally, the insurer argues that there are extraordinary circumstances because claimant is not entitled to temporary disability payments due to his

[1] We assume that since the insurer is now opposed to the reopening of the claim that it is arguing that its recommendation to reopen the claim was to provide medical benefits only. However, entitlement to medical expenses is controlled by ORS 656.245. The Board's own motion authority under ORS 656.278 allows it to authorize the payment of temporary disability benefits when a compensable condition worsens sufficiently to require surgery and/or in-patient hospitalization. A recommendation to reopen a claim under the Board's own motion authority is therefore a request for authorization to provide temporary disability benefits.

being retired.[2] However, claimant's entitlement to temporary disability payments is not directly at issue, but rather the insurer's untimely request for reconsideration of our award of the temporary disability benefits. Inasmuch as the unsupported grounds asserted by the insurer do not constitute extraordinary circumstances to warrant reconsideration of our previous decision, under OAR 438-012-0065(2), the insurer's request is denied.

IT IS SO ORDERED.

[2] The insurer relies on the criteria set forth in Weyerhauser v. Kepford, 100 Or App 410, 414 (1990) and Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989) which establishes that a worker who has voluntarily removed himself from the workforce is not entitled to the payment of temporary disability compensation.

April 4, 1998 Cite as 50 Van Natta 634 (1998)

In the Matter of the Compensation of
GARY D. BAXTER, Claimant
WCB Case Nos. 96-07374 & 96-03084
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Pacific Employers Insurance Co./Cigna Co., on behalf of Budco Group (hereafter "Budco"), requests review of those portions of Administrative Law Judge (ALJ) Poland's order that: (1) set aside its denial of claimant's current low back condition; and (2) upheld St. Paul Fire & Marine Insurance Company's denial, on behalf of In-Terminal Services (hereafter "St. Paul"), of the same condition. Claimant cross-requests review of those portions of the ALJ's order that: (1) found Budco had amended its denial to contend that claimant's low back condition had not worsened; (2) upheld Budco's denial of his aggravation claim; (3) upheld St. Paul's denial of claimant's current back condition; and (4) found claimant was not entitled to temporary disability benefits retroactive to May 21, 1997. On review, the issues are compensability, aggravation, responsibility and temporary disability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact in the Order on Reconsideration dated August 13, 1997, with the following changes. In the first full paragraph on page 3, we change the last sentence to read: "A July 1993 MRI showed mild diffuse degenerative disc disease of the lumbar spine and a minimal broad-based posterior bulge at L4-5, without evidence of frank compression at the nerve roots. (Ex. 14)."

In the third full paragraph on page 3, we replace the last two sentences with the following:

> "In November 1995, claimant continued to have low back pain and he experienced radiating pain down both legs. (Ex. 51-2). A November 11, 1995 MRI showed that the L5-S1 small central focal disc protrusion was mildly more prominent than on the July 1993 exam. (Ex. 53). The findings at L1-2 and L4-5 levels appeared unchanged. (Id.)"

CONCLUSIONS OF LAW AND OPINION

On April 28, 1993, claimant sustained a compensable low back injury while working for Budco. Budco accepted a disabling low back strain. (Ex. 6). On May 25, 1993, claimant suffered a second back injury at Budco. (Ex. 9). Budco determined that the claim was related to the April 1993 injury and should be handled under that claim. (Ex. 16). Budco denied a separate claim for the May 25, 1993 injury, but indicated benefits would be provided under the earlier claim. (Id.)

Claimant continued to receive treatment for low back pain. On September 10, 1995, he injured his low back while working for St. Paul's insured. (Exs. 43, 46). On October 6, 1995, he was diagnosed with a lumbosacral strain. (Ex. 43). Claimant began treating with Dr. Berselli on November 16, 1995. (Ex. 55). On January 5, 1996, Dr. Berselli diagnosed a left L4-5 disc herniation and recommended surgery. (Ex. 58-2).

On January 10, 1996, St. Paul accepted a disabling lumbosacral strain. (Ex. 59A). On March 6, 1996, Dr. Kirschner, neurologist, and Dr. Duff, orthopedist, examined claimant on behalf of St. Paul. (Ex. 63). They concluded that degenerative disc disease and pain syndrome were the principal causes of claimant's current low back condition. (Ex. 63-7). On March 18, 1996, St. Paul denied compensability and responsibility of claimant's current low back condition. (Ex. 64).

Claimant filed a "Notice of Claim for Aggravation of Occupational Injury or Disease" with Budco. (Ex. 65). Dr. Fuller, orthopedic surgeon, examined claimant on behalf of Budco and concluded that the major contributing cause of claimant's current low back condition was a pain magnification syndrome. (Exs. 65B, 67). On August 2, 1996, Budco denied the "current condition as it is apparent that the current condition, need for treatment and surgery is not due to the industrial injury of April 28, 1993." (Ex. 69).

Timeliness of Budco's Request for Review

Claimant argues that Budco should not be allowed to litigate an order not timely appealed. Claimant does not explain why it believes Budco's request for review was not timely. In any event, claimant's argument is not persuasive.

Budco's request for review was received on September 24, 1997, appealing the ALJ's September 22, 1997 Order Denying Reconsideration. The Order Denying Reconsideration stated that the parties' rights of appeal continued to run from the September 9, 1997 Second Order on Reconsideration. The Second Order on Reconsideration republished the August 13, 1997 Order on Reconsideration, as supplemented, and initiated the 30 day appeal period beginning on September 9, 1997. Thus, all the relevant orders were encompassed in the Second Order on Reconsideration. Budco's statement that it was appealing the Order Denying Reconsideration indicated its intent to appeal all pending orders in this case. See generally Rebecca C. Cole, 49 Van Natta 153 (1997). We are not persuaded by claimant's argument that Budco did not timely appeal the ALJ's order.

Compensability of Current Condition

The ALJ found that claimant's current treatment for an L4-5 disc protrusion was the result of a combining of the 1995 injury with St. Paul's insured and his preexisting L4-5 disc degeneration. Consequently, the ALJ determined that, to establish compensability of the claim with St. Paul, claimant must prove that the 1995 injury with St. Paul's insured was the major contributing cause of his current disability and/or need for treatment. See ORS 656.005(7)(a)(B). The ALJ found that the medical evidence did not support compensability of the St. Paul claim under a major contributing cause standard.

Regarding the 1993 injury claim with Budco, the ALJ found there was no medical evidence to establish that claimant's L4-5 disc degeneration preexisted the 1993 injury with Budco. The ALJ determined that, to establish compensability of the claim with Budco, claimant must prove that the 1993 injury with Budco was a material cause of his current disability and/or need for treatment. Relying on Dr. Berselli's opinion, the ALJ concluded that the 1993 injury materially contributed to claimant's current need for treatment. The ALJ found that Budco was responsible for claimant's current need for treatment.

Budco contends that claimant's current back condition is not compensable because it was not caused in major part by his employment. Budco argues that the ALJ incorrectly applied separate causation standards to the carriers, using the "major causation" standard as to St. Paul, but a "material causation" standard as to Budco.

Claimant has two prior accepted injury claims. We begin by determining claimant's current condition and analyzing whether ORS 656.308(1) applies to claimant's current condition. Under ORS 656.308(1), the first employer remains responsible for future compensable medical services and disability relating to the compensable condition "unless the worker sustains a new compensable injury involving the same condition." When a worker sustains a second injury to the same body part, the subsequent employer is responsible only if the second injury constitutes the major contributing cause of the worker's disability or need for treatment for the combined condition. SAIF v. Britton, 145 Or App 288, 292 (1996). ORS 656.308, however, applies only if claimant's current condition is the "same condition" as that previously processed as part of a compensable claim. Sanford v. Balteau Standard/SAIF Corp., 140 Or App 177, 181 (1996); Smurfit Newsprint v. DeRosset, 118 Or App 368, 371-72 (1993).

We examine the medical evidence to determine whether claimant's current condition is the "same condition" as either of his accepted conditions. As a result of claimant's 1993 injury, Budco accepted a disabling low back strain. (Ex. 6). St. Paul accepted a disabling lumbosacral strain resulting from the 1995 injury. (Ex. 59A). There is no medical evidence that indicates that claimant continues to suffer from a low back strain. Claimant's treating physician, Dr. Berselli, has reported that claimant's current condition is an L4-5 disc protusion/herniation. (Exs. 62-1, 73-2). Because neither the 1993 nor the 1995 accepted claims included an L4-5 protrusion or herniation, we conclude that they did not involve the "same condition" as claimant's current condition. Therefore, ORS 656.308(1) does not apply.

St. Paul contends, however, that the Budco claim did include an L4-5 disc component. We are not persuaded by St. Paul's argument. Budco's initial acceptance was specifically limited to a low back strain. (Ex. 6). On May 25, 1993, claimant suffered a second back injury at Budco. (Ex. 9). On May 26, 1993, he sought treatment and was diagnosed with a back strain. (Ex. 10). Budco wrote to claimant regarding the May 1993 injury, stating that the injury was related to the April 1993 low back injury and should be handled under that claim. (Ex. 16). Budco denied a separate claim for the May 25, 1993 injury, but indicated benefits would be provided under the earlier claim. (Id.) Under these circumstances, we are not persuaded that Budco expanded its acceptance beyond the original low back strain. Compare Georgia-Pacific v. Piwowar, 305 Or 494, 501-02 (1988) (where a carrier accepts a symptom of a disease, it also accepts the disease causing that symptom).

Claimant asserts that his current condition is an L4-5 disc protrusion, which arose out of successive work-place injuries. He argues that the ALJ properly analyzed compensability, i.e., by analyzing compensability separately as to the 1993 injury (under a "material cause" standard) and the 1995 injury (under a "major contributing cause" standard). He relies on Dr. Berselli's opinion to establish compensability under either a material or major contributing cause standard.

The issue here is whether claimant's current low back condition, which has been diagnosed by Dr. Berselli as a disc protusion/herniation at L4-5, is compensable. As a fact finder, it is our obligation to apply the appropriate legal standards to determine the compensability of a worker's claim. Daniel S. Field, 47 Van Natta 1457 (1995) (citing Hewlett-Packard v. Renalds, 132 Or App 288 (1995)).

Although claimant does not dispute the ALJ's conclusion that the L4-5 disc degeneration preexisted the 1995 injury, he contends that there is no evidence that the 1993 work injury at Budco combined with a preexisting condition. However, we are not analyzing compensability of the 1993 injury. Rather, the issue is what caused claimant's current low back condition. Dr. Berselli concluded that three factors contributed to claimant's current condition: an ongoing degenerative process, the April 1993 injury and the September 30, 1995 injury. (Ex. 73-3). The medical evidence establishes that claimant's degenerative disc disease constitutes a "preexisting condition" with respect to the current condition claim.[1] Thus, claimant is seeking to establish the compensability of a "combined" condition, i.e., the accepted low back strains and the degenerative disc disease. Claimant must prove that either the 1993 or the 1995 compensable injury was the major contributing cause of his combined condition or need for treatment of the combined condition. See ORS 656.005(7)(a)(B).

In any event, even if claimant's current condition is not a "combined condition" with respect to the 1993 injury, we find that compensability of the Budco claim must be analyzed under the "major contributing cause" standard pursuant to ORS 656.005(7)(a)(A).

Claimant relies on Dr. Berselli's opinion that the 1993 injury caused the L4-5 degenerative disc disease. Dr. Berselli testified that the 1993 injury "probably caused some degenerative changes in his lumbar spine" and that "set the stage for the bulging of the intervertebral disk that he subsequently developed." (Ex. 66-17). He explained:

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[1] The MRI on July 17, 1993 showed mild diffuse degenerative disc disease at the lumbar spine. (Ex. 14). Under ORS 656.005(24), a "preexisting condition" means "any injury, disease, congenital abnormality, personality disorder or similar condition that contributes or predisposes a worker to disability or need for treatment and that precedes the onset of an initial claim for an injury or occupational disease or that precedes a claim for worsening pursuant to ORS 656.273." Dr. Berselli signed a "Notice of Claim for Aggravation of Occupational Injury or Disease" on April 22, 1996, with Budco. (Ex. 65). Claimant's degenerative disc disease preexisted the "claim for worsening pursuant to ORS 656.273" and, therefore, constitutes a "preexisting condition."

> "I think probably you would have to say that the '93 injury was the primary cause of his problem. Because if that injury hadn't occurred, presumably the disk would not have degenerated and subsequently herniated. But that would be my best guesstimation." (Ex. 66-17, -18).

Assuming the persuasiveness of Dr. Berselli's opinion, his testimony is that the 1993 injury caused the degenerative disc disease, which, in turn, resulted in the L4-5 disk herniation. Based on that theory, claimant's L4-5 disc herniation is a consequential condition that must be decided under ORS 656.005(7)(a)(A). See Fred Meyer, Inc. v. Crompton, 150 Or App 531, 536 (1997) ("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"). Thus, with respect to the claim against Budco, we conclude that claimant must establish that the 1993 injury is the major contributing cause of his current condition and need for treatment.

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). Absent persuasive reasons to do otherwise, we generally give greater weight to the opinion of the attending physician. Weiland v. SAIF, 64 Or App 810 (1983). Although claimant relies on the opinion of his treating physician, Dr. Berselli, we find persuasive reasons not to rely on his opinion.

Dr. Berselli's opinion is not persuasive because of numerous unexplained inconsistencies. When Dr. Berselli first examined claimant on November 16, 1995, he reviewed an MRI done on November 11, 1995 and noted that it showed "degenerative disc changes in the lower level" and "[m]ild asymmetry at L4-5[.]" (Ex. 55-2). Dr. Berselli opined that claimant did not have clinically significant radiculopathy. He felt claimant had an acute back strain that was superimposed on preexisting degenerative changes at L1-2. (Id.)

However, in a concurrence letter from St. Paul's attorney signed on March 5, 1996, Dr. Berselli agreed that claimant had a left-sided L4-5 disc protrusion that was confirmed by the November 11, 1995 MRI of the lumbar spine. (Ex. 62-2). In a deposition, Dr. Berselli testified that claimant's MRI showed a "disk herniation between the 4th and 5th vertebrae on the left side[.]" (Ex. 66-4).

Thus, Dr. Berselli initially found only "[m]ild asymmetry at L4-5" on the November 1995 MRI. (Ex. 55-2). Subsequently, however, he said that the same MRI showed an L4-5 disc protrusion and an L4-5 disc herniation. (Exs. 62-2, 66-4). Because Dr. Berselli did not explain why his opinion changed regarding his interpretation of the November 1995 MRI, his opinion is not persuasive. Furthermore, there is no evidence that Dr. Berselli reviewed the May 30, 1996 MRI of claimant's lumbar spine, which showed no disc bulge, protrusion or herniation. (Ex. 65C).

Dr. Berselli also rendered inconsistent opinions regarding claimant's degenerative condition. In a concurrence letter from St. Paul's attorney, Dr. Berselli agreed that claimant had "degenerative disc disease at multiple levels of the lumbar spine, and the disc protrusion at L4-5 is most likely attributable in major part to [claimant's] preexisting degenerative disc disease." (Ex. 62-2). However, in a concurrence letter from Budco's attorney signed on October 31, 1996, Dr. Berselli agreed that "the degenerative process played a minor role in [claimant's] current condition." (Ex. 73-3). Because Dr. Berselli did not explain why he changed his opinion regarding the role the degenerative process played in claimant's current condition, we do not find his opinion persuasive. See Kelso v. City of Salem, 87 Or App 630 (1987).

In a deposition on June 17, 1996, Dr. Berselli testified that the 1993 injury was the "primary cause" of claimant's problem (Ex. 66-17), and he said that the 1993 injury "would be considered the major problem because it caused the degenerative disk disease." (Ex. 66-20). However, in a later concurrence letter from Budco's attorney, Dr. Berselli agreed it "was impossible to ascertain whether either the 1993 or the 1995 injury is the major cause of the current condition." (Ex. 73-4). He agreed that, absent either injury, claimant's current condition probably would not exist. (Id.) Thus, Dr. Berselli changed his opinion from saying that the 1993 injury was the primary cause of claimant's problem to saying that he could not ascertain whether either injury was the major problem. This represents another unexplained change of opinion, which is not persuasive.

We are unable to reconcile Dr. Berselli's various opinions. He has agreed that claimant's L4-5 disc protrusion was caused in major part by degenerative disk disease, but then later said that the degenerative process played a "minor" role in the current condition. (Exs. 62-2, 73-3). At one point, Dr. Berselli said the 1993 injury was the "primary cause" of claimant's problems, but later said he could not

determine what injury was the major cause of claimant's current condition. (Exs. 66-17, 73-4). Because Dr. Berselli did not explain the material inconsistencies between his various opinions, his opinion "as a whole" is unpersuasive because it lacks adequate explanation for these variations.

Furthermore, Dr. Berselli did not respond to medical opinions that indicated claimant's current condition was caused by a pain syndrome. Drs. Kirschner and Duff examined claimant on March 6, 1996 and found no objective signs of nerve root compression or other peripheral or central nervous system injury and no evidence of a significant orthopedic abnormality. (Ex. 63-5). They believed that claimant had a pain syndrome, which was not work-related. (Id.) They indicated there were possible psychological factors as the etiology. (Id.)

Similarly, Dr. Fuller examined claimant on May 9, 1996 and found that claimant's subjective pains were not supported by any impressive lumbar discopathy. (Ex. 65B-6). He recommended another MRI to determine if claimant had a pain syndrome. (Id.) An MRI performed on May 30, 1996 showed "[n]o disc bulge, protrusion or herniation noted." (Ex. 65C). Dr. Fuller reviewed the new MRI and concluded that there was no underlying discopathy or any objective pathology to support claimant's extensive subjective presentation. (Ex. 67-1). Dr. Fuller believed that the major contributing cause of claimant's current condition was a pain magnification syndrome. (Id.) He noted that claimant had no evidence of a back strain since indirect testing and indirect ranges of motion were normal. (Id.)

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). Because Dr. Berselli apparently did not consider the possibility that a pain syndrome was causing or contributing to claimant's current low back condition, his opinion is not persuasive.

The other medical opinions do not establish compensability of claimant's current low back condition. Drs. Kirschner and Duff reported that claimant's 1995 low back strain should have been "self-limited" and should have resolved by the end of October. (Ex. 63-7). They found no impairment from the 1995 low back strain. (Id.) They noted that it was "unclear what the 1993 injury at [Budco] contributes, as his lumbosacral MRI has an appearance compatible with that of any asymptomatic member of the general populous." (Ex. 63-6). It was unclear to Drs. Kirschner and Duff why claimant had permanent impairment from the 1993 injury. (Ex. 63-7). As we discussed earlier, they felt claimant currently had a pain syndrome. (Ex. 63-5).

Dr. Fuller reported that claimant's 1995 strain had healed and had long since become medically stationary and needed no further treatment. (Ex. 65B-6, -8). He also felt claimant was medically stationary from both the 1993 and 1995 work incidents. (Ex. 67-2). He felt claimant had no impairment from either the 1993 or 1995 injuries and he opined that claimant's diminished range of motion was under his subjective control and was not supported by objective findings. (Id.) Dr. Fuller believed that claimant had a pain magnification syndrome, which was the major contributing cause of his current condition. (Ex. 67-1).

In conclusion, we conclude claimant's current low back condition is not compensable.

Aggravation

In order to establish a compensable aggravation under ORS 656.273(1), claimant must prove two elements: (1) a compensable condition; and (2) an "actual worsening." Gloria T. Olson, 47 Van Natta 2348, 2350 (1995). If the worsened condition is not a compensable condition, compensability must first be established under ORS 656.005(7)(a). Id.

Here, Budco accepted a low back strain resulting from the 1993 injury. Claimant's current condition has been diagnosed as an L4-5 protrusion/herniation. Because claimant has not established the compensability of his current condition, he cannot prove an aggravation under ORS 656.273(1). Thus, we need not address whether claimant has established an "actual worsening." In addition, it is not necessary to address claimant's contention that Budco never raised the "no worsening" defense to an aggravation claim and should not be allowed to amend its denial.

In his reply brief, claimant contends that the aggravation claim may be "moot." He relies on amended ORS 656.262(7)(c) and Mario R. Castaneda, 49 Van Natta 2135 (1997), and argues that he need not prove a worsening of his condition to be eligible for reopening of his claim based on a post-closure, compensable condition.

Claimant's reliance on amended ORS 656.262(7)(c) and Castaneda is misplaced. ORS 656.262(7)(c) provides, in 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). In Castaneda, the claimant filed a new medical condition claim for a disc bulge at L4-5 and, after litigation, the insurer issued a modified notice of acceptance to include the L4-5 disc condition. Here, in contrast, claimant's L4-5 disc protrusion/herniation has not been found compensable. Therefore, ORS 656.262(7)(c) does not apply.

Responsibility

Because claimant's current condition and aggravation claims have not been found compensable, it is not necessary for us to address claimant's argument that St Paul is responsible for his current condition.

Temporary Disability

Claimant cross-requests review, arguing that the ALJ erred by finding he was not entitled to temporary disability benefits. Claimant asks the Board to strike the ALJ's finding.

In light of our conclusion that the claim is not compensable, we need not address any issues involving temporary disability benefits.

Penalties and/or Penalty-Related Fees

The ALJ found that claimant was entitled to a penalty for Budco's unreasonable failure to provide timely discovery of a May 30, 1996 MRI report. The ALJ assessed a penalty for the late discovery in the amount of 10 percent of any compensation due under the Budco claim. However, we have found that the underlying claim is not compensable. In light of our disposition, there are no "amounts then due" on which to base a penalty and no unreasonable resistance to the payment of compensation to support a penalty-related attorney fee. See Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991); Randall v. Liberty Northwest Ins. Corp., 107 Or App 599 (1991). Accordingly, no penalties or related attorney fees are warranted.

ORDER

The ALJ's order dated May 12, 1997, as corrected May 21, 1997, as reconsidered on August 13, 1997 and September 9, 1997, is reversed in part and affirmed in part. That portion of the ALJ's order that set aside Budco's denial of claimant's current low back condition is reversed. Budco's denial of claimant's current low back condition is reinstated and upheld. The ALJ's attorney fee awards are also reversed. That portion of the ALJ's order that directed Budco to pay a penalty equal to 10 percent of any amounts due under the Budco claim is reversed. The remainder of the ALJ's order is affirmed.

April 2, 1998 Cite as 50 Van Natta 639 (1998)

In the Matter of the Compensation of
LOUIE J. PLUMLEE, Claimant
WCB Case No. 93-01923
ORDER ON REMAND
James L. Edmunson, Claimant Attorney
Employers Defense Counsel, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Oldham v. Plumlee, 151 Or App 402 (1997). The court has reversed our prior order, Louie J. Plumlee, 46 Van Natta 2332 (1994), that affirmed an Administrative Law Judge's (ALJ's) order that set aside a Director's determination that claimant was not a subject worker. Relying on Lankford v. Copeland, 141 Or App 138 (1996), the court has concluded that we lacked juridiction to consider the alleged employer's (Oldham's) appeal of the ALJ's order. Consequently, the court has remanded with instructions to dismiss the request for review.

In accordance with the court's mandate, we dismiss Oldham's request for Board review of the ALJ's order. Jurisdiction over this matter rests with the Director.

IT IS SO ORDERED.

In the Matter of the Compensation of
BRET CLAUSSING, Claimant
WCB Case No. 95-04958
ORDER ON REMAND
Black, Chapman, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Claussing v. K-Mart Corporation, 144 Or App 552 (1996). The court has reversed our prior order, Bret Claussing, 48 Van Natta 229 (1996), which held that K-Mart, a self-insured employer, was not responsible under ORS 656.029(1)[1] for claimant's injury claim. Noting that we had not considered OAR 436-050-0040(c) in reaching our conclusion that the janitorial services claimant was performing were not a "normal and customary part or process of K-Mart's trade or business," the court remanded to us to consider the facts of this case in light of that rule. We now proceed with our review.[2]

It is first necessary to recount the factual and procedural background in some detail. K-Mart and a janitorial service (CP) entered into a contract on October 18, 1994, whereby CP would provide after-hours janitorial services for K-Mart. The contract required CP to provide workers' compensation coverage. However, when claimant was compensably injured on February 25, 1995, CP did not have workers' compensation coverage.[3] The ALJ set aside K-Mart's "de facto" denial of compensability, finding that it was responsible for providing workers' compensation coverage under ORS 656.029(1).

In our prior decision, we found that K-Mart contracted for janitorial services that were to be provided in its building after business hours and that CP agreed to provide workers' compensation insurance for its employees. We further found that K-Mart had no control or supervisory responsibility over how CP's employees performed their services. Moreover, in our prior order, we observed that K-Mart is not in the janitorial or building maintenance business; rather, its business was retail sales. There was no evidence that K-Mart employed any janitors or maintenance people. We determined that K-Mart's business purpose - retail sales - could be accomplished without janitorial service that was provided after business hours.

Considering these factors, we concluded that the provision of after-hours janitorial service accomplished no business purpose for K-Mart. While the maintenance of a clean and safe store may be a necessary element of its business, we noted that the same could be said for any business, since all businesses must, to one degree or another, provide a clean and safe work environment, if only for liability purposes. Thus, we determined that janitorial services were not part of the normal and customary business of a retailer like K-Mart and that K-Mart was not responsible for providing workers' compensation coverage for claimant under ORS 656.029(1). Bret Claussing, 48 Van Natta at 230. Accordingly, we reversed the ALJ's order and reinstated and upheld K-Mart's denial.

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[1] ORS 656.029(1) provides:

"If a person awards a contract involving the performance of labor where such labor is a normal and customary part or process of the person's trade or business, the person awarding the contract is responsible for providing workers' compensation insurance coverage for all individuals, other than those exempt under ORS 656.027, who perform labor under the contract unless the person to whom the contract is awarded provides such coverage for those individuals before labor under the contract commences. If an individual who performs labor under the contract incurs a compensable injury, and no workers' compensation insurance coverage is provided for that individual by the person who is charged with the responsibility for providing such coverage before labor under the contract commences, that person shall be treated as a noncomplying employer and benefits shall be paid to the injured worker in the manner provided in this chapter for the payment of benefits to the worker of a noncomplying employer."

[2] The parties were advised that supplemental briefing would be permitted. We have received the employer's supplemental opening brief and claimant's supplemental respondent's brief. The Department requested an opportunity to participate under ORS 656.726(3)(h). Thereafter, the Department was given 14 days from the date of mailing of the employer's reply brief to file its written position. If no reply brief was forthcoming, the Department was given 28 days from the date of mailing of claimant's brief in which to present its position. The employer did not submit a reply brief and 28 days have now passed since the date of mailing of claimant's brief. The Department has not filed a brief. Therefore, we have proceeded with our review.

[3] The record indicates that CP provided workers' compensation coverage from April 30, 1993 through October 6, 1994, when the coverage lapsed. (Trs. 18, 19). There apparently was no further coverage of CP until at least March 23, 1995.

While this matter was pending before the court, the Department intervened and contended that K-mart was responsible for workers' compensation coverage of claimant pursuant to OAR 436-050-0040(c). The rule defines "normal and customary part or process of the person's trade or business," as that phrase is used in ORS 656.029(1), as "the day-to-day activities or operations which are necessary to successfully carry out a business or trade." The court remanded for our consideration of this matter in light of OAR 436-050-0040(4)(c). After consideration of the administrative rule, and after further consideration of our prior order, we conclude that we should change our prior decision that K-Mart was not responsible for claimant's injury under ORS 656.029(1).

K-Mart's general manager testified that CP provided nightly janitorial service, which primarily involved cleaning the sales floor and restrooms, and waxing and buffing the sales floor as needed. (Tr. 24). He further testified that having a neat and clean environment was "important" for a retail establishment and that was why a janitorial service was hired to clean the store at night. (Tr. 30). The general manager also noted that maintaining a clean store was important for liability purposes as well. Id. Given this unrebutted testimony, we find that the janitorial services CP provided were a "normal and customary part or process" of K-Mart's trade or business within the meaning of ORS 656.029(1).

Moreover, we would further find, based on the above testimony, that the record establishes that nightly, after-hours janitorial services were "day-to-day activities or operations" necessary to "successfully" carry out K-Mart's trade or business. Under such circumstances, we conclude that K-Mart was responsible for providing workers' compensation coverage for claimant under the express statutory language of ORS 656.029(1) and OAR 436-050-0040(4)(c).[4]

In its prior briefs to the Board, however, K-Mart had argued alternatively that, should we decide that it was responsible for providing coverage under ORS 656.029(1), it should still escape liability for claimant's injury because CP was required to provide workers' compensation coverage under ORS 656.029(2). Because CP did not do so, K-Mart argues that CP should be treated as a noncomplying employer.

ORS 656.029(2) provides:

> "If a person to whom the contract is awarded is exempt from coverage under ORS 656.027, and that person engages individuals who are not exempt under ORS 656.027 in the performance of the contract, that person shall provide workers' compensation insurance coverage for all such individuals. If an individual who performs labor under the contract incurs a compensable injury, and no workers' compensation insurance coverage is provided for that individual by the person to whom the contract is awarded, that person shall be treated as a noncomplying employer and benefits shall be paid to the injured worker in the manner provided in this chapter for the payment of benefits to the worker of a noncomplying employer."

ORS 656.029(3) provides that, as used in this section:

> "(a) 'Person' includes partnerships, joint ventures, associations, corporations, limited liability companies, governmental agencies, and sole proprietorships.
>
> "(b) 'Sole proprietorship' means a business entity or individual who performs labor without the assistance of others."

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[4] We recognize that, in remanding this case to us, the court did not expressly direct us to "reconsider" our previous order. Rather, as previously noted, the court remanded for consideration of the facts of this case in light of OAR 436-050-0040(4)(c). Therefore, we are arguably precluded from reconsidering our previous determination of this case under the express language of ORS 656.029(1). On the other hand, the court "reversed" our prior order. Thus, none of our findings in that order are final because the order, itself, is a nullity. See Kevin P. Silveira, 47 Van Natta 2354, 2357 n. 3 (1995), on recon 48 Van Natta 298 (1996); see also Dung T. Nguyen, 44 Van Natta 477 (1992) (order on remand reached different conclusion than the order on review); Nancy C. Evenhus, 42 Van Natta 2625 (1990) (because the court had remanded for the Board to review the remaining issues raised by the denial, no finding within an order had yet become final). In any event, we reach the same conclusion in this case (i.e., that the janitorial services CP provided were a normal and customary part or process of K-Mart's trade or business pursuant to ORS 656.029(1)) applying the administrative rule.

K-Mart's analysis is that CP as a sole proprietor was a "person" within the meaning of ORS 656.029(2) and (3)(a) to whom a contract was awarded to provide janitorial services. Inasmuch as sole proprietorships are exempt from coverage under ORS 656.027(7), and because CP hired non-exempt employees, K-Mart alleges that CP was required to provide workers' compensation coverage under ORS 656.029(2). Inasmuch as CP failed to do so when claimant, an individual performing labor under the contract, was compensably injured, K-Mart argues that CP should be treated as a noncomplying employer.

We find, in order to determine the applicability of ORS 656.029(2), we must first determine whether CP was a "person" (to whom the contract was awarded) "exempt from coverage under ORS 656.027." See Liberty Northwest v. Hegerberg, 118 Or App 282, 286 (1993). It is argued that CP was a "sole proprietor" and, as such, was exempt under ORS 656.027(7). It should be noted, however, that exemptions from coverage under ORS 656.027 result from a person's employee classification.[5] That is, ORS 656.027 defines those workers not subject to the Act. After all, every employer employing one or more subject workers in the state is subject to the Act. ORS 656.023. Thus, when ORS 656.029(2) refers to a "person to whom the contract is awarded is exempt from coverage under ORS 656.027," it is referring to a person in the status of an exempt worker. Further, when ORS 656.027(7) refers to "sole proprietors" as being exempt, the statute is referring to "sole proprietors" in the capacity of (or in the status as) a worker.

Therefore, to determine the applicability of ORS 656.029(2), we must determine whether CP was an exempt worker to whom the contract was awarded. If so, then ORS 656.029(2) is applicable. If, however, the contract was awarded to CP as a subject employer (i.e., in a capacity other than an exempt worker), then that statute is inapplicable and responsibility for claimant's injury is determined pursuant to ORS 656.029(1).

As previously noted, ORS 656.023 states that every employer employing one or more subject workers is a subject employer. In this case, the Department's investigation report, compiled while determining CP's alleged noncomplying status, found that CP employed approximately 12 workers in the performance of its janitorial services. (Ex. 4-2). Moreover, claimant testified that at least two other employees performed labor for CP. (Trs. 16, 17). In addition, Mr. Reves, K-Mart's general manager, testified that CP was expected to supply its own employees under the contract in order to carry out its janitorial services. (Tr. 24). Mr. Reves also testified that he assumed that Mr. Pittman would work in the store with his employees. (Tr. 36).

Based on this evidence, we conclude that, when the contract between K-Mart and CP was let, that contract was let to CP/Mr. Pittman in his status as a subject employer. Inasmuch as ORS 656.029(2) only applies to exempt "persons" in their employee status pursuant to ORS 656.027, we conclude that ORS 656.029(2) is inapplicable.[6] Thus, we find that K-Mart was responsible for providing workers' compensation coverage under ORS 656.029(1) when claimant was injured in the course and scope of his employment.

Claimant has prevailed after remand. Under such circumstances, he is entitled to a reasonable attorney fee for services before every prior forum. See ORS 656.388(1). Because claimant's counsel provided services at hearing, on Board review, before the court and on remand before the Board, a reasonable fee for such efforts shall be awarded.

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[5] ORS 656.027 provides, in part, that:

"All workers are subject to this chapter except those nonsubject workers described in the following subsections:

" * * * * * *" (Emphasis added).

[6] The parties devote considerable attention to the issue of whether CP was a "sole proprietor" under ORS 656.029(3)(b) and to the significance of our decision in Barry Dunn, 42 Van Natta 2328 (1990), rev'd on other grounds Wood v. Dunn, 109 Or App 204 (1991). We need not address those issues because, regardless of whether CP was a "sole proprietor," CP was a statutory employer when the October 1994 contract was let. Therefore, responsibility for claimant's injury is determined under ORS 656.029(1), not ORS 656.029(2).

We first note that neither party objected to the ALJ's $3,500 attorney fee award. Accordingly, that award is republished. After considering the factors set forth in OAR 438-015-0010(4), we find that a reasonable assessed attorney fee for claimant's counsel's services before the Board on review/remand and the court is $6,500, to be paid by K-Mart. In reaching this conclusion, we have particularly considered the nature of the proceedings, the complexity of the issues, the benefit secured by claimant, the time devoted to the case (as represented by the record and claimant's appellate briefs), and the risk that claimant's counsel might go uncompensated.

Accordingly, on reconsideration, and as supplemented and modified herein, the ALJ's order dated August 8, 1995 is affirmed.[7] For services before the court and before the Board on review/remand, claimant's counsel is awarded $6,500, to be paid by K-Mart. This attorney fee is in addition to the $3,500 granted by the ALJ's order.

IT IS SO ORDERED.

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[7] K-Mart does not contest, and we also affirm, the ALJ's penalty award based on K-Mart's failure to timely accept or deny claimant's claim.

Board Member Moller dissenting.

When we originally reviewed this matter, we applied the provisions of ORS 656.029(1) to the facts as we found them. The court remanded this case to us for the limited purpose of further considering the facts of this case in light of OAR 436-050-0040(4)(c). Yet, despite the court's limited mandate, the majority reconsiders the facts of this case in light of the statute. Because this reconsideration exceeds the court's mandate, I cannot agree with the majority's reassessment of our original decision.

In addition, no party raised or argued the application of the administrative rule at hearing. The rule does not merely paraphrase the statute, but rather it provides an administrative interpretation of the statute. Assuming the rule is valid (no party has contested its validity), I would find the record insufficiently developed on the issue of whether the janitorial services CP provided were "day-to-activities or operations which are necessary to successfully carry out the business or trade" of K-Mart.

Finally, the majority renders an interpretation of the statutory scheme that, until this date, had never been articulated. Had the parties known that the Board would analyze the statutes in such a manner, it is reasonable to assume that direct evidence would have been presented on the question of whether CP had employed workers when labor commenced under its contract with K-Mart. Considering such circumstances, remand for further development of the record is appropriate. Cf. Betty Tee, 45 Van Natta 289 (1993) (Board remanded matter to ALJ in light of Supreme Court's intervening definition of relevant statutory term).

Therefore, I would remand the case to the ALJ for further development of the record on these issues.

Board Member Haynes dissenting.

The majority concludes that K-Mart is responsible for providing coverage under OAR 436-050-0040(4)(c) and ORS 656.029(1). Because I disagree with the majority's reasoning and conclusions, I respectfully dissent.

To begin, the court remanded for consideration of the facts of this case in light of OAR 436-050-0040(4)(c). It did not instruct us to reconsider our previous factual findings in light of the statute. Therefore, like Member Moller, I disagree with the majority's use of time and resources in an unnecessary and unauthorized reconsideration of our prior application of the statutory language of ORS 656.029(1) to the facts of this case.

Apart from this consideration, the Department raised the potential impact of OAR 436-050-0040(4)(c) for the first time while this case was pending before the court. Therefore, the parties have not had the opportunity to present evidence regarding whether the janitorial services CP provided are day-

to-day activities necessary for K-Mart to successfully carry out its retail sales business. Although the majority finds the evidence in the record sufficient to apply the administrative rule, I would conclude otherwise. In light of such circumstances, I submit that there is a compelling reason to remand this case for further development of this insufficiently and incompletely developed record. ORS 656.295(5).[1]

In the absence of remand, I note that an administrative agency may not, by its rules, amend, alter, enlarge, or limit the terms of the statute. See Harrison v. Taylor Lumber & Treating, Inc., 111 Or App 325, 328 (1992); Cook v. Workers' Compensation Department, 306 Or 134, 138 (1988). There are three classes of statutory terms, each of which conveys a different responsibility for the agency promulgating the rules under the statute and for the administrative/judicial body reviewing the agency's rule making: (1) terms of precise meaning, whether of common or technical parlance, requiring only factfinding by the agency and administrative/judicial review for substantial evidence; (2) inexact terms which require agency interpretation and administrative/judicial rule for consistency with legislative policy; and (3) terms of delegation which require legislative policy determination by the agency and administrative/judicial review of whether that policy is within the delegation. Springfield Education Assn. v. School Dist., 290 Or 217, 223 (1980).

I would find OAR 436-050-0040(4)(c) to be an unwarranted expansion of ORS 656.029(1) because the statutory language construed by the Department's rule ("normal and customary part or process of the person's trade or business...") are "terms of precise meaning" whose application are dependent upon fact-finding, rather than agency interpretation. See Tee v. Albertsons, Inc., 314 Or 633, 637-38 (1992) (terms of precise meaning require an agency only to apply the terms to the facts); Springfield Education Assn., 290 Or at 223 (1980).

Thus, I would not apply the administrative rule on the basis that it is invalid. Even if the rule were valid, I do not believe that consideration of this administrative rule should change the result in this case.

While maintenance of a clean and safe store is no doubt a worthy objective of any business establishment,[2] the record does not establish that "after-hours" janitorial services are necessary to successfully carry out K-Mart's trade or business. The typical general contractor-subcontractor relationship referred to in ORS 656.029 occurs in the construction business, where a contract involves performance of work that is a part of the general contractor's business. Here, the provision of after-hours janitorial service is not part of the general contractor's (K-Mart's) business, which is retail sales.[3] Under such circumstances, I would find that K-Mart is not responsible for providing workers' compensation coverage for claimant under OAR 436-050-0040(4)(c) and ORS 656.029(1).

However, even if K-Mart was responsible for providing coverage under ORS 656.029(1), I would agree with K-Mart's alternative argument that, should we decide that it was responsible for providing coverage under ORS 656.029(1), it should still escape liability for claimant's injury because CP was required to provide workers' compensation coverage under ORS 656.029(2). Because CP did not do so, I would agree with K-Mart that CP should be treated as a noncomplying employer. I reason as follows.

ORS 656.029(2) provides:

> "If a person to whom the contract is awarded is exempt from coverage under ORS 656.027, and that person engages individuals who are not exempt under ORS 656.027 in the performance of the contract, that person shall provide workers' compensation

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[1] As an additional basis for remanding, I would also find the record insufficiently developed with respect to the issue of whether CP had employees when the contract between K-Mart and CP was let. While reserving judgment on the majority's analysis of ORS 656.029(2), I would, nevertheless, disagree with its conclusion that the record supports the inference that CP employed subject workers when labor commenced under the October 1994 contract.

[2] K-Mart's general manager testified that having a neat and clean environment was "important" for a retail establishment. (Tr. 30).

[3] I recognize that the provision of "store-hour" janitorial services would likely be necessary to successfully conduct a trade or business. However, I am not persuaded that the record in this case establishes that "after-hours" janitorial services are necessary to successfully carry out the employer's trade or business.

> insurance coverage for all such individuals. If an individual who performs labor under the contract incurs a compensable injury, and no workers' compensation insurance coverage is provided for that individual by the person to whom the contract is awarded, that person shall be treated as a noncomplying employer and benefits shall be paid to the injured worker in the manner provided in this chapter for the payment of benefits to the worker of a noncomplying employer."
>
> ORS 656.029(3) provides that, as used in this section:
>
> "(a) 'Person' includes partnerships, joint ventures, associations, corporations, limited liability companies, governmental agencies, and sole proprietorships.
>
> "(b) 'Sole proprietorship' means a business entity or individual who performs labor without the assistance of others."

CP as a sole proprietor was a "person" within the meaning of ORS 656.029(3)(a) to whom a contract was awarded to provide janitorial services. Inasmuch as CP was exempt as a sole proprietor from coverage under ORS 656.027(7)(a), and because CP hired non-exempt employees such as claimant, CP was required to provide workers' compensation coverage under ORS 656.029(2). Because CP failed to do so when claimant, an individual performing labor under the contract, was compensably injured, CP was a noncomplying employer and benefits should be paid to claimant in the manner provided in ORS Chapter 656 for the payment of benefits to the worker of a noncomplying employer. See ORS 656.054.

I recognize that we have interpreted former ORS 656.029(4)(b) (since renumbered to ORS 656.029(3)(b)) to mean that, if a business entity hires other individuals to assist in the performance of labor, then the business entity does not meet the definition of a "sole proprietorship" under the statute. See Barry Dunn, 42 Van Natta 2328, 2329 (1990), rev'd other grounds Wood v. Dunn, 109 Or App 204 (1991).

However, our interpretation in Dunn of the definition of "sole proprietor" was incorrect because it would mean no business entity or individual could qualify as a "sole proprietor" under the statute if it hired any employees to perform labor. I do not believe that the legislature intended this result based on the testimony from a Workers' Compensation Division representative regarding the intent of House Bill 2590, the legislation in 1985 that added "sole proprietor" to the definition of "person" in ORS 656.029.

In construing a statute, our task is to discern the intent of the legislature. The first level of analysis is to examine both the text and the context of the statute, including other provisions of the same statute. PGE v. Bureau of Labor and Industries, 317 Or 606, 610-11 (1993). If the legislature's intent is clear, no further inquiry is necessary. If the intent of the legislature is not clear from the text and the context of the statute, we then consider the legislative history of the statute. Id. at 611-12.

In this case, the legislature's intent is not clear from the language of ORS 656.029(3)(b), which provides that a "sole proprietorship" means a business entity or individual who performs labor without the assistance of "others." I agree with K-Mart that "others" could mean other contractors or entities engaged to assist in performing labor, and not just laborers hired by the sole proprietor. Therefore, I would find the statutory language to be ambiguous. Accordingly, I would consider the legislative history that K-Mart cites.

In 1985, Senator Starkovich, in referring to the definition of a "person" in HB 2590, inquired whether the current law was being expanded. The Department's witness (Mr. Young) replied that "person" was being expanded to include sole proprietors. (Senate Committee on Labor, May 28, 1985, Tape 151, Side A at 091). Mr. Young further testified that, if a sole proprietor agreed to take a contract and hired others to assist him, he would be required to purchase workers' compensation coverage. Id. at 117-128.

I agree with K-Mart that the above legislative history supports its interpretation of the term "sole proprietor." I recognize that our holding in Dunn is contrary to K-Mart's position. Nonetheless, because our decision in Dunn was reversed by the court, our holding is of limited precedential effect.

Moreover, our opinion in that case does not contain significant analysis of the statutory construction issue, nor does our order refer to the legislative history cited by K-Mart. To the extent that our decision in Dunn holds that a business entity loses it sole proprietor status when it hires employees to assist in its performance of labor, that reasoning should be disavowed.[4]

Accordingly, I would find that CP was an exempt "person" within the meaning of ORS 656.029(2). Thus, I agree with K-Mart that CP should be treated as a non-complying employer under ORS 656.029(2). As such, following the issuance of a Director's non-complying order and referral of the claim to a statutory claims agent, benefits shall be paid to claimant in the manner provided for the payment of benefits to the worker of a noncomplying employer. ORS 656.029(2). It follows that K-Mart is not responsible for claimant's injury claim under that statute.[5]

Based on the above reasoning, I respectfully dissent.

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[4] The majority concludes that ORS 656.029(2) is not applicable because CP was in its employer status when the contract between it and K-Mart was let. However, I would conclude based on the above analysis that a sole proprietor such as CP could be exempt under ORS 656.027(7)(a) and still have employees (i.e., be an employer).

[5] Given a finding that K-Mart is not responsible for claimant's injury claim, it follows that claimant's remedy would be with the claims processor for the noncomplying employer (CP). See Larry G. Falls, 47 Van Natta 234, 235 (1995).

In the Matter of the Compensation of
KENNY R. DAVIS, Claimant
WCB Case No. 95-02310
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Thomas A. Andersen (Wausau), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Mills' order that: (1) upheld the insurer's denial of claimant's aggravation claim for his current low back condition; (2) declined to assess a penalty for an allegedly unreasonable denial; and (3) declined to award claimant an attorney fee under ORS 656.382(2) for his counsel's successful defense of the insurer's appeal of the Order on Reconsideration's temporary disability award. On review, the issues are compensability, penalties, and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt and affirm the ALJ's opinion on this issue, with the following supplementation.

Dr. Aversano, the only physician who arguably supported claimant's current condition claim (Ex. 131), subsequently opined that claimant's November 2, 1995 low back injury was the major contributing cause of his current condition. (Ex. 141). Therefore, claimant has failed to establish the requisite causal connection between his compensable 1992 low back strain injury and his current herniated disc condition at L4-5.

Penalties

Claimant requests penalties and attorney fees for an allegedly unreasonable denial. Inasmuch as we have concluded that claimant's current low back condition is not compensable, there are no

"amounts then due" on which to base a penalty and no unreasonable resistance to the payment of compensation to support a penalty-related attorney fee. See Randall v. Liberty Northwest Ins. Corp., 107 Or App 599 (1991). Accordingly, claimant is not entitled to a penalty or a penalty-related fee.

Attorney Fee

Claimant filed a claim for a low back strain. The insurer closed the claim by a January 6, 1995 Notice of Closure. The notice awarded temporary disability compensation from November 23, 1992 through January 5, 1993 and January 13, 1993 through October 11, 1994, the date claimant was declared medically stationary. (Ex. 118). Claimant sought reconsideration. A February 10, 1995 Order on Reconsideration increased the temporary disability award from November 23, 1992 through January 6, 1993, and from January 13, 1993, through October 11, 1994. (Ex. 124).

The employer sought a hearing, requesting a reduction in claimant's temporary disability award for earnings allegedly received by claimant while receiving temporary disability benefits, and an offset for the overpayment. The ALJ concluded that the insurer failed to prove that claimant received earnings and was thus not entitled to an offset. Citing Strazi v. SAIF, 109 Or App 105 (1991), the ALJ declined to award claimant's counsel an attorney fee pursuant to ORS 656.382(2).

On review, claimant contends that he should be awarded an assessed fee under ORS 656.382(2) for successfully defending against the "overpayment" request. We agree.

To be entitled to a fee under ORS 656.382(2), among other things, an ALJ must have found on the merits that a claimant's compensation award should not have been disallowed or reduced.

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 the claimant was not entitled to an attorney fee award under ORS 656.382(2) for successfully defending against a carrier's offset request. Id. We find Strazi to be distinguishable. In Strazi, the claimant's benefits had been reduced by an Order on Reconsideration. On the claimant's request, an ALJ reinstated the prior award and denied the employer's request for an offset. The ALJ awarded the claimant an attorney fee pursuant to ORS 656.382(2) for having prevailed on the employer's request for an offset. On review, we upheld the increased award, but reversed the ALJ's attorney fee award that had been based on the rejected request for an offset. We held that a request for an offset of an overpayment does not in and of itself place a claimant's benefits at risk of being disallowed or reduced; therefore, we concluded that prevailing on a request for an offset is not a circumstance for which a fee may be awarded under ORS 656.382(2).

We applied the Strazi analysis under similar circumstances in Robert W. Coburn, 49 Van Natta 1778 (1997) and Ernest C. Vroman, 49 Van Natta 809 (1997). In this case, however, unlike Strazi, Coburn and Vroman, the carrier was appealing a TTD award granted by an Order on Reconsideration, attempting to have the award disallowed or reduced. In addition, the carrier requested an offset for any overpayment granted by the ALJ. Consequently, because the insurer's request for an offset represented a challenge to the correctness of the award of compensation, claimant is entitled to attorney fees under ORS 656.382(2) for his counsel's services regarding the TTD issue. See, e.g., 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 insurer's subsequent request for an offset represented a challenge to the correctness of the award of compensation because the parties' very dispute concerned whether the award included an overpayment for which the insurer might claim an offset; therefore, the claimant was entitled to attorney fees under ORS 656.382(2) for prevailing over the insurer's challenge to the award of compensation).

After considering the factors set forth 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 temporary disability issue is $2,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the temporary disability issue (as represented by the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. Finally, claimant is not entitled to an attorney fee for his counsel's efforts in seeking an attorney fee. See Amador Mendez, 44 Van Natta 736 (1994).

ORDER

The ALJ's order dated April 30, 1997 is reversed in part and affirmed in part. That portion of the order declining to award an assessed attorney fee is reversed. Claimant is awarded a fee of $2,000 for prevailing on the TTD issue at hearing, to be paid by the insurer. The remainder of the order is affirmed.

April 2, 1998 Cite as 50 Van Natta 648 (1998)

In the Matter of the Compensation of
PATRICK L. EDWARDS, Claimant
Own Motion No. 98-0106M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable loose bodies-left elbow. Claimant's aggravation rights expired sometime in 1978[1]. 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 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 was not in the work force at the time of the current disability. Claimant has not responded to SAIF's contention. Claimant has the burden of proof on this issue and must provide 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 the prospective employer, or a letter from a doctor stating that a work search would be futile because of claimant's compensable condition for the period in question.

Accordingly, claimant's request for temporary disability compensation is denied. See id. We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order.

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

IT IS SO ORDERED.

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[1] SAIF contends it first closed claimant's file in 1973 but the file was destroyed and an exact closure date is unavailable.

In the Matter of the Compensation of
DAVID E. McATEE, Claimant
WCB Case No. 97-01943
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that: (1) upheld the self-insured employer's denial of claimant's current low back condition; and (2) declined to assess penalties for the employer's allegedly unreasonable denial. On review, the issues are compensability and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant injured his low back when he slipped and twisted his back while unloading a trailer for the self-insured employer on November 6, 1996. (Ex. 1). Claimant reinjured his low back in a second slipping incident with the employer in early December 1996. (Ex. 22). Claimant was treated by Dr. Johnson, M.D., who attributed his symptoms to the combined effects of an acute strain injury with the employer and a preexisting low back condition. Dr. Johnson further opined that claimant's injury with the employer was initially the major contributing cause of claimant's need for treatment, but that the strain should have resolved and studies indicated no other reason for the ongoing symptoms except the degenerative condition. (Ex. 28).

Claimant filed a new injury claim with the employer, and it issued a January 30, 1997 acceptance of "acute lumbar strain (combined condition)." (Ex. 29). On January 31, 1997, the employer issued a denial of claimant's current condition based on the assertion that his preexisting condition is now the major contributing cause of his medical treatment. (Ex. 30). Claimant requested a hearing regarding that denial.

Claimant's preexisting degenerative disc condition is related to an accepted claim with Wausau for a 1981 low back injury with a prior employer. Claimant's 801 Form for that injury did not reference a diagnosis and listed the affected body part as "right side low back." Wausau accepted the injury by checking the appropriate box on the claim form. (Ex. B). Claimant was ultimately diagnosed with an L5-S1 disc herniation which was surgically repaired in October 1981. The Wausau claim was reopened in January 1983 for an aggravation of claimant's low back condition resulting in further surgery at the L4-5 and L5-S1 levels in August 1983. (Exs. G, H). Operative findings included a recurrent disk herniation at L5-S1, degenerative disc disease at L4-5, and degenerative facet disease at L4 through S1. (Ex. I). The Wausau claim was then reclosed with a total award of 35 percent unscheduled permanent disability for the low back condition, and 5 percent scheduled permanent disability for the right leg. (Exs. D, J).

Claimant did not file a claim with Wausau for his current condition or otherwise attempt to join Wausau as a party in this litigation.

CONCLUSIONS OF LAW AND OPINION

Compensability

On review, claimant contends that the ALJ erred in concluding that the employer's current condition denial was valid under ORS 656.308(1). We agree.

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).

The ALJ concluded that this statutory provision had no application in the present case. In reaching that conclusion, the ALJ reasoned that: the employer's denial was issued after its acceptance of an initial claim for a combined condition under ORS 656.005(7)(a)(B)[1]; the denial was not subject to ORS 656.308(1) because that provision only applied to a denial of an initial claim, as distinct from a denial issued after an acceptance of an initial claim; and the employer's denial was otherwise valid under ORS 656.262(6)(c) and (7)(b).[2]

After the ALJ issued his order in this case, the Board addressed a similar situation in Daral T. Morrow, 49 Van Natta 1979, on recon, 49 Van Natta 2105 (1997). In Morrow, the claimant had a compensable claim with the SAIF Corporation for a 1991 low back injury with a prior employer. The claimant then reinjured his low back in 1994 while working for a self-insured employer. Both SAIF and the self-insured employer denied responsibility. The matter proceeded to hearing, and a litigation order transferred responsibility to the self-insured employer under ORS 656.308(1) based on a finding that the claimant had sustained a "new compensable injury." The employer subsequently issued a current condition denial on the basis that the 1991 injury had become the major contributing cause of the claimant's current need for treatment or disability. The claimant challenged the employer's current condition denial, and the matter ultimately came before the Board on review.

The claimant in Morrow did not join SAIF as a party in that litigation. Nevertheless, we concluded that the self-insured employer's current condition denial was invalid because it was inconsistent with the express language of ORS 656.308(1). In reaching that decision, we reasoned that ORS 656.262(6)(c) and (7)(b) have no application when a compensable preexisting condition combines with a subsequent accidental injury. We further reasoned that ORS 656.308(1) operates together with ORS 656.005(7)(a) to assign responsibility in such situations, and that the self-insured employer was responsible for the claimant's injury claim under ORS 656.308(1).

In reaching this conclusion, we reasoned that the employer's current condition denial was inconsistent with the express terms of 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," and the express terms that "all further compensable medical services and disability involving the same condition shall be processed as a new injury claim by the subsequent employer." We further reasoned that the absence of any reference to the term "new compensable injury" in ORS 656.262(6)(c) and (7)(b) demonstrated that the legislature did not intend for these provisions to apply in situations where the carrier has accepted a "new compensable injury" within the meaning of ORS 656.308(1).

We now conclude that our analysis in Morrow is controlling in the present case. As in Morrow, claimant's decision not to join Wausau as a party in this litigation does not create a procedural bar to claimant's claim. The record otherwise establishes that claimant's preexisting degenerative disc

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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."

[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."

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."

condition was processed as part of his prior accepted injury claim with Wausau.[3] Furthermore, Dr. Johnson's unrebutted medical opinion establishes that this compensable preexisting degenerative condition combined with claimant's subsequent accidental injury with the employer in the present case. Thus, ORS 656.308(1) operates together with ORS 656.005(7)(a) to assign responsibility for claimant's combined condition. Moreover, by issuing an acceptance of claimant's injury claim as an "acute lumbar strain (combined condition)," the present employer accepted responsibility for a "new compensable injury" within the meaning of ORS 656.308(1). Furthermore, the employer does not now contend that claimant's current medical treatment and disability is not compensably related to his employment generally, or that claimant has sustained another "new compensable injury" that would shift responsibility to a subsequent carrier. Consequently, pursuant to the express terms of ORS 656.308(1), the employer remains responsible for claimant's current low back condition.

In reaching this decision, we recognize certain factual distinctions between the present case and Morrow. Specifically, while the employer in Morrow was found responsible for the claimant's condition as a result of litigation under ORS 656.308(1), the present employer voluntarily accepted claimant's combined condition without litigation. Nevertheless, this factual distinction is not dispositive. Applicability of ORS 656.308(1) is not contingent on litigation under that provision and, instead, operates together with ORS 656.005(7)(a) to assign responsibility when a claimant sustains a "new compensable injury," i.e., a compensable preexisting condition that combines with a second compensable injury. Given Dr. Johnson's unrebutted medical opinion and the employer's acceptance of an "acute lumbar strain (combined condition)," we conclude that claimant sustained a "new compensable injury" within the meaning of ORS 656.308(1). Consequently, the employer's further processing of this claim is limited by the express terms of that statutory provision, and it cannot avail itself of ORS 656.262(6)(c) and (7)(b) to shift responsibility backward. Rather, as provided in ORS 656.308(1), the employer remains responsible for future compensable treatment and disability for claimant's "acute lumbar strain (combined condition)" unless he sustains a subsequent "new compensable injury." Thus, we conclude that the employer's current condition denial is procedurally invalid and must be set aside on that basis.

Claimant is entitled to an assessed attorney fee for prevailing over the employer'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, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the hearing record and claimant's appellate briefs), the complexity of the issue, the risk that claimant's counsel might go uncompensated, and the value of the interest involved.

Penalties

Claimant contends that he is entitled to a penalty for the employer's allegedly unreasonable current condition denial. We disagree.

Claimant is entitled to a penalty if the employer "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 employer 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 employer at the time it denies benefits. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

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[3] Whether an acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449 (1992). Here, Wausau did not issue a formal acceptance and, instead, checked the acceptance box on an 801 Form that did not reference a diagnosis and listed the affected body part as "right side low back." When the carrier does not identify the specific condition accepted, we look to contemporaneous medical records to determine what condition was accepted. Mary Marrs-Johnston, 49 Van Natta 1757 (1997); Timothy Hasty, 46 Van Natta 1209 (1994). Here, the contemporaneous medical documents establish that claimant's "right side low back" symptoms were caused by a herniated L5-S1 disc that was surgically repaired. The contemporaneous medical documents further establish that Wausau subsequently reopened the injury claim for further treatment of claimant's degenerative condition, including surgery to repair a recurrent L5-S1 disc herniation. On this record, we conclude that claimant's current condition involves the same degenerative changes and related surgeries that were part of the accepted claim with Wausau.

At the time the employer issued its current condition denial in this case, there was no legal decision holding that, once a compensable preexisting condition combines with a subsequent accidental injury, future claims processing is subject to the requirements of ORS 656.308(1), rather than ORS 656.262(6)(c) and (7)(b). Accordingly, we find that the employer had a legitimate doubt regarding its legal liability for claimant's current condition, and that a penalty is not warranted.

ORDER

The ALJ's order dated July 9, 1997, as republished on August 12, 1997, is reversed in part and affirmed in part. The self-insured employer's January 31, 1997 denial is set aside, and the claim is remanded to the employer for processing in accordance with law. Claimant's attorney is awarded an assessed fee of $5,000 for services at hearing and on Board review, to be paid by the employer. The ALJ's order is otherwise affirmed.

In the Matter of the Compensation of
MICHELLE R. NASSET, Claimant
WCB Case No. 97-04890
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order that reduced her award of unscheduled permanent disability from 32 percent (102.4 degrees), as awarded by an Order on Reconsideration, to 10 percent (32 degrees). On review, the issue is unscheduled permanent disability.

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

Claimant sustained a compensable cervical strain and cerebral concussion after she fell at work. After her attending physician, Dr. Stringham, declared claimant's injuries medically stationary without permanent impairment in January 1997, a Determination Order closed the claim without an award of permanent disability. (Ex. 59). Claimant requested reconsideration, which resulted in a medical arbiter's examination that included a psychiatric examination to evaluate the permanent residuals, if any, from claimant's head injury.

An Order on Reconsideration issued on May 21, 1997, which awarded 32 percent unscheduled permanent disability based on reduction in cervical range of motion and a Class II (30 percent) rating of claimant's head injury by Dr. Bellville, the psychiatric examiner, pursuant to OAR 436-035-0390(10). (Ex. 64). The employer requested a hearing challenging the award.

The ALJ reduced the unscheduled permanent disability award, eliminating the value given for loss of cervical range of motion and determining that the residuals of claimant's head injury placed her in Class I (10 percent) of head/brain impairment. Accordingly, the ALJ modified the reconsideration order and reduced claimant's unscheduled permanent disability award to 10 percent.

On review, claimant does not contest the ALJ's elimination of her permanent disability based on cervical range of motion. Instead, claimant argues that the reconsideration order's 30 percent award for head/brain impairment should be reinstated.[1] In particular, claimant asserts that we should defer to Dr. Bellville's assessment of her permanent impairment because he was specifically assigned to determine the residuals from her head injury. We disagree.

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[1] The employer does not seek further reduction of claimant's permanent disability award. (Respondent's brief page 1).

Dr. Bellville rated claimant's impairment as Class II based on his assessment that she had minimal to mild visual sensitivities and a mild degree of residual depression with symptoms of low energy and loss of interest in some usual activities. (Ex. 62-5). Although Dr. Bellville's report indicated that he reviewed some unspecified medical records, he did not acknowledge that claimant had received vision therapy from an optometrist, Dr. Vasche, who reported that claimant's visual system had returned to normal. (Ex. 52). Dr. Stringham concurred with this assessment in his closing examination. (Ex. 56). See Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666, 670 (1994) (impairment findings of a consulting physician may be considered in determining permanent impairment, provided the attending physician concurs with those findings). Moreover, Dr. Bellville did not refer to treatment that claimant had received for non-work related depression. (Exs. 45, 48).

Because Dr. Bellville gave no indication that he considered this medical evidence in making his evaluation of claimant's permanent impairment, we cannot conclude that his characterization of claimant's head impairment as Class II is well-reasoned and based on an accurate history. See Kenneth W. Matlack, 46 Van Natta 1631 (1994) (Board does not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment); Carlos S. Cobian, 45 Van Natta 1582 (1993) (Board relies on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment). Thus, we find that the ALJ properly declined to defer to Dr. Bellville's assessment. See Deborah S. Amundsen, 49 Van Natta 1156, 1158 (1997) (Medical arbiter's reasoning insufficient to support Class II brain impairment). Finally, we agree with the ALJ's reasoning that claimant's impairment should be classified as Class I.

ORDER

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

April 2, 1998 Cite as 50 Van Natta 653 (1998)

In the Matter of the Compensation of
MICHAEL HECTOR, Claimant
Own Motion No. 98-0149M
OWN MOTION ORDER
Wausau Ins. Co., Insurance Carrier

The insurer has voluntarily reopened claimant's claim pursuant to ORS 656.278 for his compensable amputated left index finger. Claimant's aggravation rights expired on May 6, 1997. The insurer asks the Board to authorize the reopening of claimant's claim.

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

In an operative report dated January 29, 1998, Dr. Seyfer, claimant's treating surgeon, noted that claimant underwent an excision of the first web space neuroma. Thus, we conclude that claimant's compensable injury has worsened requiring surgery. We therefore have the authority to authorize the reopening of claimant's claim for temporary disability compensation commencing January 29, 1998, the date he was hospitalized for the surgery. Id.

Accordingly, the information submitted to us demonstrates that the reopening of claimant's claim was appropriate. 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
GUILEBALDO G. RAMIREZ, Claimant
WCB Case No. 97-05219
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Baker's order that awarded no permanent disability, whereas an Order on Reconsideration had awarded 8 percent (25.6 degrees) unscheduled permanent disability for thoracic and low back conditions and 4 percent (6 degrees) for loss of use or function of the left hand. On review, the issue is extent of permanent disability. We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Scheduled Permanent Disability: Left Hand

The ALJ found that claimant failed to prove left hand impairment, based on the evidentiary record. We reach a different result.

A January 23, 1997 Determination Order awarded 5 percent scheduled permanent disability for loss of use or function of claimant's left hand. Claimant requested reconsideration, seeking an increased award. SAIF did not raise the issue of permanent disability on reconsideration.

A June 4, 1997 Order on Reconsideration reduced claimant's scheduled award to 4 percent (and awarded 8 percent unscheduled permanent disability for lost thoracic and lumbar range of motion).

SAIF requested a hearing, seeking reduction of claimant's awards to zero.

The ALJ reduced claimant's scheduled award to zero, based on the evidentiary record. We conclude that the Determination Order award must be reinstated, based on the following reasoning.

In Duncan v. Liberty Northwest Ins. Corp., 133 Or App 605, (1995), the court explained preservation of issues under the "ORS 656.283(7)" reconsideration process:

> "Claimant asserts, and we agree, that employer is barred from challenging the determination order award at a hearing because it did not seek reconsideration. A party may seek review of the order on reconsideration, but when a party objects at a hearing to a part of the reconsideration order that merely affirms the determination order, the party's true objections are to the determination order and ORS 656.268(5) forecloses the objection if no request for reconsideration was made. Thus, the determination order becomes the instrument that defines the maximum or minimum awards when a party fails to raise its objections through a request for reconsideration. However, if the reconsideration order changes the determination order, the propriety of that change can be raised by either party at a hearing. In this case, the determination order served as a floor, and employer could not seek reduction of the temporary or permanent disability benefits below that level because it did not request reconsideration on those issues." Duncan, 133 Or App at 610-611; see Diane's Foods v. Stephens, 133 Or App 707 (1995).

Here, as in Duncan, SAIF did not object to the Determination Order's scheduled permanent disability award during the reconsideration process. Consequently, the Determination Order's 5 percent scheduled permanent disability award is the "floor," and SAIF could not seek reduction below that level

at hearing. See Roger R. Powers, 49 Van Natta 1388 (1997). Accordingly, claimant's 5 percent scheduled permanent disability award is reinstated.[1]

Unscheduled Permanent Disability: Back Condition

We agree with the ALJ that neither the treating doctors' reports nor the medical arbiter's report constitute a preponderance of persuasive medical evidence supporting unscheduled permanent disability awards for claimant's thoracic or low back conditions.[2] See ORS 656.726(3)(f)(B). Accordingly, we adopt the ALJ's opinion on the merits of the unscheduled permanent disability issues.

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).

Finally, because claimant successfully defended against SAIF's request for reduction or disallowance of claimant's scheduled permanent disability award, claimant is entitled to an employer-paid attorney fee under ORS 656.382(2) for services at hearing.

After considering the factors set forth 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 for successfully defending against SAIF's request for reduction of his scheduled permanent disability award is $1,200, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the "scheduled reduction" issue (as represented by the hearings record and claimant's counsel's statement of services), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might be uncompensated.

ORDER

The ALJ's order dated December 2, 1997 is reversed in part and affirmed in part. That portion of the order that reduced claimant's scheduled permanent disability award for loss of use and function of the left hand to zero is reversed. The Order on Reconsideration is modified. Claimant is awarded 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of his left hand. 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 regarding the SAIF Corporation's attempt to reduce claimant's scheduled permanent disability as awarded by Determination Order, claimant's attorney is awarded a fee of $1,200, to be paid by SAIF. The remainder of the order is affirmed.

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[1] We acknowledge SAIF's contention that claimant should be barred from arguing on review that it is "precluded" from seeking reduced scheduled permanent disability, because claimant did not raise the preservation argument at hearing. We disagree. In this regard, we note that SAIF's challenge to the Determination Order's award was legally precluded under ORS 656.268(5) by SAIF's failure to request reconsideration regarding the Determination Order award (as explained above). Thus, the threshold determination at the hearings level should have been that SAIF's challenge to the award was statutorily precluded. Had that been determined, claimant's defense to the challenge would have been unnecessary. Under these circumstances, we conclude that substantial justice is served by reinstating the Determination Order's scheduled disability award in this case.

[2] We acknowledge the parties' dispute about the burden of proof. However, because the result would be the same (on this record) wherever the burden of proof rests, we need not address the issue.

In the Matter of the Compensation of
JANET Y. STUDER, Claimant
WCB Case No. 97-01321
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Hall and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that: (1) affirmed an Order on Reconsideration that awarded no scheduled permanent disability beyond the 7 percent (13.44 degrees) for the loss of use and function of the left arm awarded by a prior Notice of Closure; and (2) affirmed claimant's scheduled permanent disability award for the loss of use and function of the right forearm (wrist) of 9 percent (13.5 degrees), as awarded by an Order on Reconsideration. On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following exception. We do not adopt the ALJ's finding of fact number 8 regarding chronic condition impairment.

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted bilateral carpal tunnel syndrome claim that was closed by a Notice of Closure that awarded 7 percent scheduled permanent disability for each arm. The claim was reopened as an aggravation.

Following closure of the aggravation claim, claimant requested reconsideration of a Notice of Closure that awarded no additional scheduled permanent disability. Relying on a medical arbiter's report, an Order on Reconsideration awarded claimant 9 percent scheduled permanent disability for the right forearm (wrist), based on reduced range of motion, and nothing for the left forearm (wrist).

At hearing and on review, claimant contends that she is entitled to an award of 5 percent scheduled permanent disability due to a chronic and permanent medical condition.

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) [.]"

Claimant was examined for SAIF by Dr. Button on August 14, 1996. Dr. Button noted that claimant had returned to her regular work, but with "leeway" to vary tasks depending upon her level of symptoms. (Ex. 90-6). Dr. Button also noted that claimant's carpal tunnel syndrome had affected her daily life, because she was no longer able to sew or crochet, and she had "difficulty doing household duties, such as opening containers, etc." (Ex. 90-2). Dr. Button also found, through a review of claimant's past medical records, that claimant had lost grip and pinch strengths that were attributable to the residuals of the CTS, and not to the minor arthritic process in her left thumb. (Ex. 90-6). Finally, Dr. Button viewed claimant's impairment as in the mild range bilaterally. (Id.).

On August 22, 1996, Dr. Teal, claimant's attending physician, noted the fact that, although claimant continued to improve, she was not doing as much computer work, which seemed to bother her. (Ex. 91). On October 1, 1996, Dr. Teal concurred with Dr. Button's report.

When seen by the medical arbiter panel on January 25, 1997, claimant provided a history that she still had aching in her hands, particularly when doing a considerable amount of typing or word processing, and that such activity required her to take Ibuprofen and to slow down on occasion. (Ex. 100-2). The arbiter panel nevertheless concluded that, based on their examination, "this worker shows no objective impairment to repetitively retard the use of the hands, wrists or forearms due to a diagnosed chronic and permanent medical condition arising out of the accepted injury." (Ex. 100-4).

We find that Dr. Button's opinion, as concurred in by Dr. Teal, is more persuasive than the conclusory report of the medical arbiters, and establishes that claimant is significantly limited in the repetitive use of her wrists. Somers v. SAIF, 77 Or App 259 (1986). Dr. Button's report establishes that claimant is limited in her ability to repetitively perform tasks involving her wrists, particularly in regard to her work activities such as typing or word processing. As reported by Dr. Button, and concurred in by Dr. Teal, claimant is allowed "leeway" while performing her assignments, in which she requires medication and working at a slower pace. In addition, claimant is unable to sew or crochet and is limited in performing household tasks which require the use of the wrists. In light of such circumstances, we find that claimant is not able to perform as many repetitions with her hands and wrists. Although Dr. Button did not use the term "significantly limited" in rendering his opinion, "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 scheduled chronic condition impairment value for each forearm (wrist).

On reconsideration, claimant was awarded 9 percent scheduled permanent disability for lost range of motion of the right forearm.[1] Combining this value with a value of 5 percent for a chronic condition results in an overall value of 14 percent scheduled permanent disability for the loss of use and function of the right forearm. Former OAR 436-035-0007(17)(a).

We apply similar reasoning regarding claimant's left forearm award. Combining claimant's undisputed prior lost range of motion value (7 percent) with her 5 percent "chronic condition" value results in an overall impairment value of 12 percent scheduled permanent disability for the loss of use and function of the left forearm. (Id.)

ORDER

The ALJ's order dated June 5, 1997 is modified. In addition to the Order on Reconsideration's award of 9 percent (13.5 degrees) scheduled permanent disability for loss of use or function of the right forearm (wrist), claimant is awarded 5 percent (7.5 degrees) scheduled permanent disability, for a total award to date of 14 percent (21 degrees) for the loss of use or function of the right forearm (wrist). In lieu of the Order on Reconsideration that did not grant scheduled permanent disability beyond claimant's prior award of 7 percent (13.44 degrees) scheduled permanent disability for the left arm, claimant is awarded 12 percent (18 degrees) for the loss of use or function of the left forearm (wrist). 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.

[1] This amount was not disputed by the parties.

In the Matter of the Compensation of
NADINE D. SHOOK, Claimant
WCB Case No. AF-97028
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Garaventa's order that denied her request for an approved attorney fee. On review, the issue is attorney fees.

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

Claimant contends that she is entitled to an approved attorney fee from increased compensation in the form of permanent disability benefits. Claimant argues that those benefits flow directly from her counsel's efforts in obtaining Department approval of claimant's surgery. Claimant further contends that the cases relied on by the ALJ, see Julie A. Johnson, 48 Van Natta 29 (1996); Rogelio Munoz-Martinez, 47 Van Natta 1412 (1995) are distinguishable.

We agree that the facts of Johnson and Munoz-Martinez are distinguishable. Nevertheless, the holdings of those cases are applicable in this matter. Specifically, we have held that where the compensation is not awarded or approved by the Hearings Division or the Board, neither the ALJ nor the Board has the authority to approve an out-of-compensation attorney fee. Julie A. Johnson, 48 Van Natta at 30.

Accordingly, because there is no compensation in this case that was awarded or approved at the Hearings Division or Board level, we conclude that the aforementioned cases are on point. Moreover, we adhere to our decisions in those cases. Therefore, the ALJ's order is affirmed.

ORDER

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

In the Matter of the Compensation of
MARY I. WYTCHERLEY, Claimant
WCB Case No. 96-09601
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

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

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

In 1985, claimant injured her low back while working for another employer. The ALJ concluded that claimant proved compensability of her current low back condition under ORS 656.005(7)(a)(B). The ALJ reached this conclusion in part based on the opinion of claimant's treating neurosurgeon, Dr. Grewe. On review, the employer contends that the claim should be analyzed under ORS 656.802(2)(b) and also disputes the ALJ's reliance on Dr. Grewe's opinion.

We agree with the ALJ concerning the application of ORS 656.005(7)(a)(B), as well as his conclusion that Dr. Grewe based his opinion on an accurate history that claimant did not experience low back symptoms for a period of time before the 1996 injury. We supplement to address the persuasiveness of the medical opinions.

On August 12, 1996, claimant first sought treatment for low back pain. Claimant saw Dr. Grewe on October 29, 1996 and was diagnosed with a herniated disc; Dr. Grewe subsequently performed surgery for the condition.

Following the surgery, Dr. Rich, a neurologist who previously treated claimant in 1988, performed a record review on behalf of the employer. Dr. Rich first indicated that Dr. Grewe's surgery findings that the herniated disc had adhered to the bone showed that the herniation "was likely significantly older than the claimant's employment" with the employer. (Ex. 107-2). According to Dr. Rich, the rupture of a disc is accompanied with a "pop" or "tearing sensation." (Id.) Dr. Rich indicated that claimant's history of gradual onset and worsening did not support an acute disc herniation from her work. (Id.) Based on these factors, and the "suspicion" of "disc involvement" during treatment of claimant's prior low back injury, Dr. Rich thought it more likely that claimant's low back condition preexisted her 1996 employment. (Id. at 2-3).

Dr. Grewe was then deposed on two occasions. He testified that he thought the appearance of the herniated disc during surgery showed that it was of "recent origin" because it was "stuck to the endplates" and an older herniation "separates from the endplates." (Ex. 109A-29). Dr. Grewe further explained that the disc was not "healthy" before her employment because claimant had previously experienced similar symptoms. (Id. at 37). According to Dr. Grewe, claimant had a preexisting low back condition that combined with an injury in 1996 to result in her present need for treatment and disability. (Id. at 43). Based on claimant's history, Dr. Grewe stated that the major contributing cause of claimant's need for treatment of the combined condition was claimant's work. (Id. at 44). In particular, Dr. Grewe thought that claimant's "week's worth of activity handling that heavier [10 foot] veneer" was the major contributing cause of the disc herniation. (Id. at 52).

Absent persuasive reasons to the contrary, we generally defer to the treating physician's opinion. Weiland v. SAIF, 64 Or App 810 (1983). Here, we find no reasons not to defer to Dr. Grewe's opinion. Dr. Grewe provided a well-reasoned opinion in that he explained why he thought the disc herniation was recent and was the result of a "combined condition." As indicated above, Dr. Grewe's opinion also was based on an accurate history. The only rebutting opinion was from a physician who did not perform the surgery or examine claimant following her 1996 injury.

For these reasons, we conclude that Dr. Grewe provided the most persuasive opinion. Based on that opinion, we agree with the ALJ that claimant proved compensability of the need for treatment and disability 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 $1,500, 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 July 28, 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
LLOYD S. ABRAHAM, Claimant
WCB Case No. 97-06827
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 Administrative Law Judge (ALJ) Hoguet's order that: (1) awarded 14 percent (44.8 degrees) unscheduled permanent disability for a low back condition; and (2) awarded 5 percent (7.5 degrees) scheduled permanent disability for the loss of use or function of the left leg, whereas an Order on Reconsideration awarded no permanent disability. On review, the issues are extent of unscheduled and scheduled permanent disability. We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

As the result of a September 1996 injury, claimant has an accepted claim for "lumbar sprain/strain." A Determination Order awarded only temporary disability. After requesting reconsideration, claimant underwent an examination with the medical arbiter, Dr. Peterson. The Order on Reconsideration affirmed the Determination Order.

Relying on the medical arbiter's report, the ALJ awarded 14 percent unscheduled permanent disability and 5 percent scheduled permanent disability. The insurer challenges both awards.

Extent of Unscheduled Permanent Disability

Dr. Peterson's report found that range of motion measurements were valid. (Ex. 15-4). The report further noted that claimant had a "pre-existing injury to the lumbar spine." (Id.) Dr. Peterson added:

> "Without access to prior medical records it is impossible to determine what percentage of lumbar range of motion loss is attributable to the previous condition and what percentage may be due to the present accepted condition. Inasmuch as [claimant] now has evidence of mild left lower extremity radiculopathy, it stands to reason that a portion of this lumbar range of motion loss is attributable to the current accepted injury. It is unclear whether it is 100% attributable to the present injury." (Id.)

The report subsequently stated that, "[w]ithout access to prior medical records I cannot hazard a guess as to what [claimant's] condition was prior to the injury and therefore cannot accurately apportion [the percentage of impairment due to the accepted condition]." (Id. at 5).

Based on Dr. Peterson's range of motion measurements, the ALJ found claimant entitled to 14 percent unscheduled permanent disability. The ALJ reasoned that range of motion "must be attributable to claimant's compensable lumbar strain" because, as required by OAR 436-035-0007(5), the preponderance of medical evidence did not show that disability from a prior injury was present at the time of claimant's 1996 injury and, thus, no offset was warranted.

Although the record shows that claimant has a prior history of low back pain in 1990, (see Ex. 15-3), the record does not indicate that claimant has a prior workers' compensation claim. OAR 436-035-0007(5)[1] applies in deciding whether permanent disability from a prior claim should be offset against permanent disability awards in subsequent claims. Because there is no evidence that claimant has a prior permanent disability award, or even a prior workers' compensation claim, we find that OAR 436-035-0007 does not apply in this case.[2]

In order to be entitled to unscheduled permanent disability, however, claimant must show "permanent loss of earning capacity due to the compensable injury." ORS 656.214(5), OAR 436-035-0005(16). Unrelated impairment findings are excluded and not given a value. OAR 436-035-0007(2). When a worker has a "superimposed condition," and the compensable injury is the major contributing cause of the "overall condition," impairment is apportioned. Id. Only that portion of impairment findings "due to the compensable condition" receives a value. OAR 436-035-0007(2)(a).

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[1] The rule provides, in relevant part:

"(5) 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 and ORS 656.214. For purposes of these rules only, a prior Oregon workers' compensation claim is not considered a preexisting condition.

"(a) Before actually 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.

"* * * * *

"(c) For unscheduled disability, a worker is not entitled to be doubly compensated for a permanent loss of earning capacity in an unscheduled body part which would have resulted from the current injury or disease but which had already been produced by an earlier injury or disease and had been compensated by a prior award. * * *."

[2] Because there is an absence of evidence that claimant sustained a prior work injury or disease, we also find no merit to claimant's argument that the insurer was required to issue a denial of responsibility under ORS 656.308(1) in order to dispute, as claimant states, that "it is not responsible for the disability to which the claimant is entitled as a result of the combined condition[.]"

Here, because Dr. Peterson indicated that she could only "hazard a guess" and "considered it impossible" to determine what portion of claimant's impairment was due to the compensable condition, we find a lack of persuasive evidence concerning what portion, if any, of claimant's impairment should be given a value. In other words, Dr. Peterson's report does not provide a preponderance of evidence regarding claimant's impairment "due to the compensable condition." Consequently, we agree with the insurer that claimant is not entitled to unscheduled permanent disability.[3]

Extent of Scheduled Permanent Disability

We adopt and affirm this portion of the ALJ's order.

Claimant's attorney is entitled to an assessed fee for services on review concerning the 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 is $600, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated December 3, 1997 is reversed in part and affirmed in part. That portion of the ALJ's order that awarded claimant 14 percent (44.8 degrees) unscheduled permanent disability is reversed. The award of zero percent unscheduled permanent disability made by the Order on Reconsideration is reinstated and affirmed. The remainder of the ALJ's order is affirmed. The attorney fee award made by the ALJ is adjusted accordingly. For services on review concerning the scheduled permanent disability award, claimant's counsel is awarded a reasonable assessed attorney fee of $600, payable by the insurer.

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[3] The only other evidence in the record concerning claimant's impairment is a report from examining physicians, Dr. Bald and Dr. Farris. Claimant's treating chiropractor, Dr. Robinson, concurred with the report. The ALJ found that, at the time of claim closure, Dr. Robinson did not qualify as claimant's "attending physician" and, consequently, decided that only Dr. Peterson's report could be considered for purposes of rating impairment. We note that the insurer on review does not contest this portion of the ALJ's report. Furthermore, because the report from Drs. Bald and Farris found no permanent impairment, our conclusion would not change whether or not we considered it in deciding extent of unscheduled permanent disability.

In the Matter of the Compensation of
DAVID J. BRUNSWICK, SR., Claimant
WCB Case Nos. 97-05010, 96-10942 & 96-06580
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Agricomp Insurance requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) set aside its denial of claimant's injury claim for an L4-5 disk condition; (2) upheld the SAIF Corporation's denial of claimant's aggravation/new medical condition claim for the same condition; and (3) assessed penalties for Agricomp's allegedly unreasonable compensability denial. On review, the issues are compensability, responsibility and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt and affirm the ALJ's "Findings of Fact," with the exception of the last sentence of the final paragraph of those findings.

CONCLUSIONS OF LAW AND OPINION

Compensability/Responsibility

On review, Agricomp challenges the ALJ's conclusion that claimant's current L4-5 disc condition is compensably related to a February 19, 1996 injury with Agricomp's insured, and the responsibility of Agricomp rather than SAIF. Agricomp accepted the February 19, 1996 injury as a low back strain, and claimant has a prior accepted injury claim with SAIF for a May 13, 1987 low back strain. Claimant's current condition has been diagnosed as a posterior and anterior L4-5 disc protrusion.

In reaching his decision, the ALJ relied on the opinion of the treating neurosurgeon, Dr. Misko, that claimant's 1996 injury with Agricomp is the major contributing cause of the current need for treatment. The ALJ did not explain whether he was analyzing responsibility under ORS 656.308 or Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984).

We agree that Dr. Misko's opinion is persuasive for the reasons stated by the ALJ. In addition, we note that Dr. Misko explained that, even assuming that claimant sustained a posterior L5 disk herniation at the time of the 1987 SAIF injury, the 1996 Agricomp injury was probably the major contributing cause of a new anterior disk protrusion which requires fusion surgery. As Dr. Misko's opinion is based on the contribution of the new anterior disk protrusion, it is not undermined by the fact he did not read the actual 1987 CT scan.

Accordingly, based on Dr. Misko's opinion, we conclude that the 1996 Agricomp injury is the major contributing cause of claimant's current need for treatment. Consequently, claimant has established that her current L4-5 disc condition is compensably related to the 1996 Agricomp injury, and that Agricomp is responsible for that condition under either ORS 656.308 or Kearns.

Claimant's attorney is entitled to an attorney fee for prevailing over Agricomp's request for review regarding its denial of claimant's current L4-5 disc condition. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, to be paid by Agricomp. 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.

Penalties

Agricomp also challenges the ALJ's assessment of a penalty for its allegedly unreasonable compensability denial. Claimant is entitled to a penalty if the carrier "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." ORS 656.262(11)(a). The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991). "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the information available to the carrier at the time of the denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

Here, the ALJ concluded that Agricomp's compensability denial was unreasonable because the record did not include a medical opinion that the current L4-5 condition is not compensable. Agricomp argues that a penalty is not warranted because the medical evidence created a legitimate doubt regarding the compensability of the claim as to Agricomp, specifically. We agree. As the claim against Agricomp is based on a specific work injury, claimant must establish compensability based on that injury, without regard to any contribution from the prior SAIF injury.

Agricomp issued its May 28, 1996 denial after receiving the opinions of Drs. Martens, Farris and Silvers that the 1996 injury was limited to a lumbar strain which resolved and in no way contributes to claimant's current L4-5 disc condition. (Exs. 27 and 30). Agricomp subsequently received a similar opinion from Dr. Scheinberg (Ex. 32A), as well as an alternative opinion from Dr. Williams that degenerative lumbar disease preexisting the 1996 injury is the major contributing cause of the treatment and disability related to claimant's current L4-5 condition. These opinions provided a legitimate basis for Agricomp's May 28, 1996 compensability denial and its subsequent refusal to concede compensability. Accordingly, we find that Agricomp acted reasonably in this matter and is, therefore, not liable for a penalty.

ORDER

The ALJ's order dated July 22, 1997 is reversed in part and affirmed 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 denial issued by Agricomp Insurance, claimant's counsel is awarded a $1,500 assessed attorney fee, to be paid by Agricomp.

In the Matter of the Compensation of
ONIE I. COOLEY, Claimant
WCB Case No. 97-04662
ORDER ON REVIEW
Jean M. Fisher, Claimant Attorney
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

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

FINDINGS OF FACT

Claimant, 41 years old at the time of hearing, works for the employer as a warehouseperson. Claimant has sustained three prior work injuries. On September 17, 1990, claimant strained his low back while working for a former employer. The next two injuries occurred while claimant was working for the present employer. On May 26, 1995, claimant strained his right foot. (Ex. 25A). On January 28, 1997, claimant strained his right shoulder. (Ex. 25C). Claimant reported these three prior work injuries within a day of their occurrence. All three injuries were accepted without dispute.

Claimant alleges that, on September 15, 1996, he injured his back at work. He alleges that he felt a pop in his back while lifting a 60 to 70 pound box and turning to place it on a shelf. On September 21, 1996, claimant first sought medical treatment and was diagnosed with right sciatica. Claimant did not report that he was injured at work. Claimant continued to seek medical treatment over the next three months. During that time, his pain progressively worsened, with pain radiating from his low back to his right buttock and lower extremity. He developed a sensory deficit in the right L5 dermatome. Claimant continued working during this period.

During the three month period from September 21, 1996 to December 24, 1996, claimant sought medical treatment for his low back and radicular pain seven times with three separate physicians. He did not report any work-related injury to any physician during that time. He also did not report any work injury to his employer or co-workers.

On December 14, 1996, a lumbar MRI demonstrated a right L4-5 disc herniation, which was not present when claimant had a CT scan of his lumbar spine in August 1991. Dr. Johnson, claimant's treating physician, informed claimant about the disc herniation and referred him to Dr. Collada, neurosurgeon. (Ex. 28, Tr. 23).

On December 24, 1996, Dr. Collada examined claimant and recommended surgery. (Ex. 30). During that exam, claimant made his first report of a work injury. (Ex. 30-1).

On December 26, 1996, claimant filed a low back injury claim with the employer, alleging that he injured his back at work on September 15, 1996, at 10:00 p.m. (Ex. 25D). This was the first notice claimant gave the employer of a work injury.

Claimant underwent surgery for the herniated disc on January 21, 1997. (Ex. 34). On April 15, 1997, claimant was examined by Drs. Marble, orthopedist, and Rich, neurologist, on behalf of the employer. (Ex. 40). At that time, claimant described the alleged work incident and reported that it occurred on September 15, 1996. (Ex. 40-1).

On June 3, 1997, the employer denied claimant's low back injury claim, contending that it did not arise out of and in the course of his employment. (Ex. 43).

The prior accepted September 17, 1990 lumbar strain/sprain with another employer resulted in some radicular symptoms, without any sign of neurological impairment. Claimant was awarded five percent unscheduled permanent disability and eventually had full resolution of his symptoms. Claimant was asymptomatic and did not receive any treatment for his low back for over five years before the alleged lifting incident with the present employer.

Claimant filed an aggravation claim with the prior employer, who denied claimant sustained an aggravation. At hearing, the parties agreed that the only issue is compensability and the present employer will not "point back."

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable low back injury in 1990 while working for a former employer. However, claimant does not contend that this prior injury is responsible in any way for his current low back condition. In any event, the record contains no medical evidence that would support such a contention. Instead, both at hearing and on review, the issue is compensability of the alleged work injury denied by the current employer on June 3, 1997.

Regarding the alleged injury with the current employer, the ALJ concluded that claimant had established that his low back strain with disc herniation at L4-5 arose out of and in the course of his employment. In reaching this conclusion, the ALJ determined that the outcome of the case turned on claimant's credibility and found claimant credible.

On review, the employer argues that the record does not support the ALJ's reasoning and conclusions. For the reasons set forth below, we agree with the employer and find that claimant has failed to prove that his injury occurred within the course and scope of his employment.

Claimant has the burden of proving the compensability of an injury. ORS 656.266. An injury is compensable if it "aris[es] out of and in the course of employment." ORS 656.005(7)(a). The "arising out of" employment prong concerns the causal connection between the injury and the employment. Norpac Foods, Inc. v. Gilmore, 318 Or 363, 366 (1994). The "in the course of" employment prong concerns the time, place and circumstances of the injury. Id. The two prongs constitute a unitary work-connection test, i.e., whether the relationship between the injury and the employment is sufficient that the injury should be compensable. Id. Both the "arising out of" and "in the course of" prongs must be satisfied to some degree. Krushwitz v. McDonald's Restaurants, 323 Or 520, 531 (1996).

The ALJ found claimant credible. Claimant urges us to rely on that finding, arguing that the ALJ based her credibility finding, in part, on claimant's demeanor. Although not statutorily required, the Board generally defers to the ALJ's determination of credibility when it is based on the ALJ's opportunity to observe the witnesses. See Erck v. Brown Oldsmobile, 311 Or 519, 526 (1991). Here, contrary to claimant's argument, there is no indication that the ALJ based her credibility finding on the observation of claimant's demeanor. In any event, we are not required to defer to the ALJ's demeanor findings. See, e.g., Erck, 311 Or at 528 ("Although the Board should seriously consider the testimony the [ALJ] believes to be reliable, the 'substantial evidence' standard does not require the Board to adopt the [ALJ's] findings or to 'explain away' disparities between the Board and the [ALJ's] determinations"); James P. Mishler, 48 Van Natta 2400 (1996) (giving the ALJ's demeanor-based credibility finding little weight in light of inconsistencies between the claimant's testimony and contemporaneous medical documents); John M. Hyde, 48 Van Natta 1553 (1996) (same). Furthermore, 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).

Claimant alleges that, on September 15, 1996,[1] he injured his back at work during a very specific incident when he picked up a 60 to 70 pound box and turned to put it on a shelf. In this process,

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[1] On December 26, 1996, claimant filed an 801 form describing the alleged incident and noting the specific date and time as September 15, 1996 at 10:00 p.m. (Ex. 25D). On April 15, 1997, claimant was examined by Drs. Marble, orthopedist, and Rich, neurologist, on behalf of the employer. (Ex. 40). At that time, claimant described the alleged work incident and reported it occurred on September 15, 1996. (Ex. 40-1). In neither of these reports did claimant express any doubt about the date of the alleged incident. However, at hearing, claimant testified that the date of September 15, 1996 was just an "estimated guess" and the date was "early in September" or "around the first couple of weeks in September." (Tr. 6, 9).

claimant alleges that he felt a "pop" in his low back, but no immediate pain. The incident was unwitnessed and unreported. On September 21, 1996, claimant first sought medical treatment and reported right hip pain. (Ex. 26-1). Claimant first reported the alleged work incident to a physician on December 24, 1996, and to his employer on December 26, 1996. (Exs. 25D, 30).

From September 21, 1996 to December 24, 1996, claimant sought medical treatment for his low back and radicular pain seven times with three separate physicians, all of whom were either claimant's treating family physician (Dr. Johnson, M.D.) or physicians working in her office (Drs. Scherlie, M.D., and Krummel, M.D.). (Exs. 26, 28). During this period, claimant did not report to any of these physicians that his need for treatment was related to a work injury. In addition, an October 24, 1996 chart note from Dr. Johnson contains a handwritten notation indicating there was no injury. (Ex. 26-1). Claimant testified that he did not report the alleged work injury to any of these doctors, stating that none of them asked about any work injury. (Tr. 20, 22, 26). Regarding the indication of no injury on the October 24, 1996 chart note, claimant testified that he did not specifically tell Dr. Johnson that he did not have an injury. (Tr. 22).

Claimant was first examined regarding his current complaint on September 21, 1996, by Dr. Scherlie. (Ex. 26-1). Dr. Scherlie's chart note of that date contains two notations as to when claimant's current complaint began. A hand-written notation indicates that claimant had right hip pain shooting into the right lower leg for two and a half weeks. (Id.) A typed notation indicates claimant's right hip pain has been "present for the past several weeks." (Id.) At hearing, claimant denied telling Dr. Scherlie that the pain had been present "several weeks." (Tr. 20-21). Instead, claimant testified that he told Dr. Scherlie it had been "a couple weeks." In any event, the onset of symptoms would have been before the alleged injury date of September 15, 1996. Dr. Johnson's October 30, 1996 chart note indicated an onset of back pain radiating into the right leg of six weeks and her December 4, 1996 chart note indicates an onset of two and a half months. (Ex. 26). These latter dates of onset would be about mid-September.

Claimant has filed three workers' compensation claims in the past, two with his current employer. Claimant reported all of these injuries to his employers within a day of their occurrence and timely filed 801 forms. (Exs. 1, 25A, 25C). Those prior claims were accepted without dispute. (Tr. 16, 17). Claimant was not afraid or concerned about telling his employer about an injury. (Tr. 8). Claimant also knew how to file a workers' compensation claim with his employer, knew the importance of timely reporting injuries, and knew of his employer's requirement to report any injury, even if the injury did not require medical attention. (Tr. 18).

Claimant testified that, although he knew from the onset that this alleged injury was caused by a very specific lifting event at work, he did not report the injury to his physicians, employer, or coworkers because he thought the injury would resolve on its own. (Tr. 8, 10, 18, 28, 29). Claimant explained that he had similar pains in the past and they resolved after a couple of days. (Tr. 28). He explained that his work is physical and he considered this injury to be the equivalent of a bruise or small cut. (Tr. 27, 28). Claimant said he had numerous strained muscles or little cuts at work in the past and had just dealt with them, without notifying his employer. (Id.) He stated that the job would not get done if every bruise or cut required an accident report. (Tr. 27).

However, claimant's testimony that he did not report the injury because he considered it minor and thought it would resolve on it's own does not comport with the record. Claimant variously testified that, although the pain was not immediate, it became "unbearable" or "unbearable but tolerable" within a couple of days after the incident, which caused him to seek treatment within 4 days, 6 days, or a "couple of weeks." (Tr. 6, 7, 18, 20, 21, 28). Furthermore, claimant required ongoing medical treatment for three months before he finally reported the alleged work incident. (Exs. 26, 27, 28, 29, 30). In addition, claimant stated that over this three month period his pain continued to worsen and he was aware that his need for treatment was caused by the alleged work incident. (Tr. 19, 26, 28, 30). Obviously, if claimant was in enough pain to seek medical treatment over a period of months, the condition was not a minor injury that was resolving on its own.

Moreover, claimant had sustained prior work injuries and was aware of how to and the need for timely reporting of such injuries, even those that did not require treatment. Claimant argues that he immediately reported the past work injuries because they were incapacitating from the beginning, whereas he did not report the current alleged injury because he had no immediate disabling pain. (Tr.

14, 16, 17, 18, 24). However, that explanation is not credible, given claimant's own testimony that the alleged injury became unbearably painful within a matter of days. On this record, it simply is not credible that claimant delayed reporting a known injury because he thought it would resolve on its own, as past bruises and cuts had done within a few days.

Furthermore, claimant's reason for his delay in reporting a known work injury to the employer does not support his failing to report that injury to his medical providers. No hesitation in reporting every little injury to an employer would prevent claimant from reporting a known work injury to his treating physicians. Furthermore, when he had sustained work injuries in the past, claimant had promptly reported those injuries to his treating physicians. (Tr. 24, Ex. 4).

It is also not credible that each discrepancy between claimant's testimony and the contemporaneous medical record is caused by erroneous recording by medical providers. Even disregarding the discrepancies between claimant's explicit reports of September 15, 1996 as the date of injury and the September 21, 1996 chart note regarding the onset of pain, there is still the specific notation in the October 24, 1996 chart note indicating no injury. Claimant counters this notation by denying that he reported that he did not have an injury. (Tr. 22).

Given the above inconsistencies in the record, we find that claimant has failed to meet his burden of proving the alleged injury arose out of and in the course of his employment. Accordingly, we uphold the employer's denial.

ORDER

The ALJ's order dated October 16, 1997 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's award of attorney fees is reversed.

April 3, 1998 Cite as 50 Van Natta 666 (1998)

In the Matter of the Compensation of
DORA G. HERNANDEZ, Claimant
WCB Case No. 96-09842
ORDER ON REVIEW
Glen J. Lasken, Claimant Attorney
Lane, Powell, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

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

We adopt and affirm the ALJ's order with the following corrected finding and supplementary analysis.

Claimant's L4-sacrum fusion surgery was performed in September 1986, not September 1996.

The ALJ found that claimant's injury claim was established by medical evidence supported by objective findings. We agree. While there is evidence of symptom magnification, Dr. Woda opined that claimant did have some valid reduced motion, along with other objective findings, including a positive straight leg raising test, diminished right ankle reflex and muscle spasm. Dr. Woda also persuasively explained that the absence of reported objective findings in the initial treatment records does not establish that claimant's subsequent documented objective findings were not related to the July 29, 1995 incident. Finally, there is no persuasive evidence that claimant's prior disk herniation and related L4-sacrum fusion surgery in 1986 are the major contributing cause of those objective findings. In particular, the treating surgeon, Dr. Noall, opined that claimant made a good recovery from the 1986 surgery, Dr. Wong opined that the preexisting fusion surgery was intact and the MRI showed no evidence of a herniated disc, and Drs. Noall and Wong both opined that the 1996 incident was the major contributing cause of claimant's acute findings. We defer to the opinions of Drs. Noall and Wong for the reasons discussed by the ALJ.

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 (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated August 28, 1997 order is affirmed. For services on review, claimant's counsel is awarded a $1,200 assessed attorney fee, to be paid by the insurer.

April 3, 1998 Cite as 50 Van Natta 667 (1998)

In the Matter of the Compensation of
JAMES R. KOCH, Claimant
WCB Case No. 97-06413
ORDER ON REVIEW
Willner & Associates, Claimant Attorneys
Jacqueline A. Weber, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Galton's order that upheld the self-insured employer's denial of claimant's low back "new injury" claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted 1990 low back injury claim with the employer. Applying ORS 656.005(7)(a)(B), the ALJ concluded that claimant failed to prove a compensable "new injury." Relying on the opinion of his treating neurosurgeon, Dr. Calhoun, claimant contends that he sustained a "new injury" to his low back on January 13, 1997 as a result of work activities that day. Alternatively, claimant argues that he proved a compensable "new occupational disease."

On January 20, 1997, claimant saw Dr. Calhoun for "recurrent, significant low back pain" "over the last several weeks." (Ex. 19). The chartnote states that "[i]t is felt that this is not really a new injury but just a waxing and waning problem." (Id.)

In May 1997, Dr. Calhoun reported to the claims processor that, according to claimant, "in January he was using a jackhammer and then began having progressive right sided low back pain" and that "[a]t no time has [claimant] ever had right sided pain before" because his "symptoms have always been on the left." (Ex. 21). According to Dr. Calhoun, "with his symptoms being on the right and never having been on the left, this may represent a new injury." (Id.)

After a MRI showed an L5-S1 disc protrusion on the right, Dr. Calhoun reported that "there is a new finding at L4-5 on the right of a disc herniation," which "clearly documents that [claimant] has suffered a new injury and this is not an aggravation." (Ex. 22).

Examining orthopedic surgeon, Dr. Farris, diagnosed lumbosacral strain "by history superimposed on mild degenerative disc disease in the lower lumbar spine" and "lumbar disc herniation, L4-L5, without nerve root impingement per MRI scan." (Ex. 26-10). According to Dr. Farris, claimant "had no specific injury that day but simply described an exacerbation of his symptoms," similar to multiple prior low back exacerbations claimant had experienced since his 1990 injury. (Id. at 11). Dr. Farris further reported that "no new injury occurred" and the "symptomatic worsening of [claimant's] condition which occurred on January 13, 1997 is the result of the original injury of March 1, 1990 and the natural degenerative process." (Id.) Finally, Dr. Farris noted that "the subjective complaints far outweigh the objective findings" and found "several factors" indicating that claimant "may be embellishing his symptoms to some degree." (Id.)

Dr. Calhoun concurred with the report. (Ex. 28).

After studying a February 15, 1994 and the May 12, 1997 MRI scans, Dr. Farris reported that a prominent disc bulge at L5-S1 had diminished in size and a disc bulge at L4-S1 had enlarged. (Ex. 29). Dr. Farris thought that this interval change had occurred between February 15, 1994 and May 12, 1997 and "could be due to [claimant's] work activities, or they could simply be due to the natural degenerative process." (Id.) Dr. Farris continued to think that the L4-S1 disc bulge was not "clinically significant." (Id.)

During a deposition, Dr. Calhoun stated that he was mistaken in concurring with Dr. Farris' report and he continued to believe that claimant sustained a "new injury." (Ex. 30-5). In particular, Dr. Calhoun thought that an "injury in January was the cause of [claimant's] L4-5 disk herniation" because "this was a new finding on the MRI" and "previously he had symptoms on the opposite side." (Id.) Dr. Calhoun then stated that, based on conversations with claimant, he believed that claimant's symptoms before January 1997 were "primarily on the left side" and, after January 1997, claimant "was primarily complaining of right-sided problems." (Id. at 6, 9). Dr. Calhoun also stated that, before January 1997, claimant may "have had intermittent right-sided pain." (Id. at 9).

Dr. Farris also was deposed, stating that the L4-5 disc bulge "could have occurred in January" but, in the absence of a "specific injury," he thought it more likely that claimant's symptoms represented another exacerbation. (Ex. 31-19). Dr. Farris also indicated that it was "possible" but not likely that work activities between February 15, 1994 and May 12, 1997 caused the herniation. (Id. at 21-22).

Generally, we defer to the opinion of the treating physician absent persuasive reasons to the contrary. See Weiland v. SAIF, 64 Or App 810 (1984). Like the ALJ, we find persuasive reasons not to defer to Dr. Calhoun's opinion. First, Dr. Calhoun incorrectly believed that claimant's symptoms on the right were merely "intermittent" before January 1997. The record shows that, during a period in 1994, claimant's symptoms were on the right. (Exs. 6A, 6B, &A, &B, 7BC). Even as of March 1995, claimant reported buttock pain "which can occur on either the right or left sides." (Ex. 8A-5). Consequently, we find that Dr. Calhoun relied on an inaccurate history in rendering his opinion.

Furthermore, Dr. Calhoun relied on a history that the onset of increased symptoms were on January 13, 1997. Claimant first reported to Dr. Calhoun on January 20, 1997, however, that he had been experiencing recurrent low back pain "over the last several weeks." Consistent with this report, a coworker testified at hearing that claimant told him on the morning of January 13, 1997 that he had low back pain. (Tr. 28). Finally, although conceding that claimant has degenerative disc disease (Ex. 30-16), Dr. Calhoun did not explain or respond to Dr. Farris' opinion that the preexisting condition, rather than work activities, caused the herniated disc.

In sum, we find Dr. Calhoun's opinion insufficient to carry claimant's burden of proof. Consequently, whether we apply ORS 656.005(7)(a), as claimant urges, or ORS 656.005(7)(a)(B), we conclude that claimant failed to prove that he sustained a compensable injury.

We also reject claimant's alternate contention that he proved a compensable occupational disease. Claimant relies on Dr. Farris' opinion that the herniated disc arose between February 15, 1994 and May 12, 1997. As discussed above, Dr. Farris indicated only a "possibility" that work activities during this period caused the condition. Thus, we also find inadequate medical evidence establishing an occupational disease. See ORS 656.802(2).

ORDER

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

In the Matter of the Compensation of
THOMAS J. LUCAS, Claimant
WCB Case Nos. 97-04322, 96-09129, 96-07773 & 96-04972
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Ronald W. Atwood, et al, Defense Attorneys
Sather, Byerly, et al, Defense Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer, JH Kelly, Inc. and its processing agent, Sedgwick James (JH Kelly), requests review of those portions of Administrative Law Judge (ALJ) Otto's order that: (1) set aside its responsibility denial of claimant's occupational disease claim for degenerative joint disease of the right wrist; and (2) upheld the responsibility denial of Liberty Northwest Insurance, on behalf of employer Advanced Piping, Inc. (API), for the same condition. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the second and third findings of ultimate fact. We briefly summarize the pertinent facts as follows:

Claimant, age 51 at the time of hearing, began working as a millwright in 1979. He has worked out of a union hall for many different employers over the years. His job duties required extensive and repetitive use of his hands and upper extremities.

On May 23, 1994, while working as a millwright for PGE, claimant injured his right wrist while using an electric portable drill. He sought treatment on June 3, 1994 and was diagnosed with tendinitis. The claim was accepted as a nondisabling injury.

Claimant's right wrist pain persisted as he continued to work as a millwright. On May 24, 1995, while working for Liberty's insured, API, claimant sought treatment for his increasing symptoms. Dr. Button diagnosed long-standing intercarpal ligament disruption (scapholunate), right wrist, with secondary osteoarthritis, progressive. Dr. Button opined that claimant's May 1994 torquing injury may have precipitated claimant's right wrist symptoms, but was not the cause of his degenerative condition. Dr. Button further reported that claimant's continued work as a millwright would accelerate the symptomatology and deterioration of his right wrist.

On September 5, 1995, claimant was seen by Dr. Long on referral from Dr. Button. At this time, claimant was working for JH Kelly in a supervisory position.[1] Dr. Long concurred with Dr. Button's findings and reported that claimant would not be able to continue working as a millwright without a reconstructive surgery on his right wrist. A September 23, 1995 MRI of the right wrist revealed, among other things, severe intercarpal and radiocarpal degenerative changes. Dr. Long recommended surgery.

On November 11, 1995, Dr. Long noted that in the past week, claimant had been required to do a bit more vigorous work with his hands and, in the process of this activity, experienced a fairly dramatic worsening of his symptomatology.

On February 13, 1996, claimant sought treatment from Dr. Browing. She reported that claimant's symptoms had continued to worsen over the prior three months and that he was having to carefully select jobs where he could act as foreman and not engage in heavy millwright work.

Claimant was off work from February 15, 1996 to March 13, 1996. On March 14, 1996, he returned to work at JH Kelly for two weeks. He then stopped working on March 28, 1996 because of his right wrist pain. On April 25, 1996, Dr. Long performed midcarpal fusion surgery.

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[1] Claimant began working for JH Kelly on August 14, 1995.

On August 6, 1996, Dr. Battalia performed a records review at the request of JH Kelly. Dr. Battalia opined that claimant's employment activities after he was diagnosed by Dr. Button in May 1995 did not independently contribute to a worsening of his degenerative condition.

CONCLUSIONS OF LAW AND OPINION

Applying the last injurious exposure rule (LIER), the ALJ found that although claimant first sought treatment for his wrist symptoms in May 1995 (while he was working for Liberty's insured, API), his employment-related hand intensive activities from May 24, 1995 to March 28, 1996 independently contributed to a worsening of claimant's degenerative joint disease of the right wrist.[2] Consequently, the ALJ shifted responsibility for claimant's condition to JH Kelly, claimant's last employer prior to surgery.[3]

On review, JH Kelly argues that API has not shown that claimant's work activity for JH Kelly actually contributed to a worsening of claimant's condition. We agree.

At hearing, claimant testified that as a journeyman millwright of long experience, he had certain days that required more hand intensive activity than others. (Tr. 40). He also reported that his work for API was hand intensive. (Tr. 41). Claimant further testified that in August 1995, when he began working for JH Kelly, his primary duties were supervisory. He reported that in the six months he worked for JH Kelly (through March 28, 1996), he only spent three or four days performing work that was at all hand intensive. (Tr. 42). When asked specifically about the kind of hand intensive activity he engaged in on those three or four days, claimant responded that only one single day, when he was required to tighten nuts and bolts, was particularly strenuous. (Tr. 44). Claimant explained that he would not describe his work on those other few days (when he used a scraper to clean) as hand intensive or strenuous. Id.

Dr. Browning, who began treating claimant in February 1996, testified that the majority of degeneration and damage to claimant's right wrist occurred as a result of his work activity prior to May 1995, when Dr. Button diagnosed his condition. (Tr. 54). She reported that when claimant was working in a supervisory role and not engaged in hand intensive work, his work activity was not significantly contributing to his condition. Although she reported that further hand intensive activities after claimant's May 1995 diagnosis would probably continue to contribute to the degeneration (Tr. 57), Dr. Browning refused to speculate whether just one day of hand intensive activity independently contributed to the progression of claimant's condition. (Tr. 54-55). Dr. Browning also admitted that she could not determine to what extent claimant's work activity between May 1995 and March 1996 caused further degeneration of his right wrist because she did not know how many days claimant engaged in hand intensive activity during this time. (Tr. 57-58)

On this record, we conclude that the evidence fails to establish that claimant's work activity at JH Kelly actually independently contributed to a worsening of his condition. By his own admission, claimant only engaged in one day of particularly hand intensive activity during the six months he worked for JH Kelly, when he was working on tightening the nuts and bolts. Dr. Browning declined to speculate as to the degree that one day's hand intensive work activity contributed to claimant's disease process (Tr. 54-55, 62) and Dr. Battalia specifically opined that claimant's work activities subsequent to May 1995 did not independently contribute. (Ex. 83-5).

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[2] LIER provides that where, as here, a worker proves than an occupational disease was caused by work conditions that existed when more than one carrier was on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982). If a worker receives treatment for a compensable condition before experiencing time loss due to the condition, the date the claimant first received treatment related to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim, unless the subsequent employment contributes independently to the cause or worsening of the condition. Timm v. Maley, 125 Or App 396, 401 (1993), rev den 319 Or 81 (1994).

[3] As Bracke explains, in order to shift responsibility forward to a subsequent employer, the presumptively responsible employer must prove that employment conditions at a subsequent employer contributed to the cause of, aggravated or exacerbated the underlying disease. 293 Or at 250; See also Oregon Boiler Works v. Lott, 115 Or App 70, 74 (1992) (Later employment conditions must actually contribute to a worsening of the condition).

Accordingly, in the absence of persuasive evidence that claimant's work activities for JH Kelly between August 1995 and March 1996 independently contributed to a worsening of claimant's degenerative condition, API remains responsible for claimant's condition under the last injurious exposure rule. See Oregon Boiler Works v. Lott, 115 Or App at 74.

ORDER

The ALJ's order dated September 26, 1997, as amended October 15, 1997, is affirmed in part and reversed in part. That portion of the order that set aside JH Kelly's denial of responsibility for claimant's degenerative joint disease of the right wrist is reversed and the denial is reinstated and upheld. That portion of the order that upheld the responsibility denial of Liberty (on behalf of API) is also reversed. Liberty's responsibility denial is set aside and claimant's occupational disease claim is remanded to Liberty for processing according to law. The ALJ's $3,000 attorney fee award is payable by Liberty instead of JH Kelly. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
LAWRENCE S. RAMOS, Claimant
WCB Case Nos. 97-00001 & 96-07447
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Poland's order that: (1) set aside its denial of responsibility for claimant's "new injury" claim for a groin/hip flexor/rotator strain condition; and (2) upheld Liberty Northwest Insurance Corporation's partial denial of responsibility for the same condition. Claimant cross-requests review of those portions of the ALJ's order that: (1) declined to order Liberty to pay claimant's attorney an assessed fee for its pre-hearing rescission of its compensability denial; and (2) declined to award claimant's attorney an assessed fee under ORS 656.308(2)(d) for services regarding the responsibility issue. On review, the issues are responsibility and attorney fees.

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

On review, claimant contends his attorney is entitled to an assessed fee award under ORS 656.386(1) for Liberty's pre-hearing rescission of its compensability denial. We find, however, that the ALJ already awarded claimant's attorney an assessed fee of $1,200 under ORS 656.386(1) for services rendered in obtaining the pre-hearing rescissions of both compensability denials by SAIF and Liberty. The ALJ directed SAIF to pay the entire assessed fee based on the joint stipulation by SAIF and Liberty that the insurer ultimately found responsible for claimant's condition will pay the entire fee.

Based on our review of the record, and after considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that $1,200 was a reasonable attorney fee award for claimant's attorney's services in obtaining the pre-hearing rescissions of the compensability denials by SAIF and Liberty. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record, including the hearing requests filed by claimant's attorney), the complexity of the compensability issue, and the value of the interest involved. Furthermore, based on the insurers' joint stipulation, we conclude that the ALJ properly ordered the responsible insurer, SAIF, to pay the entire fee award.

Finally, although claimant's attorney rendered services on review in defense of the ALJ's conclusion that SAIF is the responsible insurer, we find no evidence in the record that claimant's compensation was at risk for disallowance or reduction on review. Therefore, claimant's attorney is not entitled to an assessed attorney fee under ORS 656.382(2) for his services on review concerning SAIF's request for review. See Shoulders v. SAIF, 300 Or 606, 609-10 (1986); Paul J. LaFrance, 45 Van Natta 1991, 1993 (1993).

ORDER

The ALJ's order dated August 20, 1997 is affirmed.

April 3, 1998 Cite as 50 Van Natta 672 (1998)

In the Matter of the Compensation of
MELVIN C. WODA, Claimant
WCB Case No. 96-11475
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
John M. Pitcher, Defense Attorney

Reviewed by the Board en banc.

The self-insured employer requests review of Administrative Law Judge (ALJ) McWilliams' order that set aside its denial of a claim for an irritant reaction to sawdust. On review, the issue is compensability, including whether the claim is properly analyzed as an injury or an occupational disease. We affirm.

We adopt the ALJ's findings of fact with the following correction. In lieu of the finding that claimant has worked for the employer for thirty years, we find that he has worked in the wood products industry for thirty years and for the employer since February 1996.

We otherwise adopt and affirm the ALJ's order with the following supplementary analysis.

We begin our discussion with a brief recitation of the pertinent facts. Claimant was transferred to the employer's sawmill in September 1996, where he was exposed to wood dust. Claimant came to this job with a preexisting allergic rhinitis and asthma. On his first day in the sawmill, claimant developed an acute episode of shortness of breath with coughing and wheezing. Over the following three days, claimant's symptoms worsened during work hours and improved when he was off work over the weekend. When claimant returned to work the following Monday, he experienced a severe episode of shortness of breath and sought emergency medical treatment. Claimant's acute symptoms were attributed to a transient irritant reaction to wood dust at the sawmill.

The parties do not dispute that claimant's current condition is the result of a combining of his preexisting respiratory condition and his work exposure to wood dust. Consequently, to establish a compensable injury, claimant must prove that his exposure at work is the major contributing cause of his transient irritant reaction or his acute need for treatment under ORS 656.005(7)(a)(B); and to establish a compensable occupational disease, claimant must prove that his work activity is the major contributing cause of a pathological worsening of his preexisting respiratory condition under ORS 656.802(2)(b).

The ALJ concluded that claimant's irritant reaction is properly analyzed as an injury and is compensable as a combined condition under ORS 656.005(7)(a)(B). On review, the employer contends that the claim must be analyzed as an occupational disease because the express terms of ORS 656.802(1)(a)(A) preempt an injury analysis of any and all claims caused by inhalation or contact with dust. ORS 656.802(1)(a)(A) defines an occupational disease as

> "any disease or infection arising out of and in the course of employment caused by substances or activities to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein, and which requires medical services or results in disability or death, including:
>
> "(A) Any disease or infection caused by ingestion of, absorption of, inhalation of or contact with dust, fumes, vapors, gases, radiation or other substances." (Emphasis added).

The employer argues that the inclusive language "any disease or infection" precludes an injury analysis of any condition caused by exposure to wood dust. The employer relies on the court's opinion in SAIF v. Hukari, 113 Or App 475, rev den 113 Or 475 (1992). In Hukari, the court construed former

ORS 656.802(1)(b), which defined occupational disease to include "any mental disorder arising out of and in the course of employment [.]" (Emphasis added). The Hukari court concluded that, "[b]y specifically including mental disorders in the definition of occupational disease, the legislature made clear its intent that *any* claim that a condition is *independently compensable* because it was *caused by on-the-job stress* * * * must be treated as a claim for an occupational disease under ORS 656.802." Id. at 480 (emphasis in original). The employer contends that this same rationale is applicable in the present case because ORS 656.802(1)(a)(A) and former ORS 656.802(1)(b) share the same inclusive term "any."

We disagree. The Supreme Court rejected the holding in Hukari that any claim based on stress must be analyzed as an occupational disease under former ORS 656.802(1)(b). Mathel v. Josephine County, 319 Or 235 (1994). Moreover, we are not persuaded that the Hukari court's emphasis of the term "any" has relevance beyond the narrow context of that case, i.e., application of the statutory language "any mental disorder" to a claim that a condition is independently compensable because it was caused by on-the-job stress.

Here, we must determine whether a reaction to wood dust should be analyzed as an "injury" or "occupational disease" under the particular circumstances presented in this case. In defining these terms, we rely on the text and context of the statute, and the legislative history if necessary. PGE v. Bureau of Labor and Industries, 317 Or 606, 610 (1993). The "text" of the statute includes the Supreme Court's construction of the statute. Stephens v. Bohlman, 314 Or 344, 350 n. 6 (1992). The "context" of the statute includes the pre-existing law and statutory framework. Goodyear Tire & Rubber Co. v. Tualatin Tire & Auto, 322 Or 406, 415-417 (1995), mod, 325 Or 46 (1997); Krieger v. Just, 319 Or 328, 336 (1994).

ORS 656.802(1)(a)(A) defines an occupational disease as "any disease or infection caused by ingestion of, absorption of, inhalation of or contact with dust [.]" (Emphasis added). This language was first enacted by the 1987 legislature in former ORS 656.802(1)(a).[1] See Or Laws 1987, ch 713, §4. Occupational disease statutes dating back to 1959 had previously defined "occupational disease" as "[a]ny disease or infection which arises out of and in the scope of the employment, and to which an employe is not ordinarily subjected or exposed other than during a period of regular actual employment therein."

The courts have construed the defining language "disease or infection" in prior versions of ORS 656.802. In so doing, the courts have treated a condition as an occupational disease when the symptoms are gradual in onset, not attributable to a specific activity or event, and due to an ongoing condition or state of the body. James v. SAIF, 290 Or 343 (1981); Valtinson v. SAIF, 56 Or App 184, 187 (1982); O'Neal v. Sisters of Providence, 22 Or App 9, 16 (1975). These same cases treat a condition as an injury when the symptoms occur over a discrete, identifiable period of time and are due to a specific activity or event. Id.

When it enacted former ORS 656.802(1)(a), the 1987 legislature incorporated the "disease or infection" language that the court construed in these cases. Nothing in the text or context of that provision suggests that the legislature intended to abandon the Supreme Court's construction of the terms "occupational disease" and "injury" in James, and the lower court's elaboration on that definition in Valtinson and O'Neal. Moreover, the relevant legislative history indicates that the legislature intended to retain the court's "disease versus injury" analysis in regard to toxic exposures. Former ORS 656.802(1)(a) was enacted as part of HB 2271, which was drafted and introduced by a special House Interim Task Force on Occupational Disease. Participants in the final Task Force meeting raised concerns that the proposed legislation might be interpreted as amending the court's "disease versus injury" analysis. Attorney Jim Edmunson and Task Force Administrator Terri Borchers then engaged in the following colloquy:

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[1] Former ORS 656.802(1)(a) defined "occupational disease" as "[a]ny disease or infection arising out of and in the course of employment caused by ingestion of, absorption of, inhalation of or contact with dust, fumes, vapors, gasses, radiation or other conditions or substances to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein[.]" (Emphasis added).

> Mr. Edmunson: "Injury law, because it involves material relationships, is quite different and ruled under a different doctrine than disease law, which requires major occupational relationships. * * * To propose legislation at this point [changing the court definitions of injury and occupational disease] might give the next session the impression that these [issues] have been fully examined and explored and these [changes] are the result of testimony in regard to industrial injuries. * * * Whether a person has an injury or disease is also a tortured legal process of determining[.]"
>
> Ms. Borchers: " * * * I don't think it should be assumed that the [Task Force] thought they were answering all those difficult questions. * * * The concern was with trying to understand the impact of calling something an injury versus calling it an occupational disease for purposes of the extent of statute of limitations, which was primarily the underlying purpose of this bill. * * * That's the extent to which they were trying to make the distinction between occupational disease and occupational injury."
>
> Mr. Edmunson: "Thank you. I think it's important that the legislative history reflect that. Many of my comments are directed at the record for that purpose[.]"

House Task Force on Occupational Disease, Minutes of October 8, 1986 Meeting, Tape 027 at 004. See also testimony of Task Force Chairman Bob Shiprack, Minutes of October 8, 1986 Meeting, Tape 021 at 004.

This exchange demonstrates that, when the legislature enacted the operative language at issue in this case, it did not intend to change the court-created definition of "injury" and "disease" for toxic exposure cases. This intent is further illustrated by the 1995 legislature's enactment of ORS 656.802(1)(a)(B), which defines occupational disease to include any mental disorder "whether sudden or gradual in onset[.]" (Emphasis added). By adding this language, the legislature excepted mental disorder claims from the court-created "injury versus disease" analysis. It is significant that the legislature did not provide the same exception for toxic exposure claims under ORS 656.802(1)(a)(A). See Or Laws 1995, ch 332, §56.

Thus, the relevant statutory text, context and legislative history supports the ALJ's application of the courts' long-standing definition of "injury" and "occupational disease" to claimant's irritant reaction. We also note that the ALJ's analysis is consistent with our prior decision in Cipriano Vega, 42 Van Natta 1117 (1990). In Vega, the Board concluded that an acute reaction to chemical spray should be analyzed as an injury under the traditional "injury versus occupational disease" analysis. In reaching that decision, the Board implicitly concluded that an injury analysis was not preempted under former ORS 656.802(1)(a).

We, therefore, affirm the ALJ's application of the long-standing "injury versus disease" analysis to the particular facts of the present case. Here, the onset of claimant's symptoms occurred within hours of his initial exposure to sawdust, thereafter worsened during work hours, improved when he was off work over the weekend, and worsened again when he returned to work the following Monday. Furthermore, claimant's exposure to wood dust at work resulted in an acute and transitory episode of respiratory symptoms, and it is Dr. Montanaro's unrebutted opinion that claimant's "transient irritant reaction is not a specific disease, but is indicative of a symptomatic flare of his underlying condition." Given this record, we conclude that the ALJ correctly concluded that claimant's transient irritant reaction is due to an event occurring over a discrete, identifiable period of time due to a specific activity and is, therefore, an injury rather than a "disease or infection" within the meaning of ORS 656.802(1)(a)(A). Accord James, 290 Or at 343; Valtinson, 56 Or App at 187; O'Neal, 22 Or App at 16. Finally, we agree with the ALJ's conclusion that Dr. Montanaro's unrebutted opinion persuasively establishes that claimant's irritant reaction is compensable as an injury under ORS 656.005(7)(a)(B).

We disagree with the dissent's contention that claimant's irritant reaction should be analyzed as an occupational disease because it falls within the definition of "disease" used in Mathel, 319 Or at 239-241. In Mathel, the Court determined that the claimant's heart attack should be analyzed as an injury because that characterization was consistent with both the ordinary meaning of the terms "injury" and "disease," and the definitions of those terms first enunciated by the court in James, 290 Or at 343. The Mathel decision includes the following relevant passage:

> * * * * The ordinary meaning of the term 'injury' is 'an act that damages, harms, or hurts'; 'hurt, damage, or loss sustained.' Webster's Third New Int'l Dictionary 1164 (unabridged ed 1993). The ordinary meaning of the term 'disease' is 'an impairment of the normal state of the * * * body'; 'sickness, illness.' Id. at 648. 'Sickness' is defined in part as 'the condition of being ill.' Id. at 2111. 'Illness' is defined in part as 'an unhealthy condition of the body or mind.' Id. at 1127. *The foregoing definitions suggest that a heart attack is an 'injury,' because it is an event, as distinct from an ongoing condition or state of the body or mind.*" (Emphasis added).

When we apply the definitions discussed in this passage to the present case, we conclude that claimant's irritant reaction is an "injury" because it is an acute and transient event, as distinct from an ongoing condition or state of the body or mind. Accordingly, our analysis of claimant's irritant reaction as an injury is consistent with both the long-standing "injury v. disease" analysis adopted by the courts and the ordinary meaning of those terms as discussed in Mathel.

We also disagree with the dissent's reliance on a footnote in Mathel in which the court notes that toxic exposure claims under ORS 656.802(1)(a)(A) are unique because they are defined by the cause of the occupational disease, i.e., "any disease or infection caused by ingestion of, absorption of, inhalation of or contact with dust, fumes, vapors, gases, radiation or other substances." Mathel, 319 Or at 242-243, n. 2. The dissent reasons that claimant's irritant reaction must be analyzed under ORS 656.802(1)(a)(A) because it was caused by one of the agents listed in that provision. This analysis ignores the first four words of ORS 656.802(1)(a)(A), which expressly limits the application of that provision to "any disease or infection."[2] For the reasons discussed above, claimant's acute, transient irritant reaction is not a "disease or infection" within the ordinary meaning of that term, and the court's long-standing definition of "occupational disease," which has become part of the text of the statute. See Stephens, 314 Or at 350 n. 6 (1992).

Accordingly, as supplemented herein, we adopt and affirm the ALJ's ruling that claimant's acute, transitory irritant reaction to wood dust is properly analyzed as an injury and is compensable as a combined condition under 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 $2,000, 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 and his counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated April 21, 1997 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $2,000, to be paid by the self-insured employer.

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[2] We also note that the "cause v. condition" discussion in the Mathel footnote is *dicta*, and that it is difficult to predict what significance, if any, that discussion would have in the present case.

Board Members Haynes and Moller dissenting.

The majority characterizes this claim as one for an "irritant reaction" to sawdust, analyzes it as an "accidental injury," and concludes that claimant has established that his condition is compensable. We believe claimant's claim is more appropriately characterized as a claim for a temporary flare-up of claimant's preexisting asthma condition caused by exposure to workplace dust and, as such, should be analyzed as an occupational disease. Because the medical record in this case does not support compensability of the claim as an occupational disease, we respectfully dissent.

ORS 656.802(1)(a) defines "occupational disease." It provides:

> "As used in this chapter, 'occupational disease' means any disease or infection arising out of or in the course of employment caused by substances or activities to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein, and which requires medical services or results in disability or death, including:

> "(A) Any disease or infection caused by ingestion of, absorption of, inhalation of or contact with dust, fumes, vapors gases, radiation or other substances." (Emphasis supplied).

Workers' Compensation Law does not define "disease." In Mathel v. Josephine County, 319 Or 235 (1994), the Supreme Court was required to determine whether the claimant's heart attack should be analyzed as an "accidental injury" as used in ORS 656.005(7)(a) or as an "occupational disease" as used in ORS 656.802.[1] In examining the text of those two provisions, the Court found that the ordinary meanings of the words "injury" and "disease" were consistent with the text and earlier court decisions applying those provisions. Mathel, 319 Or at 241-242. The Court also examined the context of those provisions and again concluded that the terms should be given their ordinary meanings. Id. The Mathel Court utilized the definition of "disease" given in Webster's Third New International Dictionary (unabridged ed. 1993) which defines "disease" as:

> "Any impairment of the normal state of the living animal or plant body or any of its components that interrupts or modifies the performance of vital functions, being a response to environmental factors (as malnutrition, industrial hazards, or climate), . . ." Id. at 648.

The majority does not apply this definition to the term "disease" as it is used in ORS 656.802(1)(a)(A) to determine if that provision is applicable to claimant's claim. Rather, the majority applies the caselaw definition of what constitutes an "occupational disease" to determine whether or not the provision is applicable. We submit that ORS 656.802(1)(a)(A) is a statutory definition, in and of itself, for a certain type of occupational disease. Applying the Mathel Court's definition of "disease" to ORS 656.802(1)(a)(A) indicates that an occupational disease is "any impairment of the normal state" that is "caused by ingestion of, absorption of, inhalation of or contact with dust, fumes, vapors, gases, radiation or other substances."

Here, unlike the heart attack victim in Mathel, claimant seeks benefits for a "disease or infection" within the ordinary meaning of those terms. In this regard, claimant's underlying condition has been variously described as seasonal allergic asthma/rhinitis; allergic rhinitis and asthma; and chronic atopic disease. (Exs. 2, 5, 6). Moreover, the condition for which claimant is seeking benefits has been referred to as a temporary worsening or "flare-up" of his underlying disease. (Exs. 3, 5, 6). The fact that a worker is seeking benefits for a temporary worsening of an underlying disease that is related to an acute "event" at work does not mean that ORS 656.802 is inapplicable. See Fuls v. SAIF, 321 Or 151 (1995) (post-Mathel case involving mental disorder allegedly resulting from physical greeting by customer).

In Fuls, the claimant was seeking compensation for a mental disorder which he alleged was caused by a distinct work incident. Relying on the Court's prior cases that drew a distinction between accidental diseases and occupational injuries along the lines that occupational diseases are gradual rather than sudden in onset, the claimant argued that his "sudden onset" mental disorder should be analyzed as an injury. The Court rejected the claimant's reliance on the general caselaw distinction between injuries and diseases. The court held that former 656.802(1)(b) specifically included "[a]ny mental disorder" within the definition of occupational disease and was therefore applicable, regardless of the suddenness of the onset of the condition. Id. at 158.

Similarly, ORS 656.802(1)(a)(A) applies to "any disease or infection" caused by exposure to the enumerated substances. Consistent with the rationale set forth in Fuls, because claimant's claim is for a temporary worsening of his underlying disease alleged to be related to exposure to dust, ORS 656.802 is applicable.

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[1] The majority resorts to legislative history to support its position. While we do not find the quoted testimony compelling, it should be noted that the Mathel court analyzed ORS 656.802 pursuant to PGE v. Bureau of Labor and Industries, 317 Or 606 (1993), and stated: "Because the text and context of the statute, as well as this court's prior interpretations of the relevant portions thereof, make the legislative intent clear, we do not consider legislative history or other aids to construction." Mathel, 319 Or at 242 (Emphasis supplied). In any event, we do not disagree that the court-created distinction between occupational disease and accidental injuries remains viable absent a specific statutory provision such as ORS 656.802(1)(a)(A).

In addition, unlike most statutes addressing compensability, the focus of ORS 656.802(1)(a)(A) is not on certain types of conditions, but rather on certain types of causes. As noted in Mathel, workers generally make claims for injuries or diseases, not for the causes of those injuries or diseases. Mathel, 319 Or at 242. The Court explained, however, that some provisions of the Workers' Compensation Law expressly describe certain causes, which in the words of the Court "are differentiated from the concepts of 'compensable injury' and 'occupational disease.'" Id. The Court then listed the former version of ORS 656.802(1)(a)(A) as an example of such a provision. Id.

Here, claimant's claim fits squarely within ORS 656.802(1)(a)(A). That is, his claim is for an impairment of the normal state of the body (flare-up of his preexisting asthma) that was allegedly caused by inhalation of sawdust. If such claims were to be treated as either "accidental injuries" or "occupational diseases" there would be no reason to specifically list such causes in ORS 656.802. The fact that infections or diseases caused by exposure to specific substances are listed in 656.802 clearly indicates a statutory attempt to have those types of claims treated as an occupational disease.

The same reasoning employed by the majority could be applied to ORS 656.802(1)(a)(B) as that provision also follows the general definition set forth in ORS 656.802(1)(a) and is preceded by the word "including." For example, if a claim was filed for a mental disorder that was sudden in onset or triggered by a specific incident, it would not be encompassed by 656.802. That is, under the majority's reasoning, the claim would first be analyzed under the traditional "occupational disease versus accidental injury" test and, if it were determined to be an "accidental injury," then subsection (1)(a)(B) would not be applied even though that subsection specifically encompasses all mental disorders, regardless of the timing of the onset. Such reasoning would be in direct conflict with the Court's decision in Fuls.

The majority indicates that it would not follow this analysis with regard to mental disorders and would look to subsection (1)(a)(B) to determine that an "injury-induced" mental disorder comes with the statute. However, that does not explain why the majority is unwilling to apply subsection (1)(a)(A) in the same manner. Although subsection (1)(a)(B) addresses a condition (mental disorder) whereas (1)(a)(A) addresses causes of a "disease or infection" (ingestion, absorption, or inhalation of certain substances), both are specific statutory statements with regard to what constitutes an "occupational disease" under Oregon workers' compensation law. The majority offers no persuasive reasons why claims under these two provisions are analyzed in a different fashion.[2]

Based on this, we would apply ORS 656.802(1)(a)(A) to this case and conclude that claimant has not established a compensable occupational disease.[3] Because the majority finds to the contrary, we respectfully dissent.

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[2] The majority points out that subsection (1)(a)(B) contains the language "whether sudden or gradual in onset." We do not find this determinative. That language is in regard to a specific condition (mental disorder) and is not necessary when describing a specific cause (ingestion, absorption, or inhalation of certain substances). Moreover, prior to the addition of that language, the court had held former ORS 656.802(1)(b) was applicable to "any mental disorder" regardless of the suddenness of its onset. Fuls, 321 Or at 158.

[3] As noted in the employer's brief, if claimant's claim is analyzed as an occupational disease, then the limitations set forth in ORS 656.802(2)(b) would apply and claimant would have to establish that his preexisting asthma condition pathologically worsened. The only physician to address this question is Dr. Montaro who opined that there was not a pathological worsening. (Ex. 6). Consequently, claimant's claim would not be compensable as an occupational disease.

In the Matter of the Compensation of
LINDA B. WOMBACHER, Claimant
WCB Case No. 96-10564
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Myzak's order that set aside its denial of claimant's occupational disease claim for arthritis of the DIP joint of the right index finger. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

Claimant, age 55 at the time of hearing, began working for the employer in 1987 as a disability determination specialist. A significant portion of her job involves completing disability worksheets by hand. She is right hand dominant.

In 1994, without any specific incident of injury, claimant experienced the gradual onset of pain in the DIP (distal interphalangeal) joint of her right index finger. The pain progressively worsened and she sought medical treatment in April 1996. X rays showed mild degenerative changes in the right index DIP joint.

Claimant was seen by Dr. Ellison one time only, in April 1996. Claimant was also examined by Dr. Mayhall, one time only, in September 1996 at the request of SAIF.

CONCLUSIONS OF LAW AND OPINION

Relying on the testimony of Dr. Ellison, the ALJ found that claimant's work activities were the major contributing cause of a pathological worsening of her underlying arthritis condition. On review, SAIF argues that Dr. Ellison's opinion fails to satisfy claimant's burden of proof under ORS 656.802(2). We disagree.

Under ORS 656.802(2), a worker must prove that employment conditions were the major contributing cause of the disease. If the occupational disease claim is based on the worsening of a preexisting disease or condition pursuant to ORS 656.005(7),[1] the worker 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).

Here, the uncontroverted medical evidence indicates that claimant had underlying degenerative arthritis in the DIP joint of her right index finger and that this condition "preceded the onset of [claimant's] initial claim for [her] occupational disease."[2] See ORS 656.005(24) (defining "preexisting condition"). Therefore, contrary to the ALJ's determination, this case is governed by ORS 656.802(2)(b) rather than 656.802(2)(a). We nevertheless conclude, for the reasons set forth below, that claimant has established the compensability of her degenerative arthritis of the right index finger under this subsection.

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[1] ORS 656.005(24) defines "preexisting condition" as: "[A]ny injury, disease, congenital abnormality, personality disorder or similar condition that contributes or predisposes a worker to disability or need for treatment and that precedes the onset of an initial claim for an injury or occupational disease * * * . "

[2] Both Dr. Ellison and Dr. Mayhall agreed that claimant had underlying degenerative arthritis in this joint which preexisted her need for treatment in April 1996. (See, e.g. Exs. 3-6, 7-16).

Although he did not report that claimant's work activity was the major contributing cause of the underlying degenerative arthritis condition, Dr. Ellison did opine that claimant's work activity "accelerated the progression of the DIP joint arthritis and need for treatment." (Exs. 6, 7-12). In his deposition, Dr. Ellison further explained that claimant's work activity, particularly her use of a pen or pencil and writing for extended periods of time, caused some of the pathological changes in the DIP joint of claimant's right index finger. (Ex. 7-13). He explained that claimant had "very significant" findings at this one joint as opposed to the other joints in her hands and concluded that it was more probable than not that this significant difference was due to the fact that claimant spent considerable time writing at work. (Ex. 7-21).

Dr. Mayhall, on the other hand, opined that claimant's work activity combined with her preexisting, underlying degenerative arthritis and aggravated her symptoms, but that the work activity did not materially worsen the underlying condition. (Ex. 3).

On this record, we are more persuaded by the opinion of Dr. Ellison, as it is well-reasoned and thoroughly explained. See Somers v. SAIF, 77 Or App 259 (1986) (in evaluating the medical evidence concerning causation, Board will rely on those opinions that are both well-reasoned and based on accurate and complete information). Based on Dr. Ellison's opinion, we conclude that claimant's work activity was the major contributing cause of her combined condition (symptomatic, progressive degenerative arthritis of the DIP joint of the right index finger) and a pathological worsening of the underlying disease. Consequently, we affirm the ALJ's order.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, payable by 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 October 10, 1997 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,200, payable by SAIF.

April 3, 1998 Cite as 50 Van Natta 679 (1998)

In the Matter of the Compensation of
PRISCILIANO E. LOPEZ, Claimant
WCB Case No. 97-04898
ORDER OF ABATEMENT
Willner & Associates, Claimant Attorneys
Lundeen, et al, Defense Attorneys

On March 6, 1998, we reversed an Administrative Law Judge's (ALJ's) order which set aside the insurer's denial of claimant's injury claim for a "clay shoveler's" fracture. Contending that we relied on "secondary medical opinions" (rather than the "key piece of evidence" - the x-rays interpreted by Dr. Owen), claimant seeks reconsideration of our order and affirmance of the ALJ's compensability decision.

In order to consider this matter, we withdraw our March 6, 1998 order. The insurer is granted an opportunity to respond. To be considered, the insurer's response must be filed within 14 days from the date of this order. Thereafter, this matter will be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN S. FAWVER, Claimant
Own Motion No. 96-0466M
OWN MOTION ORDER
Kasia Quillinan, Claimant Attorney

On October 31, 1996, we referred claimant's own motion request for temporary disability compensation for his compensable 1982 right knee injury with Georgia Pacific to the Hearings Division. We took this action because litigation concerning responsibility of his current degenerative right knee condition was pending before the Hearings Division. (WCB Case Nos. 96-09726, 96-09498, 96-06836).

On July 11, 1997, ALJ Michael Johnson issued an Opinion and Order that upheld the SAIF Corporation's denial on behalf of Puerto Nuevo Inn's and Georgia Pacific's responsibility denials. The ALJ set aside SAIF's compensability denial on behalf of Denali Drywall.

SAIF, on behalf of Denali Drywall requested, and claimant cross-requested, review of the ALJ's order. Subsequent to the filing of the request for review, SAIF, on behalf of Denali Drywall and claimant agreed to settle all issues between them. Claimant further announced that he was "withdraw[ing] any issues as to Georgia Pacific.

On February 20, 1998, we approved a "Stipulation and Disputed Claim Settlement Agreement," which resolved claimant's and SAIF's dispute concerning the compensability of claimant's current right knee condition which was pending review. Pursuant to that settlement, claimant agreed that SAIF's August 20, 1996 denial would remain in full force and effect.

Contemporaneous with our approval of claimant's and SAIF's agreement, we issued an Order of Dismissal finding that the parties' settlement fully and finally resolved the dispute regarding claimant's right knee condition. We further acknowledge claimant's withdrawal of any issues regarding Georgia Pacific. In light of such circumstances, we dismissed the matter with prejudice.

We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a).

In light of claimant's prior announcement, and our Order of Dismissal, the current right knee condition for which claimant requests own motion relief remains in denied status. Consequently, we are not authorized to reopen claimant's 1982 injury claim with Georgia Pacific as he is not entitled to temporary disability compensation.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT S. GRADT, Claimant
Own Motion No. 97-0588M
OWN MOTION ORDER ON RECONSIDERATION
Welch, Bruun, et al., Claimant Attorneys

Claimant requests reconsideration of our January 16, 1998 Own Motion Order in which we declined to reopen his 1988 industrial injury claim for the payment of temporary disability compensation because he failed to establish that he remained in the work force when his compensable condition worsened requiring surgery or hospitalization.

On January 30, 1998, we abated our January 16, 1998 order, and allowed claimant 30 days to submit further evidence and argument. The self-insured employer was allowed 14 days following claimant's submission in which to file a response to the motion. We have received claimant's submission. Furthermore, the time for the insurer's response has expired. Consequently, we proceed with our reconsideration.

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

It is undisputed that claimant's compensable condition has worsened requiring surgery.

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

The employer contends that claimant is retired and thus, was not in the work force at the time of the current disability. Claimant submitted as additional evidence a February 2, 1998 report from Dr. Ordonez and a February 24, 1998 report from Dr. Pena. Claimant contends that Drs. Ordonez' and Pena's reports support his assertion that "he [claimant] was fully employed on the date of his disabling and accepted workers' compensation injury and that he had full intention of continuing with [the employer] until he retired."[1] Claimant further contends these reports establish that he was "willing to work, and not seeking work because the work related injury has made his efforts futile." We disagree.

By claimant's own statement, he would have retired in 1992 when he turned 65 years old. We must then consider when claimant's compensable condition worsened requiring surgical intervention. In a November 7, 1997 IME report, Dr. Rosenbaum reported claimant's statements regarding his worsening as follows:

> "He [claimant] notes that two to three years ago he began to notice a flop foot on the left side. He was walking in the store one day shopping when he noted the weakness. His left leg pain gradually increased. There was no new injury. He subsequently desired a reevaluation and he ordered an MRI on himself and on 6/5/97 underwent an MRI ... demonstrating stenosis at the L2/3 and L3/4 levels with severe changes at the L4/5 level. He saw Dr. Ordonez in a follow up. ... Dr. Ordonez told him his MRI scan demonstrated progressive changes and he recommended surgery." (emphasis added)

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[1] In claimant's December 30, 1997 letter, he asserts that he would have been willing to continue working until retirement at age 65. Claimant retired in 1989 at the age of 62. Therefore, we interpret claimant's assertion that he "would work until he was 65," to mean he would have retired in 1992 (when he turned 65) regardless of whether the retirement was a result of his inability to work due to the compensable injury. Additionally, the medical documentation contained in the record shows that claimant was 70 years old at the time of his current worsening.

Although claimant's compensable condition may have progressively worsened throughout the years since his retirement, it was not until June 5, 1997 when his condition worsened sufficiently for Dr. Ordonez to recommend surgery. We have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction,[2] is the date he enters the hospital for the proposed surgery. Fred Vioen, 48 Van Natta 2110 (1996); John R. Johanson, 46 Van Natta 2463 (1994). The relevant time period for which claimant must establish he was in the work force is the time prior to when his condition worsened requiring that surgery. See generally Wausau Ins. Companies v. Morris, 103 Or App at 273; Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990); Jeffrey A. Kyle, 49 Van Natta 1331 (1997); Michael C. Batori, 49 Van Natta 535 (1997); Kenneth C. Felton, 48 Van Natta 725 (1996).

Therefore, claimant's assertion that he would work until he retired at 65 or until 1992, does not establish that he was willing to work but was unable to work or seek work due to his compensable condition, when his compensable condition worsened sufficient to require surgery in 1997.

Accordingly, our January 16, 1998 order is abated and withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our January 16, 1998 order in its entirety. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

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[2] The Board in its own motion jurisdiction can only authorize temporary disability from the time of surgery or hospitalization. See ORS 656.278(1)(a).

April 6, 1998 Cite as 50 Van Natta 682 (1998)

In the Matter of the Compensation of
DONALD D. DAVIS, Claimant
WCB Case No. 97-01045
ORDER DENYING RECONSIDERATION
Daniel J. Denorch, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Claimant requests abatement and reconsideration of our March 10, 1998 Order on Reconsideration and December 11, 1997 Order on Review. In his motion, claimant first argues that medical documents submitted to the self-insured employer were sufficient to qualify as "claims" for the conditions of traumatic olecranon bursistis and left lateral epicondylitis, thus requiring the employer to accept or deny such conditions within 90 days. Claimant acknowledges that he did not submit a "formal demand" to the employer to accept such conditions until after the Administrative Law Judge issued his order.

Claimant also objects to our application of ORS 656.268(16) and Julio C. Garcia-Caro, 50 Van Natta 160 (1998), in deciding that the condition of left lateral epicondylitis did not qualify as a "direct medical sequela" of the accepted condition. Finally, claimant contends that our failure to address the penalty issue in our Order on Reconsideration was "error."

Claimant's contention that he perfected claims for traumatic olecranon bursitis and left lateral epicondylitis, as well as his argument that he is entitled to a penalty and attorney fee, were extensively discussed in his briefs on review and on reconsideration. Our Order on Review adequately addresses such issues and we see no need to provide further reasoning. We further find that our Order on Reconsideration sufficiently explains our conclusion under ORS 656.268(16) and Garcia-Caro.

Accordingly, we deny claimant's motion for abatement and reconsideration. The parties' rights of appeal shall continue to run from the date of the Order on Reconsideration.

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 & Hooton, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's January 6, 1998 Notice of Closure which closed her claim with an award of temporary disability compensation from October 29, 1996 through September 18, 1997. SAIF declared claimant medically stationary as of September 18, 1997. Claimant contends that she is entitled to additional benefits as she was not medically stationary when her claim was closed. Claimant further contends that if she is found medically stationary when her claim closed, her correct medically stationary date should be December 10, 1997.

"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 January 6, 1998 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).

SAIF relies on a December 10, 1997 response letter from claimant's treating physician, Dr. Baum, to support its contention that claimant was medically stationary on September 18, 1997.[1] In his letter, Dr. Baum opines that:

> "[Claimant] has continued to have problems with her right knee and for this reason she was placed in an ACL brace on September 18, 1997. ... With the G2 brace this patient's [claimant] condition is felt to be medically stationary. She needs to be assessed in my office in the near future for closing examination."

SAIF argues that Dr. Baum's December 10, 1997 letter explicitly declared claimant medically stationary as of September 18, 1997, the date she was placed in a knee brace. Further, SAIF contends that, in the alternative, claimant should be declared medically stationary on August 20, 1997, the date Dr. Baum had last examined claimant. We need not address which of the dates between August 20, 1997 or September 18, 1997 is the correct medically stationary date because the propriety of the claim closure is based on claimant's condition at the time of the closure, i.e., January 6, 1998.

Prior to his December 10, 1997 letter, Dr. Baum had last conducted a physical examination of claimant on August 20, 1997. Subsequent to the January 6, 1998 claim closure, Dr. Baum examined claimant on February 10, 1998. On March 3, 1998, he concurred with statements as set forth by claimant's attorney wherein he changed his opinion regarding claimant's medically stationary status. Dr. Baum agreed with the following statements:

> "Would you agree that there has not been a material change in Ms. Mesplay's condition since September 18, 1997, but rather that your current treatment recommendations related to the same instability that was present at that time? Yes."
>
> "Do you expect that the use of Achilles Tendon allograft in a third reconstruction attempt is reasonably likely to cause a material improvement in Ms. Mesplay's condition? Yes."
>
> "If Ms. Mesplay's condition has remained essentially the same since September 18, 1997, and the requested third reconstructive surgery is reasonably likely to materially improve Ms. Mesplay's condition, is it not also reasonably medically probable, in retrospect, that Ms. Mesplay was not actually medically stationary in September 18, 1997 considering

[1] Claimant relies on the December 10, 1997 letter to support her contention that her medically stationary date is the date of the letter or December 10, 1997.

that the Workers' Compensation Law does not consider a worker medically stationary if there is any medical treatment (or the passage of time) that is reasonably expected to cause a material improvement? Yes."

Evidence that was not available at the time of closure may be considered to the extent the evidence addresses the condition at the time of closure. Scheuning v. J.R. Simplot & Co., 84 Or App 622, 625 (1987). Here, our review of Dr. Baum's March 3, 1998 report indicates that he no longer believes claimant was medically stationary, given the fact that claimant's condition remained essentially the same since September 18, 1997 and there is a reasonable expectation of further material improvement in claimant's condition with the proposed Achilles Tendon allograft surgery. Although the need for further medical treatment does not defeat a medically stationary status, Dr. Baum retracted his earlier opinion that claimant was medically stationary and opined that claimant's condition, as of September 18, 1997, would improve with further surgery. We find that Dr. Baum persuasively explained his change of opinion regarding claimant's medically stationary status. Thus, we conclude that claimant was not medically stationary on January 6, 1998 when her claim was closed by SAIF.

Therefore, we set aside SAIF's January 6, 1998 Notice of Closure and direct it to resume payment of temporary disability compensation commencing on September 18, 1997. When it is 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
JEFFREY J. HYSON, Claimant
WCB Case No. 96-06960
ORDER ON RECONSIDERATION
Carney, et al, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

The self-insured employer requests reconsideration of that portion of our March 16, 1998 Order on Review that affirmed the Administrative Law Judge's order that affirmed an Order on Reconsideration which awarded 30 percent (96 degrees) unscheduled permanent disability for a cerebral concussion condition.

The employer first argues that we erred in relying on the medical arbiter, Dr. Bellville, and awarding permanent disability for "organic brain syndrome."

As we held in our March 16, 1998 order, we did not award permanent disability for "organic brain syndrome." Rather, we affirmed an award of permanent disability for claimant's accepted condition of cerebral concussion. We noted that although Dr. Bellville listed "mild organic brain syndrome" as a diagnosis in his report, the doctor expressly related claimant's impairment to the accepted cerebral concussion, not to organic brain syndrome or any other condition.

The employer also argues that claimant's condition is not permanent and cannot support an award of permanent disability because Dr. Belville expected the condition to improve. First, we note that there was no contention that claimant's condition was not medically stationary. By definition, a finding of medically stationary status means that no further material improvement would reasonably be expected from medical treatment or the passage of time. See ORS 656.005(17). Second, although Dr. Belville indicates that claimant's condition could gradually and slowly improve, Dr. Belville also indicated that this was unpredictable. Under such circumstances, we are persuaded that the limitations noted by Dr. Belville are considered to be permanent.

Our March 16, 1998 order is withdrawn. As supplemented herein, we republish our March 16, 1998 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN B. SHAW, SR., Claimant
Own Motion No. 96-0277M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Craine & Love, Claimant Attorneys
VavRosky, et al, Defense Attorneys

Claimant requested reconsideration of our December 6, 1996 Own Motion Order, as reconsidered on January 2, 1998, in which we declined to reopen claimant's 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. With his request for reconsideration, claimant submitted additional evidence regarding the work force issue.

On February 2, 1998, we abated our prior orders to allow the self-insured employer sufficient time to respond to claimant's motion. We have received the employer's response. After reconsidering the work force issue, we republish our December 6, 1996 Own Motion Order, as reconsidered on January 2, 1998, with the following supplementation.

On January 2, 1998, the Board affirmed and adopted an April 27, 1997 Opinion and Order that found that claimant's claim was properly classified as nondisabling; therefore, his aggravation rights ran from the date of injury and expired five years later, on November 24, 1992. Because claimant's aggravation rights on the November 24, 1987 claim have expired, that claim is within the Board's own motion jurisdiction. ORS 656.273(4); 656.278. Therefore, ORS 656.278 governs claimant's entitlement to future monetary benefits regarding that claim, with such benefits being limited to temporary disability compensation. Id.; Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988).

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.

There is no dispute that claimant underwent surgery for his compensable neck condition on December 13, 1994. 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 December 13, 1994, when his compensable neck condition worsened requiring a two-level anterior cervical discectomy and interbody fusion at C5-6 and C6-7. 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 voluntarily retired from work on October 22, 1994 and was not working at the time of disability. Thus, in order to qualify for time loss benefits, claimant must establish that, although retired, he continued to work, to seek work, or, although willing to work, he was unable to work due to the compensable injury at the time of disability. Id.; see also Cutright v. Weyerhaeuser Company, 299 Or 290 (1985) (Court found temporary disability benefits were not available to claimants who had voluntarily removed themselves from the work force through retirement at the time their compensable conditions worsened and surgery became necessary); Robert D. Hyatt, 48 Van Natta 2202 (1996) (although retired, the claimant continued to work part-time, establishing eligibility for temporary partial disability benefits); Fred Vioen, 48 Van Natta 2110 (1996) (inasmuch as temporary disability under ORS 656.278 is only authorized beginning on the date of surgery or inpatient hospitalization, the previously retired claimant was not in the work force by the time he underwent surgery).

Claimant does not contend that he was engaged in regular gainful employment or seeking such employment after he retired. Instead, he contends that, although he was willing to work after he retired, he was not seeking work because his compensable injury made such efforts futile. In support of this contention, claimant submitted a summary of a January 30, 1998 conversation between his attorney and Dr. Franks, the surgeon who performed claimant's December 1994 surgery. Dr. Franks agreed that the conversation summary accurately reflected his statements and opinions. Dr. Franks stated that claimant was "unable to work due to his neck condition from 10/18/94 [the date of claimant's myelogram/CT] until after he recovered from his December 1994 surgery." He added a handwritten comment that claimant's recovery would have been "about 8 [weeks] post operative." In response to claimant's attorney's query as to whether it would have been futile for claimant to seek work from October 18, 1994 until the date of his surgery, Dr. Franks stated that "it would have been dangerous for [claimant] to have worked during that time because of the risk of further injury and the possibility of causing spinal cord compression." (January 30, 1998 conversation summary).

However, the employer submitted a summary of a February 13, 1998 conversation between its attorney and Dr. Franks in which Dr. Franks changed his opinion about claimant's ability to work during the period prior to the December 1994 surgery. In the February 13, 1998 conversation summary, Dr. Franks agreed that claimant's level of cervical symptoms had remained about the same for well over a year prior to the October 18, 1994 myelogram and did not worsen at the time of that myelogram. Dr. Franks also agreed that when he advised the employer and claimant in about November 1994 that claimant needed cervical surgery, he did not advise claimant to stop working or to retire. In fact, Dr. Franks did not know that claimant had retired in October 1994. Dr. Franks also agreed that he did not authorize time loss for claimant pending surgery and added the following handwritten notation: "I probably don't remember but my records do not reflect I took [claimant] off work & I do not feel I would likely have done so." (February 13, 1998 conversation summary).

In addition to agreeing to the accuracy of the February 13, 1998 conversation summary, Dr. Franks made the following handwritten comments regarding claimant's ability to work before the December 1994 surgery:

> "I apparently have discussed [with claimant's attorney] the issue of whether or not [claimant] could have worked from [the] time of [the] myelogram 10/18/94 to [the] time of surgery (12/13/94). I feel now & probably did feel then, that this decision would have or was based on [claimant's] degree of clinical distress - i.e. - either way. I feel [claimant] was probably able to work if he so could tolerate & it was I feel not medically unsafe to do so." (February 13, 1998 conversation summary).

Thus, Dr. Franks presents two conflicting opinions regarding claimant's ability to work during the period in question. We find Dr. Franks' February 13, 1998 opinion better explained. Furthermore, Dr. Franks made it clear that he was not aware that claimant had retired in October 1994. Therefore, claimant's earlier argument that there was no reason for Dr. Franks to provide a work release because claimant was retired at the time of surgery holds no weight. Based on Dr. Franks' final opinion, we find that the work injury did not render a job search futile.

On the other hand, even if we find Dr. Franks' opinions unpersuasive because they represent an unexplained change of opinion, such a finding would not support claimant's position. See Kelso v. City of Salem, 87 Or App 630 (1987) (unexplained change of opinion renders physician's opinion unpersuasive). Claimant has the burden of proving the work force issue. ORS 656.266. Dr. Franks provides the only medical evidence regarding claimant's ability to work at the relevant time. Thus, if Dr. Franks' opinions are rejected as unpersuasive, claimant is left without any persuasive medical evidence to support his contention that the work injury rendered a job search futile.

On this record, we conclude that claimant has not carried his burden of proving he was in the work force at the time of disability. Because we are only authorized to award temporary disability compensation beginning the date claimant entered the hospital for surgery (which occurred after claimant retired), we conclude that we are without authority to authorize the payment of temporary disability benefits in claimant's 1987 injury claim. ORS 656.278(1). Accordingly, claimant's request for temporary disability compensation is denied.

On reconsideration, as supplemented and modified herein, we adhere to and republish our December 6, 1996 order, as reconsidered on January 2, 1998. The parties' right of appeal 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.

April 6, 1998 Cite as 50 Van Natta 687 (1998)

In the Matter of the Compensation of
ERNEST L. SHARER, Claimant
Own Motion No. 98-0135M
OWN MOTION ORDER
Wausau Ins. Co., Insurance Carrier

The insurer has voluntarily reopened claimant's claim pursuant to ORS 656.278 for his compensable fracture of the spleen with hemorrhage in hemiperitoneus. Claimant's aggravation rights expired sometime in 1972.[1] The insurer asks the Board to authorize the reopening of claimant's claim.

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

On March 12, 1997, claimant was admitted into the intensive care unit where he was treated for septicemia secondary to Strep. pneumoniae and disseminated intravascular coagulation/purpuric necrosis. He remained in the hospital for 19 days. Thus, we conclude that claimant's compensable injury has worsened requiring in-patient hospitalization. We therefore have the authority to authorize the reopening of claimant's claim for temporary disability compensation commencing March 12, 1998, the date he was hospitalized. Id.

Accordingly, the information submitted to us demonstrates that the reopening of claimant's claim was appropriate. 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] In its recommendation form, the insurer states that their original file was destroyed but the file was closed in 1967. Thus, the aggravation rights would expire in 1972.

In the Matter of the Compensation of
KENTON L. SKEELS, Claimant
WCB Case No. 97-06367
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Lipton's order that awarded claimant an assessed attorney fee for obtaining rescission of a denial prior to hearing. In its brief, the employer also contends that the attorney fee award was excessive. On review, the issue is attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Entitlement to Attorney Fee

We adopt the ALJ's reasoning on this issue, with the following supplementation.

On review, the employer argues that compensability of the condition it eventually accepted had never been denied. Therefore, the employer contends that, because this case does not involve a "denial" which was overcome, there is no basis for an attorney fee pursuant to ORS 656.386(1).

Subsequent to the ALJ's order, the court issued its decision in Galbraith v. SAIF, 152 Or App 790 (February 25, 1998). In Galbraith, the court held that the carrier's response to the claimant's hearing request that the "claimant is entitled to no relief" constituted an express denial of the claim. Consequently, the court found that an attorney fee under ORS 656.386(1) was appropriate.

Here, as noted by the ALJ, in the September 30, 1997 "Response to Issues," the employer denied that a condition had been incorrectly omitted from the acceptance. Accordingly, under the rationale set forth in Galbraith, the employer's response was an express denial of the claim. Therefore, we affirm the ALJ's attorney fee award.

Amount of Attorney Fee

The ALJ awarded claimant's counsel an assessed attorney fee of $2,500, for services in obtaining rescission of the denial. On review, the employer argues that the attorney fee award is excessive. We agree.

ORS 656.386(1) provides that, "[i]n such cases involving denied claims where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge, a reasonable attorney fee shall be allowed." Under OAR 438-015-0010(4), in any case where an ALJ or the Board is required to determine a reasonable attorney fee, see Russell L. Martin, 50 Van Natta 313 (1998), the following factors are considered:

"(a) The time devoted to the case;

"(b) The complexity of the issue(s) involved;

"(c) The value of the interest involved;

"(d) The skill of the attorneys;

"(e) The nature of the proceedings;

"(f) The benefit secured for the represented party;

"(g) The risk in a particular case that an attorney's efforts may go uncompensated; and

"(h) The assertion of frivolous issues or defenses."

Here, claimant's counsel has not submitted a statement of services. With respect to the time devoted to the case, claimant's counsel argues that he prepared the request for hearing and, in preparation for the hearing, sent a letter to claimant's treating doctor, requested a deposition, gave notice that he would request a postponement of the case, and filed a notice of claim pursuant to ORS 656.262(6)(d). The hearing in this matter took approximately 30 minutes.

Applying the first factor in this case, we do not find that the time devoted to the case justifies a fee of $2,500. We note that there was no deposition taken and the time spent in hearing was minimal.

Next, we find that the issue concerning the L5 nerve root impingement was of average complexity. The value of the interest involved has not been shown to be above average, as the employer had previously accepted claimant's L4-5 disc protrusion in addition to a lumbar strain. The nature of the proceeding was relatively uncomplicated as it concerned a prehearing rescission.

Claimant did receive a benefit from her attorney's services in obtaining acceptance of the L5 nerve root impingement, however, as previously noted, claimant's L4-5 disc protrusion had already been accepted which entitled claimant to benefits such as medical services, temporary disability and potential future benefits. There was a risk that counsel's services would go uncompensated. There was no assertion of frivolous issues.

After considering these factors, we conclude that $1,500 is a more appropriate attorney fee award in this case. In reaching this conclusion, we particularly rely on our findings that the time devoted to the case was below average, the interest to claimant was of average value, and the issue and the nature of the proceeding were not complicated. Compare James R. Lazenby, 48 Van Natta 1058 (1996) ($2,500 was a reasonable attorney fee for prehearing rescission where counsel devoted 30 hours to the case and filed several requests for hearing); Eloy Cuellar, 48 Van Natta 814 (1996) ($2,300 was a reasonable attorney fee for prehearing rescission when counsel devoted 15.5 hours, which included generating a medical report showing causation, and secured medical benefits that included surgery).

Consequently, the ALJ's attorney fee award of $2,500 is modified to $1,500.

ORDER

The ALJ's order dated December 3, 1997 is modified in part and affirmed in part. The ALJ's attorney fee award of $2,500 is modified. In lieu of the ALJ's attorney fee award, claimant's counsel is awarded an attorney fee of $1,500, to be paid by the employer. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
JOEL D. BARBOSA, Claimant
WCB Case No. 97-00664
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Baker's order that upheld the insurer's partial denial of his thoracolumbar sprain. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

Claimant was compensably injured on December 4, 1995 when bundles of insulation fell on the back of his head and neck. Claimant fell to the floor and also injured his left hand and wrist. Following the injury, claimant treated with Dr. Grady, who diagnosed a neck strain and left wrist sprain. The claim was accepted for an injury to the neck and left hand.

On January 29, 1996, Dr. Verzosa diagnosed a lumbosacral sprain/strain, in addition to claimant's previously diagnosed upper extremity strains.

On February 28, 1996, claimant was examined by Dr. Mayhall, on behalf of the insurer. Dr. Mayhall took a history of claimant twisting his thoracolumbar spine during the December 4, 1995 incident.

On July 13, 1996, claimant was examined by Drs. Farris and Staver, on behalf of the insurer. They took a history of claimant being struck by insulation and having pain in his back.

On January 20, 1997, the insurer issued a partial denial of claimant's thoracolumbar strain.

On March 27, 1997, claimant was examined by Dr. Gritzka, medical arbiter. Dr. Gritzka reported that, at the time of injury, claimant was forced into a position of flexion and rotation, which resulted in injury to the lumbar spine.

On April 10, 1997, Dr. Mayhall agreed that, if claimant did not report thoracic or low back pain until late January 1996, the current complaints would not be related to the December 4, 1995 industrial injury.

CONCLUSIONS OF LAW AND OPINION

On review, claimant argues that the persuasive medical opinions in the record, including that of Dr. Gritzka, the medical arbiter, support compensability. We agree.

The parties agree that, because claimant asserts that his low back injury occurred as a direct result of the December 4, 1995 injury, the proper standard is a "material contributing cause." Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

Here, Drs. Verzosa, Mayhall, Farris, Staver and Gritzka all initially reported that claimant's thoracic and lumbar strains were causally related to the work injury. (Exs. 25-4, 35-7, 60-4, 76-6). In a check-the-box response, Dr. Mayhall later changed his opinion regarding causation. (Ex. 77).

For the following reasons, we do not find Dr. Mayhall's opinion to be persuasive. Dr. Mayhall's initial opinion was comprised of eight pages and discussed the reports of claimant's treating doctors, including that of Dr. Verzosa. Dr. Mayhall took an accurate history of the twisting injury and found that the mechanism of the injury was consistent with developing a thoracolumbar sprain. Dr. Mayhall opined that claimant's sprain was not idiopathic, but rather, was "work-related on a major contributing cause basis." (Ex. 35-7).

The insurer subsequently asked Dr. Mayhall if claimant's low back complaints were related to the industrial injury, in light of the fact that there was a delay in the onset of symptoms. In response, Dr. Mayhall checked "No." (Ex. 77-2). We find Dr. Mayhall's last opinion to be conclusory and unexplained. While Dr. Mayhall's first opinion is thorough and well-reasoned and discussed the mechanism of claimant's injury, his final opinion contains no reasoning or explanation. Moreover, Dr. Mayhall had previously reviewed the opinion of Dr. Verzosa, who noted a delay in the onset of low back symptoms. Notwithstanding his review of Dr. Verzosa's report, Dr. Mayhall found claimant's condition to be related to the work injury. Consequently, we conclude that Dr. Mayhall's final opinion is contradictory and unpersuasive. See, e.g., Kelso v. City of Salem, 87 Or App 630 (1987).

Finally, we conclude that the remaining reports, including the deposition of Dr. Gritzka, support compensability. Dr. Gritzka obtained an accurate history of the mechanism of claimant's injury. Furthermore, Dr. Gritzka was advised of the delay in symptoms, yet continued to opine that claimant's thoracolumbar condition was related to the accepted injury. Dr. Gritzka also explained how, similar to a whiplash injury, some spinal injuries would cause symptoms to develop after a period of time. Ex. 78. After reviewing Dr. Gritzka's deposition, we conclude that it is persuasive, as it is both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986).

Under the circumstances, we find that claimant has met his burden of proof by a preponderance of the evidence and has proven that the December 4, 1995 work injury is a material contributing cause of his thoracolumbar strain. Consequently, we reverse the order of the ALJ.

Claimant's counsel is awarded an assessed attorney fee for services at hearing and on review concerning the issue of compensability. ORS 656.385(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 at hearing and on review regarding the compensability issue is $4,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel might go uncompensated.

ORDER

The ALJ's order dated September 12, 1997 is reversed in part and affirmed in part. That portion of the ALJ's order that upheld the insurer's denial is reversed. The insurer's denial dated January 20, 1997 is set aside and the claim is remanded to the insurer for processing according to the law. Claimant's counsel is awarded an assessed attorney fee of $4,000 for services at hearing and on review, to be paid by the insurer. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
JENNY L. BOYDSTON, Claimant
WCB Case No. 97-03081
ORDER ON REVIEW
Darris K. Rowell, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by the Board en banc.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that dismissed her request for hearing from an Order on Reconsideration as untimely. On review, the issue is propriety of an order dismissing claimant's hearing request. We affirm.

FINDINGS OF FACT

Claimant's claim was closed by a December 6, 1996 Determination Order. Claimant requested reconsideration of the Determination Order contesting the award of temporary total disability. Claimant's request for reconsideration was received by the Department on February 3, 1997. Within 18 working days, an Order on Reconsideration issued on February 25, 1997. ORS 656.268(6)(d). No medical arbiter had been appointed pursuant to ORS 656.268(7).

Within 30 days of the issuance of the Order on Reconsideration, claimant filed a March 6, 1997 request asking the Department to "abate and withdraw" the February 25, 1997 Order on Reconsideration so that additional medical evidence could be considered. At that time, no party had requested a hearing before the Hearings Division. On March 12, 1997, the Department issued an Order Abating and Withdrawing the Order on Reconsideration. On March 20, 1997, a Second Order on Reconsideration issued. Again, no medical arbiter had been appointed.

On April 14, 1997, claimant requested a hearing from the March 20, 1997 Second Order on Reconsideration.

CONCLUSIONS OF LAW AND OPINION

Reasoning that claimant had to request a hearing either 30 days from the date of the first Order on Reconsideration or, if the first Order on Reconsideration had been effectively withdrawn, 30 days from February 28, 1997, the date a reconsideration request was deemed denied pursuant to ORS 656.268(6)(d), the ALJ concluded that claimant's April 14, 1997 hearing request was not timely. We agree.[1]

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[1] By letter dated November 5, 1997, the Department notified the Board that it did not wish to participate in this proceeding. See ORS 656.726(3)(h).

Former ORS 656.268(6)(d)[2] set the time limits within which reconsideration must be accomplished:

> "Reconsideration shall be completed within 18 working days from the date of receipt of the request therefor * * *. The deadline of 18 working days may be postponed by an additional 60 calendar 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 18 working days plus the additional 60 calendar 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 date the order was due to issue." (Emphasis supplied).

A party may object to an order on reconsideration by requesting a hearing within 30 days from the date of the reconsideration order. ORS 656.268(6)(f). It is undisputed that claimant did not request a hearing within 30 days of the February 25, 1997 Order on Reconsideration, nor did claimant request a hearing within 30 days of February 28, 1997 (18 working days from the date the Department received claimant's request for reconsideration). The issue, therefore, is the effect, if any, of the Department's withdrawal/abatement of its February 25, 1997 Order on Reconsideration.

An agency has plenary authority to decide matters committed to it by the legislature, absent a statutory provision limiting its authority to do so. SAIF v. Fisher, 100 Or App 288, 291 (1991). This authority includes the ability to withdraw an order and reconsider the decision embodied in the order. Id. The issue here is whether former ORS 656.268(6)(d) is a statutory limitation on the Department's authority to withdraw and reconsider an Order on Reconsideration. We conclude it does provide a limitation based on the following reasoning.

In construing a statute, our task is to discern the intent of the legislature. The first level of analysis is to examine both the text and context of the statute, including other provisions of the same statute. PGE v. Bureau of Labor and Industries, 317 Or 606, 610-611 (1993). Our analysis of the text and context of the statue includes consideration of the rules of construction that "bear directly on the interpretation of the statutory provision in context." Id. at 611. If the intent is clear, no further inquiry is necessary. If the intent of the legislature is not clear from the text and the context of the statute, we then consider the legislative history of the statute. Id. at 611-12.

The text of former ORS 656.268(6)(d) requires the Department to "complete" the reconsideration process within 18 working days of the receipt of the request for reconsideration.[3] If the Department does not timely issue an Order on Reconsideration, the reconsideration is deemed denied. Former ORS 656.268(6)(d). This is an express statutory limitation on the Department's authority to reconsider a Determination Order or Notice of Closure. Moreover, the context of the statute clearly indicates an intent by the legislature to provide the parties with an appeal mechanism where the Department has not fulfilled its statutory obligation. See Benzinger v. Oregon Dept. of Ins. and Finance, 107 Or App 449 (1991).

This is further supported by the legislative history concerning the 1991 amendments to ORS 656.268(6)(a). The 1991 amendments to that provision were added in response to the court's decision in Benzinger. (House Labor Committee Hearing on HB 3584, June 5, 1991, Tape 161-162, Side B). In Benzinger, the court had upheld a circuit court's injunction requiring the Director to issue a reconsideration order within the statutory time limit (then 15 days) regardless of whether the reconsideration process had been completed. The 1991 legislature addressed this problem by increasing the number of days allowed for the Appellate Unit to issue an order on reconsideration from 15 calendar days to 18 working days. In addition, the following language was added:

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[2] ORS 656.268(6)(d) was amended in 1997. Or Laws 1997, ch 111, sec 1; ch 382, sec. 1. The amendments, however, assuming they are applicable, do not affect the issue presented in this case.

[3] This mandate is subject to an express exception where "within the 18 working days" notice of a medical arbiter review is provided by the Department.

> "If an order on reconsideration has not been mailed on or before 18 working days from the date of receipt of the request for reconsideration or within 75 working days where a notice of 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 determination order was mailed on the 18th working day or where an order was timely mailed on the 75th day. . . ."

The text and the context of the provision, as well as the legislative history, support an intent by the legislature to limit the time which the Director has been granted to issue an Order on Reconsideration. Under these circumstances, we agree with the ALJ that the Department's authority to issue an Order on Reconsideration ended on February 28, 1997, 18 working days from receipt of claimant's request for reconsideration. Inasmuch as claimant did not request a hearing within 30 days from that date, her subsequent request for hearing was untimely and, therefore, the ALJ correctly concluded that claimant's request for hearing should be dismissed.[4]

ORDER

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

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[4] In reaching this conclusion, we agree with the ALJ that ORS 656.268(6)(b) does not apply. That statute grants the Department authority to postpone the reconsideration process. However, the Department did not postpone the reconsideration process in this matter. Consequently, ORS 656.268(6)(b) has no application.

Board Member Hall dissenting.

The majority concludes that claimant's request for hearing was not timely and therefore affirmed the ALJ's dismissal of claimant's hearing request. Because I would find that claimant's request for hearing was timely, I dissent.

I agree with the majority that the resolution of this case turns on the interpretation of former ORS 656.268(6)(a). However, I believe that the plain language of that statute compels a different result. The application of the time limits set forth in former ORS 656.268(6)(a) is contingent on the Department not performing its statutory duty, i.e., issuing an Order on Reconsideration prior to expiration of the statutory time limits. In fact, the statutory time limits are triggered "[i]f an Order on Reconsideration has not been mailed. . . ." See former ORS 656.268(6)(a).

Here, the Department satisfied its statutory duty when it issued its February 25, 1997 Order on Reconsideration within 18 working days of receipt of claimant's request for reconsideration. Inasmuch as the Department fulfilled its obligation within the mandated time period, there is no statutory limitation which would prevent the Department from withdrawing and reconsidering a timely Order on Reconsideration.

As noted by the majority, an agency's authority to decide matters committed to it by the legislature includes the ability to withdraw and reconsider an order. Fisher, 100 Or App at 291. Moreover, we have specifically acknowledged that pursuant to OAR 436-030-0008(1)(b), the Director is vested with the discretion to abate, withdraw and/or amend an Order on Reconsideration within the time limit permitted to appeal the Notice of Closure until a hearing is requested. See Terry L. Maltbia, 48 Van Natta 1836 (1996); Duane B. Onstott, 48 Van Natta 753 (1996).

Here, the second Order on Reconsideration issued on March 20, 1997. Claimant requested a hearing on that order within 30 days of March 20, 1997. Consequently, I would find that claimant's request for hearing was timely.

In sum, I would find that where an Order on Reconsideration has issued prior to the running of the statutory time limit set forth in ORS 656.268(6)(d), the running of that time limit does not prevent the Department from withdrawing and reconsidering that Order on Reconsideration. Where the Department takes such action, the 30-day time limit begins running from the date of the Department's second Order on Reconsideration.

In the Matter of the Compensation of
SCOTT D. BRUCE, Claimant
WCB Case No. 97-05058
ORDER ON REVIEW
John M. Hoadley, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Moller and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Hoguet's order that set aside its denial of claimant's occupational disease claim for bilateral wrist pain. On review, the issue is compensability.

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

On review, SAIF contends that the existence of claimant's bilateral wrist pain was not "established by medical evidence supported by objective findings," within the meaning of ORS 656.802(2)(d). Like the ALJ, we disagree with SAIF's contention. The term "objective findings" is defined by statute as:

> "[V]erifiable indications of injury or disease that may include, but are not limited to, range of motion, atrophy, muscle strength and palpable muscle spasm. 'Objective findings' does not include physical findings or subjective responses to physical examinations that are not reproducible, measurable or observable." ORS 656.005(19).

In Tony D. Houck, 48 Van Natta 2443 (1996), after reviewing the text and legislative history of ORS 656.005(19), we concluded that "objective findings" included a physician's interpretation of a worker's verifiable subjective response to clinical testing, provided the subjective response was "reproducible, measurable or observable." See Anthony D. Sherman, 49 Van Natta 1258 (1997).

In this case, claimant sought treatment for increasing pain in both wrists in February 1997. He was referred to Dr. Tennant and, during examination on March 14, 1997, Dr. Tennant elicited complaints of tenderness with palpation along the triangular fibrocartilage complex. (Ex. 5-1). In deposition, Dr. Tennant testified that he performed the palpation "more than once" during the examination and that the testing was "pretty consistent." (Ex. 14, pp. 18-19). Dr. Tennant also measured "markedly" reduced grip strength and reduced pinch strength in the right (dominant) hand, as compared to the left. (Id.) Based on examination findings, the doctor diagnosed bilateral wrist pain and prescribed wrist splints and anti-inflammatories. (Id.)

Dr. Tennant performed a follow-up examination on April 14, 1997. (Ex. 7).[1] He reported that claimant "remain[ed] tender over the triangular fibrocartilage complex." (Id.) Dr. Tennant was uncertain as to the cause of claimant's wrist pain, but in subsequent reports and in deposition, the doctor opined that it is more likely than not that claimant developed bilateral wrist pain due to his work activity. (Exs. 11, 13, 14-40).

Based on Dr. Tennant's reports and testimony, we find that claimant's subjective responses to clinical testing, i.e., tenderness upon palpation at the triangular fibrocartilage complex and reduced grip and pinch strength, were verifiable indications of an injury or condition causing wrist pain. We also find that claimant's subjective response of tenderness at the triangular fibrocartilage complex was elicited more than once by Dr. Tennant, thus establishing its reproducibility. Finally, we find that claimant's reduced grip and pinch strength were "measurable" subjective responses to clinical testing. Based on this record, therefore, we conclude that the existence of claimant bilateral wrist pain was established by medical evidence supported by objective findings.

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

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[1] Although Exhibit 7 indicates that the April 14 examination was performed by a "Dr. Butler," Dr. Tennant clarified in deposition that he actually performed the examination that day and that the reference to "Dr. Butler" was a typographical error. (Ex. 14, pp. 4-5).

that a reasonable fee for claimant's attorney's services on review is $1,100, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 6, 1997 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,100, payable by SAIF.

In the Matter of the Compensation of
MARY A. DORAMUS, Claimant
WCB Case No. 97-05152
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Moller and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) set aside its denial of claimant's current left knee condition; and (2) awarded a penalty for SAIF's allegedly unreasonable denial. On review, the issues are compensability and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability

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

Penalty

The ALJ awarded claimant a 25 percent penalty on the ground that SAIF did not have a "legitimate doubt" about its liability for claimant's left knee condition when it issued its June 12, 1997 denial of compensability and responsibility. On review, SAIF contends that its denial was reasonable. We agree.

Claimant is entitled to a penalty if the carrier "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." ORS 656.262(11)(a). The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991). "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the information available to the carrier at the time it denied benefits. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

Here, claimant compensably injured her left knee in 1981 when a car door was shut on her left leg while she was in the course and scope of her employment with SAIF's insured. On August 21, 1995, claimant reported to Dr. Dahlin, her current attending physician, that she had developed an "achey knee" as a result of her work in an Alzheimer's unit.[1] (Ex. 50). On December 11, 1995, Dr. Dahlin attributed the August 1995 treatment to temporary overuse at work prior to claimant's appointment. (Ex. 51). On May 28, 1997, Dr. Dahlin again confirmed that claimant's need for treatment in August 1995 was due to overuse and repetitive work activity in the Alzheimer's unit. (Ex. 56-2).

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[1] Claimant was working at the time as a "Geri-aide" at a nursing home for an employer insured by Liberty Northwest, which was not joined in this proceeding. Apparently, hearing requests against Liberty Northwest were dismissed with prejudice. (Ex. 51D).

Although we agree with the ALJ that claimant sustained her burden of proving that her current left knee condition is compensably related to the 1981 injury, we nevertheless conclude that, based on the medical evidence available to SAIF when it issued its June 12, 1997 denial, it had a legitimate doubt regarding its liability for claimant's current left knee condition. Thus, we conclude that the June 12, 1997 denial was reasonably issued. Therefore, we reverse the ALJ's decision to award a penalty.

Attorney Fees on Review

Claimant's attorney is entitled to an assessed fee for services on review regarding the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We have also considered that claimant is not entitled to a fee for defending the ALJ's decision on the penalty issue. Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The ALJ's order dated December 3, 1997 is reversed in part and affirmed in part. That portion of the ALJ's order that assessed a penalty for an allegedly unreasonable denial is reversed. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by SAIF.

In the Matter of the Compensation of
PHYLLIS M. HAYS, Claimant
WCB Case No. 95-13427
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Myzak's order that: (1) denied the insurer's motion to continue the hearing for receipt of Dr. Klecan's testimony and written report (Exhibit 60); (2) set aside its denial of claimant's aggravation claim for a current psychological condition; (3) awarded claimant's attorney an assessed fee of $28,500; and (4) approved the insurer's stipulation to pay $480 in expert witness costs. On review, the issues are continuance, compensability, aggravation , attorney fees and costs. We modify in part and affirm in part.

We adopt and affirm the ALJ's order regarding the issues of continuance, compensability, aggravation and costs, with the following supplementation.

Continuance

We agree with the ALJ's finding that the insurer did not exercise due diligence in obtaining Dr. Klecan's opinion prior to or at the time of the hearing, and that the insurer did not have the right to present final rebuttal evidence. (See O&O, p. 7-8). Accordingly, it was not an abuse of discretion for the ALJ to deny the insurer's motion to continue the hearing for receipt of Dr. Klecan's testimony or written report (Exhibit 60). See OAR 438-006-0091.

Compensability/Aggravation

We agree with the ALJ's finding that the accepted 1991 injury was the major contributing cause of claimant's psychological condition. We further find, based on the thorough and well-reasoned opinion of Dr. Henderson, that the psychological condition represented a pathological worsening of claimant's compensable condition since the last award or arrangement of compensation. (Day 3 Tr. 102-103).

Attorney Fee

For prevailing over the insurer's denial of claimant's aggravation claim for her current psychological condition, the ALJ awarded claimant's attorney an assessed fee of $28,500. The ALJ based the fee award on claimant's attorney's "summary of services" which reported 113 hours spent on this case, and on claimant's attorney's request that her hours be compensated at the extraordinary rate of $250 because of her extensive skill and experience, the significant value of the disability and medical benefits obtained for the psychological condition claim, the complexity of the factual and legal issues, and the risk that her services may have gone uncompensated. The ALJ noted that the insurer did not submit a response to claimant's attorney's attorney fee request and summary of services.

On review, the insurer contends that the claimant's attorney's summary of services overstates the hours she spent on this case and that, in any event, a $250 hourly rate is excessive for the number of hours spent on the case. We find no basis for the insurer's assertion that claimant's attorney's summary of services is inflated. However, after considering the factors in OAR 438-015-0010(4), we find that the requested $250 hourly rate was excessive. In particular, we note that, although the compensability issue was of above-average complexity, both factually and legally, the complexity was not so great as to justify a $250 hourly rate. Claimant's psychological condition was claimed as a "consequential condition" resulting from her accepted 1991 injury claim; therefore, she was not required to establish the compensability of her condition as a "mental disorder," a far more complex and difficult claim to establish. Furthermore, because claimant already had an accepted claim, the value of adding a psychological condition to her injury was significant, but not as great as the value of establishing an initial injury/disease claim. Finally, because of the relatively less complex task of establishing a "consequential condition" claim for the psychological condition (as opposed to a mental disorder claim), the risk that claimant's attorney's services may have gone uncompensated was somewhat limited. Therefore, after considering the factors in OAR 438-015-0010(4), with particular attention to the aforementioned factors of complexity, value, and risk, we find that a reasonable hourly rate for claimant's attorney's 113 hours of service is $175. Accordingly, we reduce the ALJ's assessed fee award to $19,775.

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 continuance and compensability issues is $2,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved. Because attorney fees and costs are not "compensation," we have not considered the time devoted to the attorney fee and cost issues. See Saxton v. SAIF, 80 Or App 631, rev den 302 Or 159 (1986).

ORDER

The ALJ's order dated July 17, 1997 is modified in part and affirmed in part. The portion of the ALJ's order that awarded claimant's attorney an assessed fee of $28,500 is modified to reduce the assessed fee award to $19,775. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $2,000, payable by the insurer.

April 8, 1998 Cite as 50 Van Natta 697 (1998)

In the Matter of the Compensation of
RACHAEL A. ENTENMAN, Claimant
WCB Case No. 97-07756
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order that reduced claimant's unscheduled permanent disability award for a low back condition from 22 percent (70.4 degrees), as awarded by an Order on Reconsideration, to zero. On review, the issue is extent of unscheduled permanent disability.

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

Alternatively, assuming (without deciding) that claimant is entitled to redetermination of her permanent disability award, we would not find that the medical arbiter's report constitutes "a preponderance of medical evidence" or that the arbiter's examination provides the most thorough, complete, and well-reasoned evaluation of claimant's impairment. See ORS 656.726(3)(f)(B); OAR 436-035-0005(10); OAR 436-035-0007(13). We reach this conclusion because we are unable to reconcile the arbiter's opinion that claimant's lumbar strain has "objectively resolved" with his reduced range of motion measurements. (Ex. 26-2).

ORDER

The ALJ's order dated December 8, 1997 is affirmed.

In the Matter of the Compensation of
KATHERINE M. HODGE, Claimant
WCB Case No. 96-03215
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Employers Defense Counsel, Defense Attorney

Reviewed by Board Members Bock and Moller.

The insurer requests review of Administrative Law Judge (ALJ) McWilliams' order that set aside its denial of claimant's injury claim for a cervical strain with radiculitis, C5-6 disc herniation, carpal tunnel syndrome and a right upper trapezius condition. On review, the issue is compensability. We reverse.

EXHIBITS

The "Exhibits" section of the ALJ's order is corrected as follows. At the end of the second paragraph, we add the following sentence: "Exhibit 2A was admitted pursuant to the ALJ's Interim Order dated November 15, 1996."

FINDINGS OF FACT

Claimant, a clerical worker, began working for the employer in 1989. (Tr. 5). In March or April 1995, claimant was fishing with her husband and a friend and slipped on a rock. (Tr. 10-11). She slid down the large rock, with her knees collapsing when she hit the bottom and landed face forward, bruising her chin on a rock. (Tr. 21- 23). Her husband and friend thought claimant had been knocked unconscious. (Tr. 23, 24). Claimant said she was very sore after the incident, but did not receive any medical treatment or miss any work. (Tr. 12).

On September 18, 1995, claimant testified that between noon and 1:00 p.m. she felt pain in her neck as she reached down and pulled up her articulating computer keyboard. (Tr. 6). She then went to lunch and continued to work that day. Claimant completed an injury report. (Ex. 1). She started experiencing pain in her right arm that night while sleeping. (Tr. 7).

Claimant testified that she saw a nurse in employee health three days later. (Tr. 7). On September 22, 1995, she sought treatment from Dr. Andresen, who diagnosed cervical strain with radiculitis. (Ex. 2a). He felt that her problem was most likely of musculoligamentous etiology with some referred pain and muscle aching about the shoulder girdle muscles. (Id.)

On January 2, 1996, claimant was examined by Dr. McGirr, neurosurgeon. (Ex. 3B). Based on an MRI, Dr. McGirr concluded that claimant had a very large right-sided C5-6 disc herniation. (Id.) On January 22, 1996, Dr. McGirr performed an anterior discectomy and fusion at C5-6. (Ex. 3C).

On March 25, 1996, the insurer denied that claimant's employment was the major contributing factor towards "development of cervical strain with radiculitis, C5-6 disc herniation, carpal tunnel syndrome and right upper trapezius[.]" (Ex. 5).

CONCLUSIONS OF LAW AND OPINION

Cervical Condition

Claimant agrees that she has a preexisting cervical degenerative condition and ORS 656.005(7)(a)(B) applies to this case. Because of the multiple possible causes of claimant's disability or need for treatment, this issue presents a complex medical question that must be resolved on the basis of expert medical evidence. Uris v. Compensation Dept., 247 Or 420 (1967); Barnett v. SAIF, 122 Or App 281 (1993).

Dr. McGirr rendered the only medical opinion on causation. In evaluating the medical evidence concerning causation, we rely on opinions that are well-reasoned and based on accurate and complete information. Somers v. SAIF, 77 Or App 259 (1986). In this case, we need not make express credibility findings because, even if we assume that claimant is credible, we are not persuaded by Dr. McGirr's opinion that the September 18, 1995 incident was the major contributing cause of claimant's disability or need for treatment for her cervical condition, including the C5-6 herniation.

Dr. McGirr expressed his opinion in terms of a "precipitating" or "immediate" cause analysis. When he first examined claimant, he noted there was a strong temporal relationship between the onset of claimant's neck symptoms, which subsequently developed into radicular symptoms, and the keyboard incident at work. (Ex. 3B-2, -3). On May 29, 1996, Dr. McGirr reported that, based on claimant's history, he felt that her herniated disc was most probably related to the September 18, 1995 injury, "innocuous as it apparently was." (Ex. 7-2; emphasis added). He weighed most heavily the fact that claimant's symptoms occurred on that date, "since it was obvious to me then and remains obvious to me now that the physical act of pulling the keyboard out from beneath the desk is in itself is quite innocuous and for me, this is a situation where it seems clearer that her injury occurred while at work, though less clear that it occurred because of work * * *." (Id.)

In a deposition on July 24, 1996, Dr. McGirr explained that he felt claimant's injury on September 18, 1995 was "innocuous" because there is generally not much physical effort required in pulling an articulated drawer containing the weight of a computer keyboard. (Ex. 8-5). When he was asked about causation of claimant's herniated disc, Dr. McGirr explained:

> "Well, probable cause is a difficult one, and my difficulty with this has been expressed for me by a colleague who said if a bridge is driven over a hundred times by a hundred cars, the hundredth car being your client's and it falls under the weight of that hundredth car, it's quite clear that that hundredth car brought the bridge down, but where is blame here?
>
> "Is it completely on that hundredth car or is it one one-hundredth on that car and ninety-nine out of a hundred on the preceding ninety-nine cars?
>
> "This is, I think, a very analogous situation. I felt that the physical act of pulling the keyboard out was quite innocuous and may have even been coincidental. My opinion is that it wasn't. My opinion, as I've expressed here, is that there was a relationship.
>
> "But blame for me is hard because clearly this is somebody who had -- the disk was set up and it happened then. Speculating, it may have happened in the future for other equally innocuous injuries, but it didn't, it happened at work.
>
> "And so when I assigned, if you will, blame, I hope that that analogy captures for you the conflicting concerns that I have. And if -- I'm not the referee in this case and I'm not sure that I understand the legal ramifications of exactly how you assign blame. It seems very strongly temporally related to that in that the symptoms described as radicular occurred at that time and not preceding. Enough said." (Ex. 8-14, -15; emphasis added).

The fact that a work injury may be an immediate or precipitating cause is not necessarily the "major contributing cause," absent a comparison of the relative contribution of all causal factors. Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev dismissed 321 Or 416 (1995). Here, part of Dr. McGirr's opinion is based on the type of reasoning rejected by the court in Dietz because he indicated that the work injury was the major contributing cause of claimant's need for treatment because it was the precipitating event that led claimant to seek medical treatment.

However, Dr. McGirr also indicated that claimant's degenerative cervical condition was the major contributing cause of the C5-6 herniation. He testified that claimant had preexisting degeneration in the C5-6 disc. (Ex. 8-6). He said the disc "clearly wasn't a normal disk" and he referred to loss of height of the disc and some irregularities at the end plates. (Ex. 8-21). Dr. McGirr said that the changes were more of a chronic and degenerative sort, rather than a simple soft, single fragment of extruding material. (Ex. 8-6).

In Dr. McGirr's first deposition, the insurer's attorney asked further questions about the bridge analogy:

> "If the bridge is, in fact, rotted and the hundredth car drives over it and the bridge falls, if I ask you what the major contributing case -- and that's fifty percent or more -- would it be the rotting bridge or would it be the hundredth car?
>
> "A. My answer, which is my opinion and not based on medical training and certainly not on legal knowledge, is that it would be related to the rotting. It would be then quickly be pointed out to me that had that hundredth car not driven across that rotting bridge, one can never know whether it would have stayed up or fallen. And so it seems that you blame the car, although my opinion that it's the rotting.
>
> "Q. And the analogy is appropriate to [claimant's] herniated disk in that there was prior degeneration in the disk, correct?
>
> "A. I will -- yes, it is, and it is appropriate." (Ex. 8-20, -21).

That portion of Dr. McGirr's testimony indicates that claimant's cervical degeneration was the major contributing cause of the C5-6 herniation.

Nevertheless, Dr. McGirr's later testimony about the "bridge analogy" again focused on the precipitating or immediate cause:

> "I understand that I'm to be responsive to a question phrased in the following manner: Is it medically probable that the disk herniated on the basis of X, Y or Z.
>
> "And I always have the trepidation of answering that question based on, if you will, the bridge analogy. I have to answer that if the car didn't drive, the bridge wouldn't have fallen and then therefore it's medically probably that that was the culminating event.
>
> "And I swallow hard when I answer that question because of my concern about the rot that's preceded. I accept that people can cough, can bend over and tie a shoe, can turn over in bed at night and have the acute onset of neck or low back symptoms with radiculopathy. It seems clear that the disk herniated then.
>
> "Where I am unable to go is to say that it was just that or primarily that that was the culprit and I freely admit that I always have difficulty answering that question: Is it medically more probable that the majority causes that? I answer yes because I know if the car hadn't driven, if you will, the bridge would still be there." (Ex. 8-30, -31).

Dr. McGirr's opinion is, at best, inconsistent and confusing. Although he felt that claimant's September 18, 1995 work incident was "innocuous," he focused on the fact that her symptoms began on that date to conclude that the C5-6 herniation was most probably related to the work incident. (Ex. 7). In the "bridge analogy" in the first deposition, Dr. McGirr at one point indicated that the major contributing cause of the herniation was the prior disc degeneration (Ex. 8-20, -21), but he later focused on the precipitating work incident. (Ex. 8-30, -31).

Dr. McGirr further complicated the issue of causation by indicating that claimant's fishing incident could be the major contributing cause of the C5-6 herniation. Although Dr. McGirr was not initially told about claimant's fall while fishing, he said that sort of trauma could be associated with the herniation of a cervical disc. (Ex. 8-8, -9). However, he noted that even more innocuous traumas have been associated with herniation. The symptoms after the event were important. (Ex. 8-9). Dr. McGirr testified that a history of observed stiffness and soreness and complaints of neck pain would be consistent with someone who had a disc injury that was evolving towards a herniation. (Ex. 8-12, -13). In a later deposition, Dr. McGirr said that complaints of neck pain and observable decreased range of motion could indicate a substantial cervical injury. (Ex. 9-31).

In a second deposition in February 1997, Dr. McGirr was asked what the major contributing cause would be if claimant had sustained a substantial injury resulting from the fall from fishing, but not a ruptured disc. He replied:

> "It is very difficult to answer that question directly. I am not trying to be evasive. It is very difficult to assign degrees of blame. If a disk is substantially injured by chronic use or by traumatic incident and there is a significant degree of symptoms, for example, let's just say you could definitely say were due to that disk -- and there is much controversy about that even -- if that disk later herniates, I think I would be of the opinion that much of the blame still rests on the preexisting condition rather than the episode around its herniation." (Ex. 9-17, -18).

Although claimant denied that she had experienced neck pain before the September 18, 1995 incident (Tr. 12, 20, 26), two witnesses testified that they had observed that claimant had decreased ranges of motion in her neck or complaints of neck pain after the fishing incident and before the September 18, 1995 work incident.[1] (Tr. 59-60, 65-69).

In any event, even if we rely on claimant's testimony rather than the testimony of other witnesses, we conclude that claimant has not established her burden of proof. Dr. McGirr's opinion is not sufficient to establish that the September 18, 1995 incident was the major contributing cause of claimant's disability or need for treatment related to the C5-6 disk herniation. Part of Dr. McGirr's opinion focused only on a "precipitating" or "immediate" cause analysis. Later in his July 1996 deposition testimony, he concluded that the degenerative condition was the major contributing cause of the herniation. Dr. McGirr's opinion is not persuasive because it is inconsistent and is not well-reasoned. Under these circumstances, we uphold the insurer's denial of claimant's cervical condition.[2]

Carpal Tunnel Syndrome and "Right Upper Trapezius"

On March 25, 1996, the insurer denied that claimant's employment was the major contributing factor towards "development of cervical strain with radiculitis, C5-6 disc herniation, carpal tunnel syndrome and right upper trapezius[.]" (Ex. 5).

Claimant contends that there is no evidence of a claim for carpal tunnel syndrome or a right shoulder condition. She argues that the denial of carpal tunnel syndrome should be set aside as premature.

We find no evidence in the record that claimant was diagnosed with carpal tunnel syndrome or a right upper trapezius condition. Moreover, we find no evidence that claimant filed a "claim" for either condition. Therefore, because the insurer's denial of those conditions was issued in the absence of a claim, those portions of the denial are a nullity and have no legal effect. See Stephenson v. Meyer, 150 Or App 300, 304 (1997) (because no claim was made, the legal predicate for an award of attorney fees did not exist); Altamirano v. Woodburn Nursery, Inc., 133 Or App 16, 19-20 (1995) (because there was

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[1] Although the employer also relies on the testimony of Mr. Killion, his testimony refers to a different time period. Mr. Killion said that claimant complained about a sore neck, but he thought the problem began shortly before Christmas 1995. (Tr. 38-39).

[2] In light of our disposition, we need not address claimant's former attorney's request that the Board approve a $5,000 lien for attorney fees for his services at hearing.

no claim that the claimant's current condition required medical treatment or resulted in disability, the employer's attempted denial was ineffective); Vicki L. Davis, 49 Van Natta 603 (1997) (carrier's precautionary partial denial of lumbar degenerative conditions was premature and had no legal effect because the claimant had not filed a "new medical condition" for the conditions).

We conclude that the insurer's denial of carpal tunnel syndrome and "right upper trapezius" was premature. Therefore, we set aside those portions of the denial as a nullity.

Because we have determined that claimant has made no "claim" for carpal tunnel syndrome or "right upper trapezius," she will receive no benefits as a result of our holding that those portions of the insurer's denial were premature and a nullity. Thus, we conclude that claimant has not "prevailed" over a denied claim with respect to those conditions and is not entitled to an assessed attorney fee under ORS 656.386(1). See Stephenson v. Meyer, 150 Or App at 304; Vicki L. Davis, 49 Van Natta at 606.

ORDER

The ALJ's order dated August 21, 1997 is reversed. The portion of the ALJ's order that set aside the insurer's denial of claimant's cervical condition is reversed. The insurer's denial of claimant's cervical condition is reinstated and upheld. The ALJ's attorney fee award is also reversed. The insurer's denial of carpal tunnel syndrome and "right upper trapezius" condition is set aside as a nullity.

In the Matter of the Compensation of
ROYAL S. BUELL, Claimant
WCB Case No. 97-06006
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Garrett, Hemann, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock and Hall.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Thye's order that: (1) declined to order the insurer to amend its acceptance of claimant's right hand injury to include a "crush injury to right hand"; and (2) declined to award an attorney fee pursuant to ORS 656.386(1). On review, the issues are scope of acceptance and attorney fees.

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

The ALJ held that claimant was not entitled to have a "crush injury" to the right hand accepted as a compensable condition. In doing so, the ALJ agreed with the insurer's contention that, under the facts of this case, "crush injury" was a description of the mechanism of injury, not a medical condition or diagnosis.

On review, claimant contends that "crush injury" is a diagnosis or condition that the insurer should be required to accept. In support of his argument, claimant cites several cases in which he asserts that "crush injury" was determined to be an accepted "condition." See Steve W. Hooten, 49 Van Natta 1870 (1997); Vickie L. Wing, 49 Van Natta 1468 (1997); Chris W. Poe, 49 Van Natta 1367 (1997); Bessie B. Mitts, 49 Van Natta 799 (1997); Michael T. Alioth, 49 Van Natta 688 (1997); and Richard L. Henley, 49 Van Natta 621 (1997).

Claimant's contentions notwithstanding, we agree with the ALJ's reasoning. While the cases claimant cites did concern crush injuries, none of them contained a determination on the merits that a "crush injury" is a distinct medical condition or diagnosis. Even if they had, we decide this case based on the medical evidence in this case. See Ellen G. Johnson, 49 Van Natta 1360, 1363 n. 1 (1997). Based on that evidence, we agree with the ALJ's reasoning and conclusions.

ORDER

The ALJ's order dated November 18, 1997 is affirmed.

Board Member Hall dissenting.

The majority affirms the ALJ's order that declined to order the insurer to amend its acceptance of claimant's right hand injury to include a "crush injury to right hand." Because I believe that claimant is entitled to specific acceptance of a "crush injury," I cannot agree with the majority's decision.

The ALJ accepted the insurer's argument that it should not be required to accept a "crush injury" because it was a description of the mechanism of injury, rather than a diagnosis or medical condition. My review of the medical records does not support the distinction the insurer draws.

The mechanism of injury was clearly described in the medical records as claimant injuring his right hand after having it caught between a fence post and the bucket of a tractor. (Ex. 2). The resultant diagnosis or condition, however, was a "crush injury." Therefore, contrary to the ALJ's and the majority's suggestion, requiring acceptance of a "crush injury" is not similar to ordering a carrier to accept a "blow to the head" or a "fall off a ladder."

Moreover, the current acceptance, which consists of finger fractures, does not (in my opinion) adequately apprise claimant and his doctors of the full nature and extent of the compensable injuries claimant suffered. See ORS 656.262(7)(a). Thus, I would reverse the ALJ's decision and order acceptance of a "crush injury to right hand." In reversing, I would make it clear that the insurer's acceptance was too limited and that "crush injury" includes the diagnosed conditions identified in the record: not just the fracture of the right third metacarpal and nondisplaced fracture of the index metacarpal (both of which the insurer has accepted), but also tissue and tendon damage above the affected fingers (Ex. 12), superficial scrape of the wrist (Id.) and an irritated nerve (Ex. 3-3).[1]

In conclusion, the insurer must satisfy its duty under ORS 656.262(7)(a) to reasonably apprise claimant and his medical providers of the nature of the compensable conditions. The limited acceptance, which the majority affirms, does not do so. Because the majority's decision allows the insurer to avoid its statutory obligation of reasonably apprising claimant and his medical providers of the accepted conditions, I respectfully dissent.

[1] These additional diagnosed conditions have not been denied. There is no evidence that these additional conditions are anything other than compensable components of the work related injury claimant suffered.

April 8, 1998 Cite as 50 Van Natta 703 (1998)

In the Matter of the Compensation of
STEVEN C. ELLIS, Claimant
WCB Case No. 97-04410
ORDER ON REVIEW
Jean M. Fisher, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) T. Lavere Johnson's order that upheld the SAIF Corporation's denial of his occupational disease claim for a right foot condition. On review, the issue is compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant did not carry his burden to prove a pathological worsening of the preexisting arthritis in the right foot and, therefore, upheld SAIF's denial of his right foot claim. On review, claimant argues that he presented sufficient medical evidence to prove that his preexisting

arthritis was pathologically worsened by his work activity of prolonged standing on hard surfaces. We disagree. As the ALJ reasoned, Dr. Gallagher, claimant's treating orthopedist, opined that claimant suffered a symptomatic worsening of his preexisting arthritis, not a worsening of the underlying arthritis condition itself. (Exs. 11, 14, 15-8). Therefore, we adopt the ALJ's conclusion and opinion that claimant did not establish the compensability of the right foot arthritis condition as an occupational disease.

However, claimant's right foot claim also included, in addition to the right foot arthritis condition, a posterior tibial tendinitis condition. (Exs. 5-3, 15-4). Dr. Gallagher described the tendinitis condition as "independent" from the arthritis condition, though the effects from each condition "at times" combined to cause claimant's right foot symptoms and need for treatment. (Ex. 15, pp. 12-13). In any event, Dr. Gallagher felt that the tendinitis, not the arthritis, was the "primary" source of claimant's foot pain. (Ex. 15, pp. 13-14). Dr. Gallagher's diagnosis of tendinitis was supported by the diagnosis of claimant's primary care physician, Dr. Sanders, who also diagnosed tendinitis when claimant first sought treatment in August 1996. (Ex. 1).

Only Dr. Woll appeared to disagree with the tendinitis diagnosis, stating that during his examination in March 1997, claimant's right foot pain appeared to be located more in the area of the arthritis (i.e., mid-foot region) rather than on the posterior tibial tendon. (Ex. 9). However, because Dr. Woll saw claimant only once, whereas Dr. Gallagher saw claimant on several occasions, we are more persuaded by the diagnosis of Dr. Gallagher, who had a better opportunity to evaluate claimant's right foot condition over time. See Weiland v. SAIF, 64 Or App 810, 814 (1983).

Dr. Gallagher opined that the tendinitis did not preexist claimant's employment. (Ex. 15-4). He also did not identify any preexisting condition which contributed to or predisposed claimant to the onset of the tendinitis condition.[1] Because the tendinitis claim is not "based on the worsening of a preexisting disease or condition," claimant need not prove a "pathological worsening" to establish an occupational disease claim for the tendinitis. See ORS 656.802(2)(b). Instead, the claim may be established under ORS 656.802(2)(a), which provides that "[t]he worker must prove that employment conditions were the major contributing cause of the disease."

Dr. Gallagher opined that the major cause of the right foot tendinitis was the length of time that claimant spent on his feet on a hard surface at work. (Ex. 15-4). His opinion in this regard is unrebutted. SAIF contends that Dr. Gallagher's causation opinion is unpersuasive because he was not aware that the onset of claimant's symptoms occurred while he was driving a cart at work. However, it is undisputed that, aside from driving a cart, claimant's work activities also required prolonged standing/walking on hard surfaces. Therefore, the injurious exposure that Dr. Gallagher identified as the major cause of the tendinitis had already occurred when claimant drove the cart. Under these circumstances, the doctor's lack of awareness as to the precise activity that coincided with the onset of claimant's symptoms does not undercut his ultimate conclusion that the prolonged standing/walking at work was the major cause of the tendinitis. For these reasons, we conclude that claimant carried his burden to prove the compensability of his right foot tendinitis condition. SAIF's denial of that particular condition shall be set aside.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review in prevailing over the denial of the right foot tendinitis condition. See ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable attorney fee for services at hearing and on review regarding the tendinitis claim is $2,900, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the tendinitis claim (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's efforts may have gone uncompensated. Claimant's attorney is not entitled to an assessed fee for services regarding the right foot arthritis condition.

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[1] In its brief, SAIF suggests that claimant's flat foot and an apparent fused accessory navicular may have played a role in the onset of claimant's right foot symptoms, (Resp. Br. 4); however, we find no medical opinion in the record to support a finding that either of those conditions contributed to or predisposed claimant to the development of tendinitis.

ORDER

The ALJ's order dated October 22, 1997 is reversed in part and affirmed in part. The portion of the order that upheld SAIF's denial of claimant's occupational disease claim for right foot tendinitis is reversed. SAIF's denial is set aside to the extent it denied the right foot tendinitis claim, and the claim is remanded to SAIF 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 $2,900, payable by SAIF.

In the Matter of the Compensation of
THERESE M. HASKELL, Claimant
WCB Case No. 97-06301
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that upheld the SAIF Corporation's denial of her occupational disease claim for a left elbow condition. On review, the issue is compensability.

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

On review, claimant contends that the ALJ erred by accepting the opinion of Dr. Duff, who examined claimant on SAIF's behalf, over the opinion of Dr. Alaimo, claimant's treating physician. Claimant argues that the opinion of Dr. Duff should not be accepted merely because it is eight pages long, while Dr. Alaimo's opinion consists only of chartnotes and a half page report.

We do not find that the ALJ rejected Dr. Alaimo's report on the basis argued by claimant. Rather, the ALJ found, and we agree, that Dr. Alaimo's opinion does not provide any discussion of causation or claimant's preexisting condition. (Ex. 14). In light of claimant's lengthy history of chronic pain, including elbow pain, we conclude that Dr. Alaimo's opinion, which does not discuss claimant's preexisting condition, is not persuasive. See Pamela A. Burt, 46 Van Natta 415 (1994).

Moreover, although Dr. Alaimo has opined that work is the major cause of claimant's elbow condition, he has provided no reasoning or explanation to support his conclusion. Under the circumstances, we conclude that the ALJ correctly rejected his opinion and found that claimant failed to meet her burden of proof. See Blakely v. SAIF, 89 Or App 653, 656, rev den 305 Or 972 (1998) (physician's opinion lacked persuasive force because it was unexplained); David W. Blair, 49 Van Natta 1974 (1997); Somers v. SAIF, 77 Or App 259 (1986).

ORDER

The ALJ's order dated December 8, 1997 is affirmed.

In the Matter of the Compensation of
CYNTHIA L. McLAUGHLIN, Claimant
WCB Case No. 97-00472
ORDER ON REVIEW
Gary L. Tyler, 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) Podnar's order that set aside its denial of claimant's occupational disease claim for a stress-related mental disorder. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant has been employed at Oregon Health Sciences University since 1985 and has worked as an equipment services technician for the last four years. (Ex. 27A-3). At work, claimant spends the majority of the workday outside of the equipment pool department in other areas of the hospital reissuing equipment. She spends only about two hours of the workday in the equipment pool department. In a typical day, claimant begins work at 7 am, prepares paper work and then goes out into the hospital to reissue equipment in other areas of the hospital until about 9 am when she returns to the department and for about a half hour and then goes back out into the hospital until lunch. After lunch, claimant returns to the department for a half hour sometime between 2:30 and 3:30 PM and then leaves for the day.

Claimant's co-workers, who spend their entire workday in the department, often listen to the radio or a CD player for entertainment. Usually there is only one source of music, but there have been instances where more than one music source was playing at one time. Music has been played in the department in which claimant works since at least 1990. (Tr. 56). In March 1996, claimant began to have difficulty concentrating on her work when co-workers played the radio or CD player. On March 7, 1996, claimant and a co-worker, Arthur, had an argument over Arthur's use of the radio. Claimant's supervisor, Ms. Berkshire made an agreement with claimant that the radio would be turned off between 3:00 and 3:30 and would be turned down when claimant was working in the department. (Ex. 18). In spite of this agreement, the radio was not consistently turned down when claimant was in the office because co-workers were sometimes unaware of her presence. Also, when the radio was turned down or off, co-workers would sometimes sing or whistle.

In addition to the agreement to turn down the radio, Ms. Berkshire also arranged for testing to monitor noise levels in the department. The testing was performed in April 1996 and revealed that the noise levels in the equipment pool were below any regulatory threshold. However, the safety education officer who conducted the testing concluded that the ambient sound pressure level might, at times, get high enough to slightly interfere with communication and potentially alter work performance. (Ex. 19).

In late July 1996, claimant had a confrontation with another co-worker, Chase, in which claimant unplugged Chase's CD player. (Ex. 21).

On August 7, 1996, claimant filed a claim for "aggravation in the work place which leads to the inability to concentrate." (Ex. 22). After the claim was filed, claimant, a union representative and claimant's supervisor signed an agreement that the radio would be turned down while claimant was in the department during the day and would be turned off from 3:00 to 3:30 PM. (Exs. 25; 26). After this agreement was made, claimant perceived that her co-workers would begin to sing or whistle when she entered the department. (Ex. 27-10). Claimant felt that she was being harassed.

Claimant had the measles at the age of 15 months with a high fever. This caused her to have developmental delays and decreased intellectual functioning. She attended special education classes from the fifth grade through high school. Claimant has a past history of depression and was hospitalized in December 1985 for depression.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant had established that her work activity was the major contributing cause of her need to seek treatment for an adjustment disorder. On review, SAIF argues that the ALJ erred in finding that music is an employment condition which is not generally inherent in every working

situation. In addition, SAIF argues that the medical evidence does not establish that workplace music was the major contributing cause of claimant's adjustment disorder. Claimant seeks to have the ALJ's order affirmed, arguing that continuous playing of music caused claimant's mental condition and that the playing of music is not a condition which is generally inherent in every working situation.

To establish the compensability of a stress-related mental condition, claimant must prove that employment conditions were the major contributing cause of her disease. ORS 656.802(2)(a).[1]

Two medical experts address the nature and cause of claimant's mental condition. Dr. Lowenstein, psychiatrist, examined claimant on behalf of SAIF. He diagnosed an adjustment disorder with depressed mood and anxiety which had resolved. Dr. Lowenstein also opined:

> "It is this author's opinion that the pre-existing psychiatric condition predisposed [claimant] to the adjustment disorder. Without the pre-existing conditions, [claimant] more than likely would have tolerated the situation without significant symptoms. It is [claimant's] limited cognitive function and long-standing mood lability and difficulty she has in processing that contributed to the development of her adjustment disorder. The symptoms that would be new is her inability to concentrate, tearfulness on the job, sleep disturbance and a feeling of an inability to go to her work station to do her job. These symptoms appear to have developed due to a regular exposure to the Intensive Care setting coupled with the radio playing in the work setting. This stimuli was beyond what [claimant] could process due to her limited cognitive ability and long-standing emotional lability."

Dr. Lowenstein indicated that "it is primarily the work exposure to the ICU environment and the radio that contributed to the worker's condition, again based on her pre-existing difficulties with mood stability and cognitive function."

Dr. Binder, psychologist, also examined claimant on behalf of SAIF. Dr. Binder opined that claimant did not have a diagnosable mental disorder at the time of his examination of claimant. Dr. Binder indicated that if claimant had had an adjustment disorder which had resolved as diagnosed by Dr. Lowenstein, the major contributing cause of that condition would be claimant's abnormal character traits. Dr. Binder expressed no opinion on whether claimant previously had an adjustment disorder, but opined that if claimant did previously have an adjustment disorder, it was equally possible that the distress claimant manifested was an exacerbation of her abnormal personality traits as opposed to an adjustment disorder. (Ex. 33-39).

To the extent that Dr. Lowenstein's opinion supports a conclusion that claimant had a compensable mental disorder that has resolved, we do not find his opinion persuasive for the following reasons. First, Dr. Lowenstein had a history that it was not until claimant filed a claim that her supervisor took her complaints seriously. The record documents that claimant's supervisor had in fact taken action on claimant's complaint about the radio and CD players prior to the filing of the claim and had arranged for testing of the area and instructed that the radio be turned down when claimant was in the office. In addition, it is unclear from Dr. Lowenstein's report whether he was aware that claimant spent only a limited portion of her work day in the area where the radio was playing. Finally, in giving the causes of claimant's resolved adjustment disorder, Dr. Lowenstein indicated that it was exposure to the ICU environment and the radio that contributed to claimant's condition. Dr. Lowenstein's opinion conflicts with claimant's testimony that the music played by her co-workers alone was the cause of her problems.

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[1] Additionally, the employment conditions producing the mental disorder must exist in a real and objective sense and must be conditions other than those generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment, or employment decisions attendant upon ordinary business or financial cycles. Furthermore, there must be a diagnosis of a mental or emotional disorder that is generally recognized in the medical or psychological community and there must be clear and convincing evidence that the medical disorder arose out of and in the course of employment. ORS 656.802(3)(a)-(d).

By contrast, we find that Dr. Binder had a more accurate and complete history regarding claimant's work activities and the events surrounding her claim. Dr. Binder was aware that claimant spent only a portion of her workday in the department and was aware of the actions taken by claimant's supervisor to remedy claimant's problem with the radio and CD player. Under such circumstances, we are more persuaded by Dr. Binder's opinion. See Somers v. SAIF, 77 Or App 259 (1986) (in evaluating the medical evidence, we rely on those opinions which are both well-reasoned and based on accurate and complete information). Based on Dr. Binder's opinion, we are unable to find by clear and convincing evidence that claimant's mental disorder arose out of and in the course of employment. Accordingly, based on this record, claimant has not established that her work activities were the major contributing cause of her mental condition. ORS 656.802(2)(a).[2]

ORDER

The ALJ's order dated August 7, 1997 is reversed. SAIF's denial is reinstated and upheld. The ALJ's award of an attorney fee is also reversed.

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[2] Because we find that the medical evidence does not establish that the conditions at work were the major contributing cause of claimant's mental condition, we need not address whether music is a condition which is generally inherent in all working situations.

In the Matter of the Compensation of
LOWELL D. ARMON, Claimant
Own Motion Nos. 98-0146M & 98-0070M
OWN MOTION ORDER REFERRING FOR CONSOLIDATED HEARING
Coughlin, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant has requested own motion relief for the same current condition in two separate claims. On November 2, 1978, claimant suffered an injury to his right ear. That claim was accepted for a large central perforation of the tympanic membrane w/conductive loss of hearing, right ear (Claim No. 4343417J, Own Motion No. 98-0146M). On August 8, 1979, claimant suffered an injury to his left leg. That claim was accepted for a left leg cut laceration (Claim No. KD394335, Own Motion No. 98-0070).

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable large central perforation of the tympanic membrane w/conductive loss of hearing, right ear (Claim No. 4343417J, Own Motion No. 98-0146M). Claimant's aggravation rights expired on May 10, 1984. SAIF contends claimant's current torn medial meniscus, left knee condition is causally related to the accepted condition and that it is responsible for claimant's current condition. However, SAIF recommends against reopening on the grounds that claimant was not in the work force at the time of the current disability.

Claimant requested own motion relief in Claim No. KD394335 (compensable left leg cut and laceration), contending his left knee had "worsened to where [claimant] now needs surgery." In this claim, SAIF denied the compensability of claimant's current torn medial meniscus, left knee condition on which claimant has filed a request for hearing with the Hearings Division. (WCB Case No. 98-01116). SAIF has not submitted a recommendation form in this claim.

Therefore it appears that own motion benefits are being requested in two separate claims for the same current condition, which has been denied in one claim and accepted in another that has work force issues. As litigation is pending regarding the compensability of claimant's current condition, we conclude that it would be in the best interest of the parties to consolidate these own motion matters with the pending litigation.

WCB Case No. 98-01116 is currently scheduled before Administrative Law Judge (ALJ) Peterson on April 23, 1998. At the hearing, if the current request for treatment is found to be causally related to either compensable injury, the ALJ shall make findings of fact and conclusions of law and opinion on

the issue of whether claimant was in the work force at the time claimant's condition worsened. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990); Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

At the conclusion of the hearing, the ALJ shall forward to the Board a separate, unappealable recommendation with respect to the own motion matter and a copy of the appealable order issued in WCB Case No 98-01116. In addition, if the matter is resolved by stipulation or disputed claim settlement, the ALJ is requested to submit a copy of the settlement document to the Board. After issuance of the order or settlement document, the parties should advise the Board of their respective positions regarding own motion relief.

IT IS SO ORDERED.

April 9, 1998 Cite as 50 Van Natta 709 (1998)

In the Matter of the Compensation of
JAMES F. LAU, Claimant
WCB Case No. 97-02082
ORDER ON REVIEW
Parker, Bush, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes, Hall and Bock.

KC Sheet Metal, a noncomplying employer, requests review of Administrative Law Judge (ALJ) Poland's order that upheld the SAIF Corporation's acceptance of claimant's injury claim for a right acetabular fracture dislocation, right distal radius fracture, and left thumb dislocation. On review, the issue is subjectivity. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the following supplementation.[1]

Claimant was a Michigan resident at the time of his injury, but he traveled all over the country to work as a sheet metal worker where he could find employment. He lived in a camping trailer in campgrounds before and during his Oregon employment. (Tr. 75).

Claimant is a member of a Kentucky local union hall. He was hired by the employer after contacting the Oregon union hall and asking to be put to work as a "traveler." (Tr. 74).

CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the relevant facts, noting that they are not disputed.

Claimant, a sheet metal worker, relocated from Michigan to Washington, hoping to find work.

The employer, a Washington corporation, hired claimant in Oregon to work in Oregon. After working about 10 days at the Toledo, Oregon job site, claimant fell and injured his hands on the job. He filed claims in Washington and Oregon.

The Washington claim was accepted and benefits were provided.

SAIF, as a statutory claim processing agent under ORS 656.054, accepted the Oregon claim on the employer's behalf. The employer requested a hearing.

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[1] The last sentence of the first full paragraph on page three of the ALJ's order is corrected to read, "Claimant did not return to work on the Toledo job after the July 2, 1996 injury.

The ALJ found that claimant was not injured at an Oregon "temporary workplace" as that phrase is defined in former ORS 656.126(7).[2] We agree and adopt the ALJ's reasoning and conclusions in this regard. See James Crawley, 47 Van Natta 364 (1995) (where the employer worked at an Oregon site for more than 30 days in a year, it did not have a temporary workplace in Oregon under ORS 656.126); Jerry M. Banks, 44 Van Natta 2561, 2562 (1992). However, that does not end our inquiry.

The ALJ found the permanent employment relationship test inapplicable in this case, reasoning that claimant was not exempt from ORS Chapter 656 coverage because the employer's Oregon job lasted more than 30 days. Shortly before the ALJ's order, the court stated that ORS 656.126 and the Washington/Oregon reciprocity agreement "are silent about when an injury occurs at a nontemporary workplace." Carothers v. Robert Westlund Construction, 149 Or App 457, 461 (1997); see former ORS 656.126(2).[3]

In Carothers, the employer did not operate a temporary workplace in Washington, so "the question of who [was] a subject Oregon worker at the employer's 'nontemporary' workplace in Washington" was properly determined under the permanent employment relation test. Id. at 461-62.[4]

Here, because claimant was injured at the Washington employer's nontemporary Oregon workplace, claimant's subjectivity is similarly evaluated under the permanent employment relation test. See Phelan v. H.S.C. Logging, Inc., 84 Or App 632 (1987) (permanent employment relation test applied where the issue was whether claimant was a worker from another state temporarily working in Oregon); Luis A. Cordoba, 48 Van Natta 18, 19 (1996) ("the key inquiry is the extent to which a claimant's work in the state-of-injury is temporary").

"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." Carothers, 149 Or App at 462 (citing Northwest Greentree, Inc. v. Cervantes-Ochoa, 113 Or App 186, 189-90 (1992)).

In this case, claimant was hired and injured in Oregon. He was hired out of an Oregon local union hall, solely for Oregon work. However, claimant was a member of a Kentucky local at the time. (Tr. 77). He had merely contacted the Oregon local to be put to work as a "traveler." (Tr. 74).

When claimant was hired by the employer, he had a Washington address. His automobile license plates, driver's license and voter's registration were all issued in Michigan.[5]

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[2] Former ORS 656.126(7) defines 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."

We note, as did the ALJ, that the 1997 legislature amended ORS 656.126, but the changes are not applicable here. See Or Laws 1997, ch 234, §1 (effective October 4, 1997).

[3] Former ORS 656.126(2) provides, in part:

"Any worker from another state and the employer of the worker in that other state are exempted from the provisions of this chapter while the employer has a temporary workplace within this state and the worker is within this state doing work for the employer: * * * *"

[4] The court commented:

"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." Id. at 462.

[5] We note that Oregon residency is not required for Oregon Workers' Compensation coverage. However, it is one of the factors to be considered in determining whether a worker is an Oregon worker or an out-of-state worker temporarily working in Oregon.

The equipment and tools for the Oregon job were sent to the job site from Washington. Workers on this job were paid by checks issued on a Washington bank. Claimant was hired for this job only. The employer did not anticipate that claimant would continue in its employ (in Oregon or elsewhere) and claimant had no such expectation. Finally, we note that claimant's Washington workers' compensation claim for this injury has been accepted and claimant has received benefits under the claim.[6]

Considering the above-described circumstances, we conclude that claimant was an out-of-state worker, temporarily working in Oregon, when he was injured. In other words, even though the Oregon workplace was "nontemporary" (under former ORS 656.126(7)), claimant was only a temporary worker in Oregon. Because his employment circumstances did not satisfy the permanent employment relation test, claimant was not covered by ORS Chapter 656 when he was injured. See Carothers, 149 Or App at 462; see also Haney v. Union Forest Products, 129 Or App 13, 17 (1994); Phelan, 84 Or App at 635.

ORDER

The ALJ's order dated September 12, 1997 is reversed. The SAIF Corporation's acceptance is set aside. The ALJ's attorney fee award is reversed.

[6] We also note that the employer is a Washington employer with no fixed place of business in Oregon. Almost all of the employer's work is performed in Washington. The employer maintains Washington workers' compensation coverage for all its employees; it conducts its financial business in Washington; and it is generally subject to Washington law.

In the Matter of the Compensation of
SCOTTLAND FOWLER, Claimant
WCB Case Nos. 97-05071, 97-04980 & 97-03869
ORDER ON REVIEW
Rasmussen, et al, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Twin City Fire Insurance Company (Twin City)[1], on behalf of Olsten Staffing, requests review of those portions of Administrative Law Judge (ALJ) Myzak's orders that: (1) set aside its aggravation, current condition and responsibility denials of claimant right forearm condition; (2) upheld the SAIF Corporation's responsibility denial of the same condition; (3) awarded an assessed attorney fee of $3,200, to be paid by Twin City, and (4) directed it to pay claimant[2] temporary disability compensation from April 17, 1997 to June 9, 1997. On review, the issues are compensability, aggravation, responsibility, attorney fees and interim compensation. We reverse in part, modify in part, and affirm in part.

FINDINGS OF FACT

On August 7, 1996, claimant compensably injured his right forearm while working for Twin City's insured. Twin City accepted a ruptured muscle of the right forearm. (See Ex. 20; Depo. Ex. 1). He was released to regular work in concrete construction without restrictions on September 20, 1996. (Ex. 4-2). The claim was closed on January 6, 1997 with an award of one percent scheduled permanent disability for the right forearm (wrist). (Ex. 7A).

[1] We note that Twin City is also described as "Hartford" in the ALJ's order and in the file.

[2] The "order" portion of the ALJ's order ordered Twin City to pay temporary disability compensation to "claimant's attorney." However, it is clear from the ALJ's order that claimant was entitled to compensation, not his attorney (except for an out-of-compensation attorney fee).

Claimant later began working in concrete construction for SAIF's insured. On February 5, 1997, a cement mixer was clogged and claimant was involved with trying to correct the problem. The machine flipped and claimant was thrown about 10 feet and landed on his right arm. (Tr. 11-13). He experienced immediate pain and symptoms similar to the August 1996 injury. (Tr. 13). He sought immediate medical treatment and was released from work. (Ex. 8).

Claimant initially filed a claim with SAIF's insured. (Ex. 11). On April 1, 1997, SAIF denied claimant's right forearm injury, stating that his "condition(s) and need for treatment may be the result of a separate injury or occupational disease." (Ex. 16). SAIF advised claimant to file a claim with Twin City's insured. (Id.)

On April 17, 1997, claimant signed a "Notice of Claim for Aggravation of Occupational Injury or Disease," listing Twin City's insured as the employer. (Ex. 17A). Dr. Butters signed the form on April 16, 1997 and indicated that time loss was authorized. (Id.) On June 9, 1997, Twin City notified claimant that it had received his aggravation claim and denied the claim "as the major contributing cause of your current need for treatment of your right forearm is a result of an on the job injury that occurred on February 5, 1997." (Ex. 18A).

Claimant's attorney filed requests for hearing concerning the denials, as well as procedural entitlement to temporary disability benefits.

CONCLUSIONS OF LAW AND OPINION

A hearing was held on August 13, 1997 regarding compensability, aggravation, responsibility and interim compensation. The ALJ bifurcated WCB No. 97-04980, which dealt with interim compensation.[3] In an Opinion and Order dated October 29, 1997, as reconsidered November 28, 1997 (concerning WCB Nos. 97-05071 & 97-03869), the ALJ ordered Twin City to provide a copy of Exhibit 17A with a legible date stamp showing the date of its receipt of that document.

Compensability

The ALJ found that, based on Dr. Butters' opinion, claimant had established compensability of his current right forearm condition. The ALJ applied ORS 656.308(1) and found that Twin City was responsible for claimant's current condition.

Twin City argues that the issue at hearing was whether claimant had sustained a compensable aggravation claim, not the compensability of his current condition. Twin City contends that claimant cannot establish an "actual worsening" and, therefore, we should uphold its aggravation denial.

In contrast, claimant contends that Twin City's June 9, 1997 letter denies an aggravation claim and his current condition. For the following reasons, we agree with claimant.

Claimant signed a "Notice of Claim for Aggravation of Occupational Injury or Disease," listing Twin City's insured as the employer. (Ex. 17A). On June 9, 1997, Twin City notified claimant that it had received his aggravation claim. Twin City stated, in part:

> "We must respectfully deny your above captioned claim for aggravation as the major contributing cause of your current need for treatment of your right forearm is the result of an on the job injury that occurred on February 5, 1997. We believe that [SAIF's insured] may be responsible for current medical treatment and disability." (Ex. 18A).

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[3] Although the ALJ bifurcated these cases, we consolidate the cases on review. We have taken this action because the cases were litigated together at hearing, without objection from the parties. In light of such circumstances, because the issues are intertwined, the Board considers it to be in the interests of substantial justice and administrative efficiency to address and resolve these interrelated issues in one final order.

Twin City's June 9, 1997 letter not only denied claimant's aggravation claim, it also denied claimant's "current need for treatment of [his] right forearm[.]" (Id.) Thus, Twin City was denying benefits for claimant's treatment of his current right forearm condition. Therefore, we agree with claimant that Twin City's June 9, 1997 letter denied an aggravation claim and his current condition. The discussion at the beginning of the hearing was not to the contrary. At hearing, claimant's attorney framed the issue as "compensability and responsibility of a right forearm condition." (Tr. 3). Both claimant's attorney and Twin City's attorney agreed with the ALJ's characterization of Twin City's denial as an "aggravation of current condition[.]" (Id.) In opening statement, Twin City's attorney asserted that the major cause of claimant's "immediate need for care is this SAIF injury." (Tr. 5). Under these circumstances, we conclude that the ALJ properly addressed the compensability of claimant's current condition.

Current Condition

Under ORS 656.308(1), the first employer remains responsible for future compensable medical services and disability relating to the compensable condition "unless the worker sustains a new compensable injury involving the same condition." When a worker sustains a second injury to the same body part, the subsequent employer is responsible only if the second injury constitutes the major contributing cause of the worker's disability or need for treatment for the combined condition. SAIF v. Britton, 145 Or App 288, 292 (1996). ORS 656.308, however, applies only if claimant's current condition is the "same condition" as that previously processed as part of a compensable claim. See Sanford v. Balteau Standard/SAIF Corp., 140 Or App 177, 181 (1996); Smurfit Newsprint v. DeRosset, 118 Or App 368, 371-72 (1993).

Here, the first issue is whether claimant's current right forearm condition is the "same condition" as the one previously accepted by Twin City. Although there is only one medical opinion in the record, even an uncontradicted medical opinion is not binding on the trier of fact. Randy L. Carter, 48 Van Natta 1271, 1272 (1996). Here, however, we are persuaded by the opinion of claimant's treating physician, Dr. Butters, because it is well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). We also rely on Dr. Butters' opinion because he had the opportunity to treat claimant for both injuries. See Weiland v. SAIF, 64 Or App 810 (1983).

Dr. Butters first examined claimant on August 8, 1996, after his injury at Twin City's insured. (Ex. 2). He treated claimant again after the February 1997 injury at SAIF's insured. (Ex. 10). On March 31, 1997, Dr. Butters reported that claimant's condition "should be considered the same as the diagnosis in continuation of the same injury for which I saw him in August of 1996." (Ex. 15). In later opinions, Dr. Butters said that the second injury in February 1997 represented the same problem that claimant had as a result of the August 7, 1996 injury. (Ex. 19-1, 20-13).

Based on the opinion of Dr. Butters, we conclude that claimant's August 1996 compensable injury and the February 1997 injury involved the "same condition." Therefore, under ORS 656.308(1), Twin City is presumptively responsible for claimant's current right forearm condition. To establish a "new injury," Twin City must establish that the February 1997 injury with SAIF's insured was the major contributing cause of claimant's current disability or need for medical treatment.

The medical evidence, however, does not establish that claimant's February 1997 injury was the major contributing cause of his disability or need for medical treatment. To the contrary, Dr. Butters opined that claimant's August 1996 injury was the major contributing cause of his need for treatment on February 5, 1997 and thereafter. (Ex. 19-1, 20-16, -26, -27). Because the medical evidence does not establish that claimant's February 1997 injury was the major contributing cause of his disability or need for medical treatment, we conclude that claimant did not sustain a "new compensable injury" in 1997. Consequently, responsibility for claimant's right forearm condition remains with Twin City. See ORS 656.308(1).

Aggravation

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. Id.

Here, the only medical opinion is from Dr. Butters. In a "check-the-box" letter from claimant's attorney, Dr. Butters did not agree that claimant had sustained a pathological worsening of his August 7, 1996 work injury. (Ex. 19-2). There is no other medical evidence that would support a conclusion that claimant's symptoms had increased to the point that it could be said that the August 7, 1996 compensable condition has worsened. Therefore, we agree with Twin City that its aggravation denial should be upheld. The ALJ's order is reversed on this issue.

Attorney Fees

Twin City contends that the assessed attorney fee award of $3,200 is excessive, asserting that this was a "finger injury" and claimant's attorney produced "no helpful evidence."[4] (Twin City's brief at 9).

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.

The issues in dispute were compensability, aggravation and responsibility of claimant's current right forearm condition. Twenty-four exhibits were received into evidence, one of which was generated by claimant's counsel. One deposition took place, which lasted 50 minutes. The transcript consists of twenty-seven pages. Claimant testified on his own behalf. In his statement of services, claimant's counsel indicated that he spent 14 hours on this case at hearing.

The compensability issue primarily involved an evaluation of medical evidence and was of a complexity level that is normally faced by the Board and its Hearings Division. Because claimant's current right forearm condition has been found compensable, he is entitled to further workers' compensation benefits. Nevertheless, the value of the interest, as well as the benefit secured in the form of medical services, is generally considered to be rather modest. See Melvin L. Martin, 47 Van Natta 107, on recon 47 Van Natta 268 (1995). The parties' attorneys were skilled and presented their positions in a thorough, well-reasoned manner. No frivolous issues or defenses were presented. Finally, considering the conflicting medical evidence, there was a risk that claimant's counsel's efforts might go uncompensated. Considering all these factors, we find that $1,750 is a reasonable fee for claimant's counsel's services at hearing concerning compensability of the current condition. The ALJ's order is modified accordingly.

Under ORS 656.308(2)(d), claimant's counsel is entitled to an attorney fee for services at hearing and on review for finally prevailing over Twin City's responsibility denial. Claimant neither asserts nor do we find "extraordinary circumstances" warranting an attorney fee in excess of the statutory maximum $1,000 attorney fee. Therefore, claimant's counsel is awarded a $1,000 attorney fee for services at hearing and on review, payable by Twin City. See Foster-Wheeler Constructors, Inc. v. Smith, 151 Or App 155 (1997).

Claimant's attorney is also entitled to an assessed fee for services on review regarding Twin City's current condition compensability denial. 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 regarding the current condition compensability denial is $1,000, payable by Twin City Fire Insurance Company, on behalf of Olsten Staffing. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief),

[4] Twin City also contends that SAIF may be responsible for paying the assessed attorney fee. Although Twin City argues that SAIF denied compensability, claimant and SAIF assert that SAIF's denial was of responsibility only. At hearing, the ALJ asked: "And SAIF's denial is a denial of responsibility of a new injury -- responsibility only of a new injury?" (Tr. 3). Claimant's attorney, SAIF's attorney and Twin City's attorney agreed with the ALJ's statement of the issues. (Id.) Because Twin City did not contend at hearing that SAIF's denial included a denial of compensability, we decline to address that issue on review. See Stevenson v. Blue Cross, 108 Or App 247, 252 (1991). In any event, based on the parties' positions at hearing, the record does not support a conclusion that SAIF's denial extended to the compensability of claimant's current condition.

the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review concerning the unsuccessful aggravation issue or the attorney fee issue. See Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986).

Interim Compensation

In an Opinion and Order dated October 29, 1997, as reconsidered November 28, 1997 (concerning WCB Nos. 97-05071 & 97-03869), the ALJ ordered Twin City to provide a copy of Exhibit 17A with a legible date stamp showing the date of its receipt of that document. The ALJ later found that Twin City had not provided a copy of Exhibit 17A with a legible date stamp showing its date of receipt. The ALJ also found that Twin City did not comply with OAR 438-007-0018, which requires carriers to provide, index and submit all relevant exhibits in a legible form. The ALJ indicated that, when it is within the power of a party to produce evidence and it fails to do so, it is appropriate to presume that evidence is contrary to that party's position. The ALJ determined that the date of Twin City's notice or knowledge of claimant's medically verified inability to work resulting from a compensable worsening was April 17, 1997. Therefore, the ALJ concluded that claimant was entitled to interim compensation from Twin City's date of notice or knowledge on April 17, 1997 to the date of its denial on June 9, 1997.

Twin City contends that the ALJ incorrectly assumed that Exhibit 17A was received on the same day it was signed. Twin City argues that claimant has the burden of proving Twin City's receipt of Exhibit 17A.

Under the aggravation statute, a claimant's entitlement to interim compensation in the form of temporary disability benefits depends on when the carrier received notice or knowledge of a medically verified inability to work in a medical report that satisfies the requirements of ORS 656.273(3). Laura D. Girard, 49 Van Natta 1417 (1997); Russell D. Parker, 49 Van Natta 83 (1997). ORS 656.273(3) requires that the claim for aggravation be in writing in a form and format prescribed by the Director and signed by the worker or the worker's representative. The statute further requires that the aggravation claim "be accompanied by the attending physician's report establishing by written medical evidence supported by objective findings that the claimant has suffered a worsened condition attributable to the compensable injury." See David L. Dylan, 50 Van Natta 276 (1998).

On April 17, 1997, claimant signed a "Notice of Claim for Aggravation of Occupational Injury or Disease," listing Twin City's insured as the employer. (Ex. 17A). Dr. Butters signed the form on April 16, 1997 and indicated that time loss was authorized. (Id.) However, we cannot determine from the record when Twin City received the aggravation claim form. See Russell D. Parker, 49 Van Natta at 84 (chart note did not aid the claimant's cause because the record did not reveal when the carrier received it). Under these circumstances, we conclude that claimant has not sustained his burden of proving that Twin City was obligated to pay interim compensation between April 17, 1997 and June 9, 1997. The ALJ's order is reversed accordingly.

ORDER

The ALJ's order dated October 29, 1997, as reconsidered November 28, 1997, is affirmed in part, modified in part, and reversed in part. Twin City's denial insofar as it pertained to claimant's aggravation claim is reinstated and upheld. Twin City's denial insofar as it denied claimant's current condition is set aside and the claim is remanded to Twin City for further processing. The ALJ's $3,200 assessed fee award is modified to award $1,750 under ORS 656.386(1), payable by Twin City. 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 Twin City. For services on review regarding the current condition denial, claimant's attorney is awarded is $1,000, payable by Twin City.

In addition, the ALJ's order dated November 28, 1997, as amended on December 1, 1997, is reversed. The ALJ's attorney fee award is also reversed.

In the Matter of the Compensation of
KATHLEEN L. LIKOS, Claimant
WCB Case Nos. 94-08968, 94-06781 & 94-03441
ORDER ON REMAND
Cole, Cary, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys
Dennis L. Ulsted (Saif), Defense Attorney
Stoel Rives LLP, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. United Parcel Service v. Likos, 143 Or App 486 (1996). The court has reversed our prior order, Kathleen L. Likos, 47 Van Natta 1402 (1995), which had affirmed an Administrative Law Judge's (ALJ's) order that found Liberty Northwest Insurance Corporation responsible for claimant's right carpal tunnel syndrome. The court determined that substantial evidence supported our findings that claimant's disability arose during her period of self-employment and that her "post-self-employment" work exposure did not contribute to her condition. However, reasoning that claimant's self-employment was not subject to the Workers' Compensation Law, the court held that she was not entitled to receive compensation. Concluding that we erred in assigning responsibility to Liberty Northwest, the court has reversed and remanded for reconsideration.

Prior to proceeding with our reconsideration, the parties were granted an opportunity to submit supplemental briefs. In response, claimant has forwarded a copy of her respondent's brief that she presented to the court. In doing so, "to the extent that [we] further review[] the facts in this case," claimant relies on her argument to the court that we erred in finding that she first sought treatment for her right carpal tunnel syndrome while she was self-employed. Specifically, claimant contended to the court that her first treatment for her condition occurred several years later, when she was working for Old Peak Construction (insured by the SAIF Corporation).

As previously noted, the court has expressly concluded that "[s]ubstantial evidence supports the Board's findings that claimant's disability arose during her period of self-employment and that the condition is work-related." The court further determined that "[t]he evidence supports the Board's findings that claimant's subsequent employments at McClellan Temporaries and at Old Peak Construction did not contribute to claimant's condition." In light of such conclusions, the court stated that, "[u]nder the last injurious exposure rule of proof, claimant would have met her burden to establish that her claim is compensable and the responsibility of Genesis Services if Genesis Services had been a subject employer." Nonetheless, the court has specifically held that "[c]laimant is not entitled to receive compensation, however, because General Services [claimant's self-employment], the last potentially causal employment before claimant sought medical treatment and at which claimant's claim accrued, was not subject to the Workers' Compensation Law."

Considering the court's precise conclusions, we are without authority to "further review the facts" to reach a determination contrary to our prior findings that claimant's disability arose while she was self-employed and that her subsequent employments did not contribute to her condition. Alternatively, even if we were authorized to reconsider the facts, we would continue to make the same findings as those reached in our previous order.

Consequently, in light of the court's conclusions and holdings, claimant is not entitled to receive compensation for her claim. Accordingly, on reconsideration, the ALJ's order dated December 9, 1994, as amended December 12, 1994, is reversed in part and affirmed in part. Liberty Northwest Insurance Corporation's denial is reinstated and upheld. The ALJ's attorney fee award is reversed. The remainder of the ALJ's order is affirmed.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAWN M. SEWELL-JOHNSON, Claimant
WCB Case No. 96-05519
ORDER ON REVIEW
Michael M. Bruce, Claimant Attorney
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Hall, Bock and Moller.

The self-insured employer requests review of Administrative Law Judge (ALJ) Mongrain's order that set aside its partial denial of claimant's injury claim for an L5-S1 disc protrusion. On review, the issue is compensability.

We adopt and affirm the ALJ's order, with the exception of the last sentence and quotation in the "OPINION" portion of the order.

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

ORDER

The ALJ's order dated June 23, 1997 is affirmed. Claimant's attorney is awarded an assessed fee of $2,200, payable by the self-insured employer.

Board Member Moller dissenting.

The doctors have unanimously opined that claimant's work activity of pulling and stacking boards on March 26, 1996 was the major cause of the L5-S1 disc protrusion that required surgery. However, because the doctors' opinions were based on claimant's history that she had no significant back symptoms for several years prior to the incident, and that history was contradicted by claimant's sworn testimony in a civil deposition in 1994, I conclude that their opinions are unreliable and insufficient to support the L5-S1 disc claim. I therefore dissent.

The decisive question is whether the doctors assumed the correct history in reaching their causation opinions. They assumed, based on claimant's reported history, that she did not have any significant back symptoms between June 1992 and the March 1996 work incident. Claimant testified to the same history at hearing. The problem is that claimant gave directly contradictory testimony in a 1994 civil deposition relating to a civil lawsuit she filed against her brother-in-law for injuries sustained during a brutal beating with a baseball bat or large wooden stick in 1992. In the deposition, claimant testified that she was taking over-the-counter pills because of "severe pain in [her] back." (Ex. C-21). Claimant now explains that she lied in the 1994 deposition.

The ALJ and the majority found claimant's explanation persuasive, based primarily on the testimonies of claimant's witnesses that they neither observed any back pain behavior nor heard any complaints of back pain from claimant prior to the March 1996 work incident. However, those witnesses--a friend, former co-worker, and a former employer--had limited contacts with claimant and, therefore, could not rule out the possibility that claimant had been taking pills for "severe" back pain, as she testified in 1994. The witness who was in the best position to observe claimant's back condition was her ex-husband, Robin Sewell, who testified that claimant continued to have fluctuating back symptoms following the 1992 beating. His testimony was corroborated by his half-sister, Molly Rhea, who recalled claimant complaining of, or exhibiting, back problems after the beating.

I find the testimonies of Mr. Sewell and Ms. Rhea more persuasive than those of the other witnesses. Based on their testimonies, as supported by claimant's own words during the 1994 deposition, I would find that claimant did, in fact, have significant back symptoms prior to the March 1996 work incident. I would further find that claimant's contrary testimony in this hearing was self-serving and not credible.

Because the doctors had a materially inaccurate history regarding the existence of preexisting back symptoms, their causation opinions should be discounted. Without expert medical evidence to support the L5-S1 disc claim in this "medically complex" case, the claim must fail. Therefore, I would conclude that the partial denial should be reinstated and upheld, limiting the accepted conditions to a cervical and lumbosacral strain. For these reasons, I dissent.

In the Matter of the Compensation of
THOMAS E. SUBY, Claimant
WCB Case No. 96-06597
ORDER ON REVIEW
Gloria D. Schmidt, Claimant Attorney
Schwabe, et al, Defense Attorneys

Reviewed by the Board en banc.

Claimant requests review of Administrative Law Judge (ALJ) Baker's order that: (1) declined to award temporary disability compensation; and (2) declined to assess penalties for the self-insured employer's allegedly unreasonable failure to pay temporary disability. On review, the issues are temporary disability and penalties. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the facts. A prior ALJ set aside the employer's denial of claimant's aggravation claim for a low back injury and remanded the claim to the employer for processing according to law. (Ex. A). The claim remains in open status. Subsequently, claimant's treating surgeon, Dr. Hacker, requested authorization for a lumbar fusion with instrumentation at L5-S1. This level had previously been surgically fused prior to the initial closure of claimant's claim. The employer declined to authorize the surgery and claimant requested Director review.

By an order dated December 20, 1995, the Director determined that the proposed surgery was not appropriate for the compensable injury and ordered that the employer was not liable for the surgery if it was rendered to claimant. (Ex. 4). This order was not appealed and became final by operation of law. On May 9, 1996, claimant underwent the proposed surgery, performed by Dr. Hacker. (Ex. 4A). Thereafter, Dr. Hacker authorized time loss from the date of the surgery and indicated that claimant was released to light duty, five hours per day, as of June 5, 1996. (Ex. 6).

The ALJ reasoned that claimant must prove that the treating physician authorized time loss for a compensable condition. Because the treating physician authorized time loss regarding a surgery that the Director had found not appropriate, the ALJ determined that the record contained no such authorization. We agree.

It is well-established that the purpose of temporary disability compensation is to replace income lost as a result of the compensable injury. See Weyerhaeuser Co. v. Surprise, 89 Or App 296, 300 (1988). When the injured worker loses income as a result of treatment that is a compensable consequence of a compensable injury, the Court of Appeals has held that the lost income is also deemed to be a result of the compensable injury. Id. This Board has applied that holding in several previous decisions, determining that temporary disability is due when the compensable injury requires necessary medical treatment. See Walter Olinger, 42 Van Natta 2504 (1990); Ronnie D. Sturgill, 42 Van Natta 536 (1990); Gene A. Hawkins, 41 Van Natta 630 (1989).

In this case, however, the Director has finally determined that the proposed surgery (which claimant eventually underwent and for which time loss was authorized by the treating surgeon, Dr. Hacker) is not appropriate treatment for the accepted injury. (Ex. 4). The question is what effect does the Director's final determination have in this forum on the issue of claimant's entitlement to temporary disability for the period he was released from work due to the disapproved treatment.

The rule of issue preclusion provides that, if a claim is litigated to final judgment, the decision on a particular issue or determinative fact is conclusive in a later or different action between the same parties if the determination was essential to the judgment. North Clackamas School Dist. v. White, 305 Or 48, 53 (1988). Here, at claimant's request, the parties actually litigated the "appropriateness of surgery" issue before the Director pursuant to ORS 656.327. The Director determined that the proposed surgery would not be appropriate treatment for the accepted injury. Claimant did not appeal the order and it became final.

Several months later, claimant requested a hearing before the Board's Hearings Division, seeking temporary disability benefits for the period of his time loss due to the disapproved surgery. In support of his request, claimant submitted his treating surgeon's authorization for time loss from the date of the disapproved surgery. Based on that authorization, the dissent finds that claimant's lost income was "due to" the accepted injury and, therefore, that claimant is entitled to receive temporary disability benefits. In reaching that conclusion, however, the dissent gives no effect to the Director's final determination that the surgery was inappropriate treatment for (and therefore not a compensable consequence of) the injury. Furthermore, the dissent is incorrect in stating that no statute authorizes the Director to determine "compensability." In this regard, in the context of determining the appropriateness of medical services, ORS 656.327(2) provides, in relevant part: "If the director issues an order declaring medical treatment to be not compensable, the worker is not obligated to pay for such treatment." (Emphasis added).

The dissent is also incorrect in its attempt to narrowly define compensability as involving only a determination of the causal relationship between the need for treatment and the work injury. To the contrary, in order to establish compensability of disputed medical services, a claimant must prove both the necessary causal relationship between the medical services and the compensable injury and the reasonableness and necessity of the medical services. See ORS 656.245. Van Blokland v. Oregon Health Services University, 87 Or App 696, 698 (1987) (applying former ORS 656.245, the court determined that a proposed weight reduction program to treat preexisting obesity was both causally related to the compensable injury and reasonable and necessary treatment, concluding that the claimant had established the program was a compensable medical treatment); James v. Kemper Ins. Co., 81 Or App 80, 84 (1986) (applying former ORS 656.245 and citing Wetzel v. Goodwin Brothers, 50 Or App 101, 108 (1981), the court held that "[p]alliative medical expenses are compensable only to the extent that they are reasonable and necessary"); West v. SAIF, 74 Or App 317, 320 (1985); Douglas A. Eichensehr, 44 Van Natta 1755 (1992).

If either element is lacking, the medical services are not compensable. The Director has jurisdiction to determine the reasonableness and necessity of a medical treatment. The Director has conclusively done so here, determining that the medical service in question is not reasonable and necessary. Therefore, lacking a prerequisite for compensability, those medical services are not compensable. Further, because the medical services are not compensable, it follows that time loss due to those services is likewise not compensable. We find Weyerhaeuser v. Surprise, 89 Or App at 299-300, instructive on this point.

In Surprise, the claimant was referred to a Pain Center for treatment of low back pain due to a compensable injury. The employer had denied the Pain Center treatment as not reasonable and necessary. The claimant nevertheless participated in the program. On de novo review, the court affirmed our finding that the treatment was reasonable and necessary. 89 Or App at 299. In addition, the court quoted with approval the referee's finding that the Pain Center treatment was compensable and, therefore, the claimant was entitled to time loss during the period of that treatment. 89 Or App at 300. The court rejected the carrier's attempt to have it "distinguish between a claimant who is physically unable to work and one who, because of necessary treatment, is unavailable to go to work." Id. (Emphasis added). In refusing to make that distinction, the court found that "[w]hen the treatment is a consequence of the compensable injury, that physical inability to work is also a result of the injury." Id. The court reasoned that the "purpose of TTD is to replace income lost as a result of injury; to deny it in these circumstances would defeat the statutory purpose." Id.

Thus, in Surprise, the court first determined that the medical services were reasonable and necessary. [Apparently, there was no dispute as to the causal relationship between the medical services and the work injury]. Then, it determined that the claimant was entitled to time loss incurred due to those necessary medical services. Conversely, it follows that a claimant would not be entitled to time loss resulting from medical services that were not reasonable and necessary.

Given this requirement of both proof of the necessary causal connection and the appropriateness of the treatment to find disputed medical services compensable, we find unpersuasive the dissent's argument that issue preclusion does not apply to the facts of this case. The Director's unappealed determination that a particular treatment is inappropriate does finally determine compensability of that treatment which, in turn, affects the benefits that may flow from that treatment. Here, as a result of the Director's final determination that the surgery for which time loss was authorized is not compensable, issue preclusion bars claimant from asserting that the time loss he sustained due to the surgery was a compensable consequence of the accepted injury.

Additional support for this result is found in the court's recognition, in the "consequential condition" context, that the reasonableness and necessity of treatment for an accepted injury is an essential link in the chain of compensability between the accepted injury and a subsequent injury suffered as a result of the treatment. In Barrett Business Services v. Hames, 130 Or App 190, rev den 320 Or 492 (1994), the claimant's shoulder was dislocated in an industrial accident. As a result of the necessary immobilization of the shoulder, adhesive capsulitis (or "frozen shoulder") developed. Physical therapy was then prescribed to restore shoulder movement. As a result of necessary therapy, the claimant's ulnar nerve was injured. The claimant filed a claim for the ulnar nerve injury, which was denied.

The Hames court held that the ulnar nerve injury was a compensable consequence of the accepted shoulder injury. Noting that there was a certain, almost tragic, inevitability to what followed the shoulder injury, the court concluded that the nerve injury flowed directly and inexorably from the shoulder injury. The court ruled that "[w]here . . . a claimant suffers a new injury as the direct result of reasonable and necessary treatment of a compensable injury, the compensable injury is the major contributing cause of the consequential condition for purposes of ORS 656.005(7)(a)(A)." Id. at 193. The court further stated that "where necessary and reasonable treatment of a compensable injury is the major contributing cause of a new injury, a distinction between the compensable injury and its treatment is artificial." Id. at 196.

Although the Hames court was deciding the compensability of a consequential condition, rather than entitlement to temporary disability, its opinion is helpful in determining when the chain of compensability between an accepted injury and treatment for that injury is broken. In Hames, because the shoulder immobilization and physical therapy were reasonable and necessary treatment for the accepted shoulder injury, the court found that the resultant nerve injury "flowed directly and inexorably" from the original injury and, thus, was a compensable consequential condition.

Applying the Surprise and Hames analyses to this case, the Director's final determination that the lumbar fusion surgery was not appropriate treatment for the accepted injury has broken the chain of compensability between the accepted injury and the fusion surgery. Time loss sustained as a result of surgery that is not reasonable and necessary treatment for the compensable injury does not "flow directly and inexorably" from the injury. The dissent's argument to the contrary (i.e., that "the surgery is a consequence of the compensable low back injury") is inconsistent with the court's analysis in Surprise and Hames, as well as the rule of issue preclusion. For these reasons, we affirm the ALJ's decision not to award temporary disability in this case.[1]

Finally, because we find that claimant is not entitled to temporary disability benefits resulting from a noncompensable surgery, we necessarily find that the employer's refusal to pay such benefits was not unreasonable. ORS 656.262(11)(a). Therefore, we agree with the ALJ that claimant is not entitled to a penalty. Id.

ORDER

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

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[1] We also note that the logical extension of the dissent's reasoning could include awarding additional benefits for the noncompensable surgery, such as vocational services or permanent disability benefits at claim closure.

Board Chair Bock specially concurring.

I agree with the ultimate conclusion that claimant is not entitled to temporary disability benefits. Because the reasons for my decision differ from those expressed by the lead opinion, I offer this special concurrence.

I can envision a fact scenario where an attending physician provides medical verification of a claimant's inability to work irrespective of an unauthorized surgery request. In such a situation, even if the surgery is determined inappropriate, the physician's "medical verification" (if found persuasive) could form the basis of a claim for temporary disability based on a "compensable worsening." See ORS 656.273(6). This case, however, does not present the fact scenario previously described.

Prior to claimant's unauthorized back surgery, his attending physician had not authorized temporary disability. That medical verification only arose once the unauthorized surgery was performed. Because the surgery has been conclusively determined to be inappropriate medical treatment for claimant's compensable condition, the surgical procedure is, in essence, an "intentional injury" or "injurious practice." See ORS 656.156(1); ORS 656.325(2). As such, any disability arising from this unauthorized and inappropriate treatment under the Workers' Compensation Act is not the responsibility of the self-insured employer.

In conclusion, based on the foregoing reasoning, I agree with the lead opinion's determination that claimant's attending physician's temporary disability authorization was not related to the compensable injury. Consequently, I concur that claimant is not entitled to temporary disability based on the physician's request.

Board Members Hall and Biehl dissenting.

Because we would find claimant entitled to the disputed temporary disability benefits, we respectfully dissent.

The heart of this case can be stated in simple terms: Is the need for authorized temporary disability benefits materially related to, i.e., due to, the underlying compensable condition? We respectfully submit that the majority misunderstands the dissent's analysis, which can be summarized as follows. There is a material relationship between claimant's underlying compensable low back condition and the authorization (need) for temporary disability. Issue preclusion does not bar claimant asserting such a relationship because that relationship was not an issue litigated before the Director, essential to the judgment by the Director, or even within the Director's jurisdiction. The surgery that claimant underwent, apparently at his own expense, was for the underlying compensable condition and does not constitute a consequential condition. Much of the confusion in this case stems from a misunderstanding of just what it was the Director decided. In order to eliminate this confusion, we will address each element separately.

I. The Director's December 20, 1995 "Proposed and Final Order Concerning a Medical Services Dispute."

A. Statutory Authority

The Director's statutory authority to review disputed medical treatment is found in ORS 656.245(6) and ORS 656.327(1)(a). In this regard, 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[1] or 656.327. The decision of the director is subject to the contested case review provisions of ORS 183.310 to 183.550." (Footnote added).

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[1] ORS 656.260 involves Managed Care Organizations and is not applicable to the present case.

Thus, ORS 656.245(6) gives the Director jurisdiction over medical services disputes. ORS 656.245(6) does not grant the Director jurisdiction over temporary disability disputes and specifically recognizes that the Director does not have jurisdiction over the compensability of the "underlying claim."

In addition, ORS 656.327(1)(a) provides:

> "If an injured worker, an insurer or self-insured employer or the Director of the Department of Consumer and Business Services believes that the medical treatment, not subject to ORS 656.260, that the injured worker has received, is receiving, will receive or is proposed to receive is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services, the injured worker, insurer or self-insured employer shall request review of the treatment by the director and so notify the parties."

According to the Director's order, the medical services dispute in this case was reviewed pursuant to ORS 656.327. Like ORS 656.245(6), ORS 656.327(1)(a) strictly involves disputed medical treatment and does not provide the Director with jurisdiction over temporary disability disputes or compensability of the underlying condition. Specifically, ORS 656.327(1)(a) spells out the jurisdiction of the Director to "review treatment" if such treatment is believed to be "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services." The legislature has made a distinction between jurisdiction over the regulation of medical services and jurisdiction over compensability of the underlying claim. See SAIF Corp. v. Shipley, 326 Or 557, 564-65 (1998) (Court found that, pursuant to ORS 656.245(6), Department had exclusive jurisdiction over dispute involving only a claim for medical benefits on previously accepted claim).

In this regard, we respectfully submit the majority misuses the term "compensable" in characterizing the Director's decision both as a "final determination that the surgery . . . is not compensable" and as a determination that the surgery was "not a compensable consequence of" the injury. The specific order in this case indicates that the Director was not exercising jurisdiction to judge the "compensability" (the causal relationship)[2] between the underlying accepted condition and the proposed treatment.[3]

The fact that the Director has determined that "the proposed surgery is not appropriate" and that the employer "is not liable for the proposed surgery if rendered" is not determinative of the issue now before the Board. (Ex. 4-3). Original jurisdiction over disputes regarding entitlement to procedural temporary disability benefits rests with the Hearings Division. ORS 656.283(1); Alfredo Martinez, 49 Van Natta 67 (1997). Thus, while the Director has jurisdiction over the medical services dispute under ORS 656.245 and ORS 656.327, that jurisdiction does not extend to the procedural temporary disability issue that is before us.

B. Language of the Director's Order.

Assuming the Director has jurisdiction to decide whether treatment is causally related to the underlying compensable claim (as opposed to jurisdiction to regulate the appropriateness of disapproved treatment), such "compensability" was not at issue before the Director. Specifically, the first two paragraphs of the Director's order state:

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[2] See discussion of "compensability" definition at page 13, infra. As explained by the Court in Shipley, the Director may well have jurisdiction to decide "compensability" of treatment, but that was not an issue before the Director in the present case.

[3] The majority points out that ORS 656.327(2) states, in part, "[i]f the director issues an order declaring medical treatment to be not compensable, the worker is not obligated to pay for such treatment." Assuming that this statute authorizes the Director to determine "compensability" in some sense, it also explicitly limits the result of such a determination to the worker not being obligated to pay for the treatment. In any event, as discussed below, "compensability" (in the sense of a causal connection between the treatment and the underlying condition) was not at issue before the Director in the present case.

"On September 21, 1995, [claimant], through his attorney, requested a Director's review under ORS 656.327 and OAR 436-10-046 to determine the appropriateness of treatment. Compensability is not at issue in this forum.

"The issue before the Director is the appropriateness of a lumbar fusion with instrumentation at L5-S1, proposed for the worker by Robert Hacker, M.D. (Neurosurgery)." (Ex. 4-1) (Emphasis added).

In addition, the Director's findings, reasoning and conclusions all deal solely with the appropriateness of the proposed lumbar surgery. (Ex. 4). In pertinent part, the Director's opinion stated: "ORS 656.327 and OAR 436-10-046(1) and (16) allow the Director to determine appropriateness [of treatment] and issue an order affirming or denying the treatment." (Ex. 4-3). The Director summarized the medical basis for his findings and concluded "that the proposed surgery is not appropriate for [claimant]." Id. Finally, the Director's order language stated: "The Director orders that [the employer] is not liable for the proposed surgery if rendered to [claimant]." Id.

Thus, the Director's order dealt solely with the appropriateness of the proposed surgery, pursuant to ORS 656.327. Furthermore, the stated result of the order was that the employer was not liable for the proposed surgery, if claimant chose to proceed with it. The Director did not decide any other matter and limited his jurisdiction to the appropriateness of treatment pursuant to ORS 656.327.

II. Temporary Disability Analysis

A. Legal Analysis of Temporary Disability

Procedural temporary disability benefits are those benefits payable under ORS 656.268 while an accepted claim is in open status. See SAIF v. Taylor, 126 Or App 658 (1994). Because claimant's claim remained open, the issue in this case concerns entitlement to procedural temporary disability. During an open claim, a claimant is entitled to procedural temporary disability for those periods of time for which an attending physician has authorized temporary disability. ORS 656.262(4)(a) and (f). Accordingly, claimant's entitlement to temporary disability depends upon whether the need (authorization) for such disability is materially related to the underlying compensable condition. ORS 656.210; 656.212; Botefur v. City of Creswell, 84 Or App 627 (1987).

B. Factual Analysis of Temporary Disability

Claimant must prove both that: (1) his attending physician, Dr. Hacker, authorized temporary disability; and (2) the need for time loss was materially related to the compensable low back injury. We would find that claimant has established both elements.

First, there is no dispute that Dr. Hacker authorized temporary total disability beginning May 9, 1996, the date of claimant's surgery, and temporary partial disability beginning June 5, 1996, the date claimant was able to return to modified work. (Ex. 6).

Second, claimant has established a material relationship between the need for time loss and his compensable low back injury. We respectfully submit that the majority errs in focusing on the relationship between the time loss and the disapproved surgery rather than on the relationship between the time loss and the underlying compensable condition. Again, regardless of the surgery and anyone's liability for it, if there is nevertheless a material relationship between the need for temporary disability and the underlying compensable condition, then claimant is entitled to the authorized time loss. In this case, the underlying low back condition remains compensable. While the form of treatment was deemed inappropriate, no one disputes that the treatment was nevertheless provided for the compensable low back condition. To state it another way, the treatment was not provided for an unrelated, noncompensable condition. The need for time loss is materially related to the compensable injury.

The majority cites several cases dealing with "compensability" of medical services in support of their contention that the dissent is attempting to narrowly define compensability as involving only a determination of the causal relationship between the need for treatment and the work injury. Indeed, how the term "compensable" is defined and utilized is critical to the analysis.

A "compensable injury" is defined in ORS 656.005(7)(a) as "an accidental injury . . . arising out of and in the course of employment requiring medical services or resulting in disability or death." The term "compensable" standing alone is not defined in Chapter 656. Relying on the text and context of the statute itself, it is apparent that "compensable" is defined as that which arises out of and in the course of employment (i.e., the causal relationship).

That a form of treatment is appropriate, effective, or reasonable does not answer the separate question of whether the underlying need for treatment arose out of and in the course of employment. After all, a form of treatment may be deemed appropriate for a given condition or ailment, yet the underlying need for that treatment may not be causally related to work. Under such circumstances, the treatment itself would not be "compensable." It should be noted, however, that when the "compensability" of treatment is at issue, it is the causal relationship which is being questioned.[4] In the present case, claimant is not before the Board seeking review of the appropriateness of the surgery and, conversely, the issue before the Director was not whether claimant's injury, or the need for treatment, arose out of and in the course of employment.

The majority and the employer submit that Dr. Hacker's authorization for temporary disability does not meet the requirements for temporary disability because that authorization related to a "noncompensable" surgery. The employer argues that, because the surgery performed on claimant was not "compensable," no temporary disability is owed to claimant during the period of convalescence from that surgery. Again, the majority's and the employer's use of the term "compensable" clouds the issue. The Director did not address the "compensability" of the surgery; he addressed only the appropriateness of the surgery. As discussed above, the consequence of this finding was spelled out in the Director's order -- the employer was not liable for the surgery if claimant chose to go forward with it. However, as the dissent finds, notwithstanding the "inappropriateness" of the surgery, it was still treatment of the underlying compensable low back condition. The temporary disability was authorized for a compensable injury.[5]

The majority also overlooks this factor in arguing that the dissent's conclusion is inconsistent with the court's holding in Weyerhaeuser Co. v. Surprise, 89 Or App 296, 300 (1988). In Surprise, the issues were: (1) the reasonableness and necessity of a full-time pain treatment program for a work-related back injury; and (2) whether there should be a distinction between being physically unable to work due to a compensable injury and being unavailable to go to work due to treatment that is a consequence of a compensable injury.[6] Id. The court summarily agreed with the Board's finding that the treatment was reasonable and necessary but refused to make the above distinction regarding availability and inability to work. The court held:

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[4] Like the term "compensable," the phrase "reasonable and necessary" is subject to misuse as the two elements are routinely . . . almost automatically . . . linked together as if they were one element. The reasonableness (appropriateness) of treatment is not determinative of causation.

[5] Even if the authorization for time loss was based on the need to convalesce from the surgery, that "cause" of the need for time loss does not defeat the fact that there is also a material relationship between the authorization and the underlying compensable condition.

[6] We note that the court quoted the referee [now referred to as an ALJ] with approval regarding this second issue. The majority incorrectly characterized the court's reasoning when the majority states that "the court quoted with approval the referee's finding that the Pain Center treatment was compensable and, therefore, the claimant was entitled to time loss during the period of that treatment." To the contrary, the court's approval was not directed at the finding of "compensability." Rather, the court was examining the issue of physical inability to work versus unavailability for work, concluding it "need not find that claimant was physically unable to do his customary work if he had been available." 89 Or App at 300. It was in support of this determination that the court quoted the referee as saying:

> "[D]uring this time claimant would not have been able to work at the job he held at the time of his injury, either at Weyerhaeuser (if the mill had been open) or elsewhere * * *. I find the Pain Center treatment to be compensable. Thus, claimant is entitled to [TTD] during the period of this treatment." Id.

> "A claimant who must undergo full-time treatment is physically unable to have regular employment at the same time. When the treatment is a consequence of a compensable injury, that physical inability is also a result of the injury. The purpose of TTD is to replace income lost as a result of injury; to deny it in these circumstances would defeat the statutory purpose." Id. (Footnote omitted).

In paraphrasing the above holding, the majority actually expands it, stating that the court held that loss of income as a result of "treatment that is a compensable consequence of a compensable injury" is also deemed to be a result of the compensable injury. (Emphasis added). However, it is important to realize that, because the court agreed that the treatment was reasonable and necessary, the court did not address the issue in the present case, i.e., whether time loss is due when treatment is provided for a compensable condition, although the treatment has been found not appropriate.

We respectfully submit that the majority fails to make that distinction. In other words, the majority essentially finds that, because Surprise holds that temporary disability benefits are due when reasonable and necessary treatment causally related to a compensable injury renders the worker unable or unavailable for work, it also holds the converse, i.e., temporary disability benefits are not due when inability or unavailability to work is caused by treatment of a compensable condition, although the form of treatment has been found "inappropriate." We disagree that the decision in Surprise supports this converse "holding." The issue simply was not addressed by the Surprise court.

Furthermore, if anything, the court's decision supports the dissent's position. After all, as the court stated, the "purpose of TTD is to replace income lost as a result of injury." Id. Here, while the employer is not responsible for payment of the surgery pursuant to the Director's order, the surgery was performed to treat the compensable low back injury. Therefore, the lost income is due to the compensable injury. Accordingly, Dr. Hacker authorizes temporary disability due to the compensable injury.

In addition, the majority misconstrues our reliance on Dr. Hacker's authorization for temporary disability. In this regard, the majority implies that we rely solely on the requirement under ORS 656.262(4)(f) that an attending physician's authorization is required to establish entitlement to "procedural" temporary disability and overlook the fact that temporary disability is intended to replace income lost due to the compensable injury. However, as explained above, Dr. Hacker's authorization meets both requirements.

III. Issue Preclusion

We strongly disagree with the majority's argument that issue preclusion bars claimant from asserting that the time loss he sustained was materially related to the underlying compensable condition. In making this argument, the majority overlooks the limited nature of the Director's determination.

Issue preclusion bars future litigation between the same parties concerning an issue that was actually litigated and determined by a final and valid judgment and the determination was essential to the judgment. Drews v. EBI Companies, 310 Or 134, 139-40 (1990). Here, the same parties were before the Director. However, the only issue actually litigated and determined by a final and valid judgment was the issue of whether the proposed surgery was appropriate. The issue of whether there was a material relationship between the compensable condition and a need for temporary disability was not litigated before the Director. Nor was that issue essential to the judgment by the Director, or even within the Director's jurisdiction.

Furthermore, the "appropriateness of surgery" issue is not essential to the Board's determination. The Board is not redetermining the appropriateness of the surgery. Claimant is not, in the case before us, challenging the Director's final decision. Claimant is not seeking payment for the surgery. The Director's determination that the proposed surgery was not appropriate and thus not the responsibility of the employer, is not essential to the judgment in the case before us. The causal relationship between the need for time loss and the underlying compensable condition is not impacted by or otherwise dependent on the appropriateness of the surgery. As the majority acknowledges, an issue or fact must be essential to the previous final determination before the doctrine of issue preclusion

applies. Accordingly, issue preclusion does not apply in this case because the elements of issue preclusion are simply not present.[7]

IV. Barrett Business Services v. Hames, 130 Or App 190, rev den 320 Or 492 (1994) is Not Applicable.

The majority's reference to Hames is not helpful to the analysis of the instant case. As the majority acknowledges, the particulars of the two cases are different. The instant case does not involve a "consequential condition" for which a claimant must establish a major contributing cause relationship. Instead, here, claimant need only establish a material relationship between the already compensable low back injury and the need for temporary total disability for such time loss to be "due to" the compensable injury.

Furthermore, the majority treads on dangerous ground when it asserts that the legal, causal connection between time loss and the compensable injury was broken because claimant went ahead with the low back surgery. By severing the causal relationship between the compensable injury and claimant's entitlement to time loss benefits, the majority is imposing a severe sanction against claimant for proceeding with elective surgery at his own expense. In fact, the majority goes beyond the sanction imposed by ORS 656.325(2)[8] against workers who commit "insanitary or injurious practices which tend to either imperil or retard recovery." Pursuant to ORS 656.325(2), payment is suspended with the consent of the Director and no payment is made for the period of time during which those practices occur. The majority's sanction of severing the causal relationship has no such limitation. Conversely, the Director's order actually recognized that claimant could pursue the proposed surgery; however, the employer would not be responsible for the surgery if claimant went forward with it. No further consequences should be inferred from the Director's order. To do so expands that order beyond what the Director had authority to decide.

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[7] Parenthetically, we note that the elements of claim preclusion are also not present in the current case. The court recently addressed claim preclusion in Hewlett-Packard v. Leonard, 151 Or App 307 (1997). The court quoted Drews v. EBI Companies, 310 Or at 140, in summarizing the elements of claim preclusion as follows:

> "'[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 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.'" Hewlett-Packard v. Leonard, 151 Or App at 310-11.

Further relying on Drews, the court also stressed that "[c]laim 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." 151 Or App at 311. However, claim preclusion does require both that the opportunity to litigate the issue be present and that there be finality in the former adjudication. Id. In Leonard, the court found that the claimant had no opportunity to litigate the issue of compensability of a current condition (diagnosed after claim closure) in a prior proceeding because that proceeding was limited to the issue of whether the claimant was medically stationary on the date of the claim closure, without considering subsequent changes in the claimant's condition.

Here, too, claimant did not have the opportunity to litigate the issue of his entitlement to temporary disability compensation in the proceeding before the Director. Claimant could not litigate that issue because the Director had no jurisdiction to decide the matter. As previously explained, original jurisdiction over disputes regarding entitlement to procedural temporary disability benefits rests with the Hearings Division. Thus, claim preclusion does not bar litigation of this issue.

[8] ORS 656.325(2) provides, in relevant part:

> "For any period of time during which any worker commits insanitary or injurious practices which tend to either imperil or retard recovery of the worker, or refuses to submit to such medical or surgical treatment as is reasonably essential to promote recovery, or fails to participate in a program of physical rehabilitation, the right of the worker shall be suspended with the consent of the director and no payment shall be made for such period."

Finally, we disagree with Chair Bock's special concurrence in which she characterizes claimant's pursuit of the low back surgery as an "intentional injury" or "injurious practice," citing ORS 656.156(1)[9] and 656.325(2). Claimant's pursuit of the low back surgery does not come within the parameters of either ORS 656.156(1) or 656.325(2). In this respect, there is no evidence that claimant pursued the surgery with the intent of producing an injury or committing an unsanitary or injurious act to delay his recovery.

V. Possibility of Future Disability Benefits.

The majority poses a question about the possibility of future benefits "for the noncompensable surgery, such as vocational services or permanent disability benefits at claim closure." The issue of possible future benefits is not before us. As with the issue of entitlement to temporary disability, the Director did not have authority to determine issues regarding the consequences of the surgery. The Director only had authority to determine whether the proposed surgery was appropriate. Whether claimant can establish the necessary legal nexus between the underlying compensable condition and the need for future services or benefits is a burden he will have to carry on another day.

IV. Penalty

Regarding the penalty issue, we agree with the majority that no penalty is due but for the following reason. We would find that the employer did not unreasonably refuse to pay temporary disability compensation because it had a legitimate doubt about its payment obligations given the unique circumstances of this case, the Director's order finding the employer not liable for the proposed surgery, and the lack of prior precedent. ORS 656.262(11)(a); Brown v. Argonaut Ins. Co., 93 Or App 588 (1988).

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[9] ORS 656.156(1) provides:

"If injury or death results to a worker from the deliberate intention of the worker to produce such injury or death, neither the worker nor the widow, widower, child or dependent of the worker shall receive any payment whatsoever under this chapter."

April 13, 1998 Cite as 50 Van Natta 727 (1998)

In the Matter of the Compensation of
EVELYN D. HEDGE, Claimant
WCB Case No. 97-06072
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Steven T. Maher, Defense Attorney

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) found that her low back claim was not prematurely closed; and (2) affirmed an Order on Reconsideration that awarded no permanent partial disability. On review, the issues are premature closure and extent of unscheduled permanent disability.

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

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). The issue of claimant's medically stationary status is primarily a medical question to be decided on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981).

On review, claimant contends that she was not medically stationary as of March 31, 1997 (the medically stationary date used by the Notice of Closure), as her condition continued to improve. Claimant argues that, even on May 30, 1997, her treating doctor prescribed three or four weeks of physical therapy.

First, we note that the dispositive issue is whether there was a reasonable expectation of material improvement in claimant's compensable condition at the time of claim closure, which was July 15, 1997. See Glenn C. Smith, 48 Van Natta 192, aff'd mem 145 Or App 261 (1996). In this regard, we do not find evidence to support claimant's contention. Moreover, we note that, on June 11, 1997, claimant's treating doctor agreed with Dr. Gripekoven's opinion that any ongoing need for treatment that claimant experienced was due to her preexisting degenerative condition and not her compensable condition. (Exs. 30, 33).

Accordingly, we agree with the ALJ that claimant did not prove that her claim was prematurely closed. We also adopt the ALJ's conclusions regarding the issue of permanent disability.

ORDER

The ALJ's order dated December 8, 1997 is affirmed.

In the Matter of the Compensation of
RENE KELLY, Claimant
WCB Case Nos. 97-07683, 97-07386 & 97-05837
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Randy Rice, Defense Attorney
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

EBI Insurance Company (EBI) requests review of those portions of ALJ Peterson's order that: (1) set aside its denial of claimant's occupational disease claim for bilateral upper extremity conditions; and (2) upheld the SAIF Corporation's denial of the same conditions. Claimant requests an attorney fee under ORS 656.308(2)(d). On review, the issues are responsibility and attorney fees.

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

We agree that responsibility does not shift forward from EBI, in the absence of persuasive evidence establishing that claimant's subsequent exposure with SAIF's insured actually contributed to a worsening of her underlying pathology (not just her symptoms).[1] See Oregon Boiler Works v. Lott, 115 Or App 70, 74 (1992); Roy D. Hodgkin, 49 Van Natta 1279 (1997).

The ALJ awarded a $3,692.50 fee for 21.1 hours of attorney services, to be paid by SAIF. Our review of the statement of services submitted to the ALJ reveals that the claimant's counsel's 21.1 hours of services were devoted to compensability and responsibility issues. Under these circumstances, having considered the factors set forth in OAR 436-015-0010(4) and applying them to this case, we conclude that the ALJ's order must be modified as follows. The fee for services at the hearings level is awarded as follows: $2,892.50 for services devoted to the compensability issue, to be paid by SAIF, and $800 for services devoted to the responsibility issue,[2] to be paid by EBI (the responsible insurer). See SAIF Corp. v. Severson, 105 Or App 67, 73 (1990), mod on other grounds 109 Or App 136 (1991) (citations omitted) (award of attorney fees greater than claimed by claimant's attorney is abuse of discretion).

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[1] We acknowledge that Dr. Altrocchi eventually checked a box indicating concurrence with a statement that claimant's work for SAIF's insured after February 22, 1996 independently worsened her conditions. (Ex. 17). However, considering Dr. Altrocchi's previous focus on claimant's worsened symptoms (and the evidence indicating that claimant's condition did not change, based on a comparison of nerve conduction studies), we agree with the ALJ that Dr. Altrocchi's ultimate check-the-box opinion is potentially inconsistent, inadequately explained, and unpersuassive. (See Ex. 17; compare Exs. 11, 12, 15).

[2] We agree with claimant that he is entitled to an attorney fee under ORS 656.308(2)(d) for services at hearing and on review devoted to finally prevailing over EBI's responsibility denial. See ORS 656.308(2)(d); Paul R. Huddleston, 48 Van Natta 4, on recon 48 Van Natta 203 (1996); Julie M. Baldie, 47 Van Natta 2249 (1995).

In addition, claimant is awarded a $200 attorney fee, payable by EBI, for services devoted to the responsibility issue on review. See ORS 656.308(2)(d). Since claimant's attorney's arguments regarding the responsibility issue were unsuccessful, we find no demonstration of extraordinary circumstances to justify an attorney fee of more than $1,000 for services at hearing and on review concerning the responsibility issue. See Foster-Wheeler Constructors, Inc. v. Smith, 151 Or App 155 (1997); Jack L. Barbee, 48 Van Natta 1855, 1858 (1996).

ORDER

The ALJ's order dated October 27, 1997, as amended December 1, 1997, is modified in part and affirmed in part. That portion of the order that awarded a $3,692.50 attorney fee to be paid by the SAIF Corporation is modified. $2,892.50 of that fee shall be paid by SAIF and $800 of that fee shall be paid by EBI Insurance Company. For services on review, claimant is awarded a $200 attorney fee under ORS 656.308(2)(d), to be paid by EBI. The remainder of the order is affirmed.

April 13, 1998 Cite as 50 Van Natta 729 (1998)

In the Matter of the Compensation of
MARK F. KING, Claimant
WCB Case Nos. 97-06195, 96-07945 & 97-01513
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
Thomas A. Andersen, Defense Attorney
Steven A. Wolf (Saif), Defense Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Baker's order that: (1) set aside Liberty Northwest Insurance Corporation's denial of claimant's claim for his current L4-5 low back condition; (2) upheld Wausau's denial of claimant's aggravation claim for the same condition; and (3) upheld the SAIF Corporation's denial of claimant's "new injury" claim for the same condition. On review, the issue is responsibility.

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

On review, claimant argues that the ALJ erred by not accepting the opinion of Dr. Buza, claimant's treating doctor. We disagree.

Dr. Buza has changed his opinion several times with respect to the issue of causation. Dr. Buza first believed that claimant's current L4-5 condition was due to the 1996 sink moving incident because claimant had a "disc on the right," whereas claimant's prior surgeries were for disc disease on the left. (Ex. 74f-2). However, Dr. Buza subsequently agreed with Dr. Scheinberg that the original 1986 work injury was the major cause of his current condition. (Ex. 81). Dr. Buza later conceded that Dr. Scheinberg had "brought to light many other injuries that [claimant] has sustained over the years, and also the fact that he has had surgeries before." (Ex. 83-2).

In his next opinion regarding causation, Dr. Buza again changed his opinion. Without an explanation for his changed opinion, other than to indicate that he had reviewed claimant's prior medical records, Dr. Buza agreed that the 1996 injury was the major cause of claimant's need for surgery. (Ex. 86-5). In his concurrence, Dr. Buza emphasized that claimant's right leg symptoms occurred on June 5, 1996, but prior to that, his symptoms had been only bilateral low back and left leg pain. Dr. Buza agreed that the findings supported a new disc fragment in the right canal at L4-5 as a result of lifting the sink. (Ex. 86-5).

For the following reasons, we do not find Dr. Buza's opinion to be persuasive. First, we note that Dr. Buza has changed his opinion several times, but has not provided a reason for his change of opinion. See Kelso v. City of Salem, 87 Or App 630 (1987). We further find that Dr. Buza does not

have a complete history. Dr. Buza apparently based his "new injury" theory on a finding that claimant had not experienced right leg symptoms prior to the 1996 incident. However, the record contains numerous reports of claimant's right leg problems over the years beginning in 1989 and following the 1994 surgeries. (Exs. 13, 54, 55, 60). Accordingly, Dr. Buza's opinion is not based on an accurate history. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977). Alternatively, if Dr. Buza was aware of claimant's right leg symptoms, as claimant contends, his opinion is not persuasive without further explanation. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980).

Finally, as SAIF notes, the ALJ was not persuaded that the 1996 sink lifting incident occurred as it was described by claimant. Therefore, we are unable to conclude that Dr. Buza's opinion is based on an accurate history of an incident in 1996. See, e.g., Betty F. Sanger, 48 Van Natta 1889 (1996).

Under the circumstances, we are not persuaded that the 1996 incident was the major contributing cause of claimant's current condition. Consequently, we agree with the ALJ that Liberty remains responsible for claimant's L4-5 condition.[1]

ORDER

The ALJ's order dated October 24, 1997, as reconsidered November 21, 1997, is affirmed.

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[1] We acknowledge that claimant and Liberty entered into a Claim Disposition Agreement (CDA) regarding claimant's low back condition. (Ex. 75). The CDA received Board approval on October 24, 1995.

April 10, 1998 Cite as 50 Van Natta 730 (1998)

In the Matter of the Compensation of
CHARLES V. BURKHART, Claimant
WCB Case No. 97-03144
ORDER OF ABATEMENT
Philip H. Garrow, Claimant Attorney
Reinisch, et al, Defense Attorneys

Claimant requests abatement and reconsideration of our March 12, 1998 Order on Review that reversed the Administrative Law Judge's (ALJ's) order setting aside the insurer's denial of claimant's current low back condition claim. In moving for abatement and reconsideration, claimant asserts that the Hearings Division and the Board lacked jurisdiction under SAIF v. Shipley, 326 Or 557 (1998), because the matter concerned only medical services.

In order to consider this matter, we withdraw our March 12, 1998 order. The insurer is granted an opportunity to respond. To be considered, the insurer's response must be filed within 14 days from the date of this order. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
DONALD N. POWELL, JR., Claimant
WCB Case No. 95-10685
ORDER ON REVIEW
Cole, Cary, 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) Brazeau's order that: (1) admitted Exhibits 22 and 23 and claimant's testimony into evidence at hearing, although they were not part of the Department's reconsideration record; and (2) increased claimant's unscheduled permanent disability award for a low back injury from 19 percent (60.8 degrees), as awarded by an Order on Reconsideration, to 27 percent (86.4 degrees). On review, the issues are evidence and extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

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

In lieu of the ALJ's finding that claimant did not complete high school or receive a GED, we find that claimant completed 12 years of education.

In lieu of the finding that claimant's job-at-injury was described in DOT 819.384-014, with the strength demand of "heavy," we find that claimant's job-at-injury was described in DOT 819.384-010, with the strength demand of "medium."

CONCLUSIONS OF LAW AND OPINION

Evidence

Although finding that ORS 656.283(7) unambiguously barred the admission at hearing of evidence that was not previously submitted at the Department's reconsideration proceeding, the ALJ concluded that the evidentiary limitation violated claimant's constitutionally protected right to due process. The ALJ relied on ALJ Howell's reasoning in his prior Opinion and Order in Joshua V. Sol (WCB 92-06831 and 93-03236). The ALJ therefore declined to apply ORS 656.283(7) to bar admission of Exhibits 22 and 23 and claimant's testimony, even though they were not submitted at the reconsideration proceeding.

On review, SAIF contends that the ALJ's evidentiary ruling must be reversed in light of the Board's subsequent decision in Joe R. Ray, 48 Van Natta 325, recon 48 Van Natta 458 (1996), that the exclusion of "post-reconsideration" evidence in ORS 656.283(7) did not violate the claimant's due process rights with regard to his entitlement to permanent partial disability benefits. We agree.

Moreover, the Court of Appeals has subsequently stated that ORS 656.283(7) unambiguously bars the admission at hearing of "post-reconsideration" evidence regarding the extent of permanent disability, which was not previously submitted at the reconsideration proceeding. E.g., Fister v. South Hills Health Care, 149 Or App 214, 217 (1997); Precision Castparts Corp. v. Plummer, 140 Or App 227, 231 (1996). Claimant argues that ORS 656.283(7) contains an exception for "post-reconsideration" evidence concerning issues that arose from the reconsideration order itself. Based on our reading of the statutory language itself, however, we find no expression of legislative intent to allow the admission of any "post-reconsideration" evidence regarding the extent of permanent disability, even evidence relating to issues arising out of the reconsideration order itself. See Cathy M. Montgomery, 48 Van Natta 1170, 1171 (1996). Therefore, because Exhibits 22 and 23 and claimant's testimony were not submitted at the reconsideration proceeding, and SAIF objected to their admission at hearing (Tr. 2), we conclude that their admission was an abuse of discretion. Accordingly, Exhibits 22 and 23 and claimant's testimony are excluded from the record in accordance with ORS 656.283(7) and Ray.

Unscheduled Permanent Disability

The parties disagreed as to the factors of education and adaptability only. Regarding the education factor, the ALJ relied on "post-reconsideration" evidence, Exhibits 22 and 23 and claimant's testimony, to find that claimant did not complete the 12th grade and did not obtain a GED. However, based on the admissible evidence in the record, specifically claimant's signed "801" injury claim form (Ex. 2), we find that claimant completed 12 years of education. Therefore, claimant's formal education value is zero. See former OAR 436-35-300(2)(a) (WCD Admin. Order 93-056). Claimant's total education factor is valued at 2.

Regarding the adaptability factor, the ALJ relied again on inadmissible "post-reconsideration" evidence to find that claimant's job-at-injury was best described by DOT 819.384-014 with a "heavy" strength demand. After excluding that evidence, we find that claimant's job-at-injury, which is described in claimant's "801" form as "welder/mechanic" in the manufacturing of motor homes, is best described in DOT 819.384-010.[1] Based on that DOT's "medium" strength demand, we find that claimant's base functional capacity (BFC) is medium. See former OAR 436-35-310(4)(a). Therefore, when the "medium" BFC is compared to claimant's residual functional capacity (RFC) of "medium/light," claimant's adaptability factor is valued at 2. See former OAR 436-35-310(6).

The remaining factors' values are uncontested. We therefore combine the factors. The values for age (0) and education (2) are added for a sum of 2. That sum is then multiplied by the adaptability value (2) for a product of 4. That product is then added to the impairment value (15) for a total unscheduled permanent disability award of 19 percent. The ALJ's increased award is reversed accordingly.

ORDER

The ALJ's order dated January 2, 1996 is reversed. The Order on Reconsideration dated September 7, 1995 is affirmed in its entirety. The ALJ's attorney fee award is reversed.

[1] Citing Donald L. Odell, 49 Van Natta 1872 (1997), claimant argues that the Board may take administrative notice of DOT codes and asks that we take notice of the "appropriate" DOT code in this case. However, in Odell, there was evidence to support our decision to take notice of a DOT code. Here, there is no admissible evidence to establish that claimant's job-at-injury is best described by a DOT other than DOT 819.384-010. Therefore, Odell is distinguishable on its facts.

April 10, 1998 Cite as 50 Van Natta 732 (1998)

In the Matter of the Compensation of
KENNETH C. FELTON, Claimant
Own Motion No. 96-0005M
OWN MOTION ORDER OF ABATEMENT
Zimmerman & Nielsen, Defense Attorneys

The insurer requests reconsideration of our March 24, 1998 Own Motion Order Reviewing Carrier Closure on Reconsideration, in which we set aside the insurer's July 3, 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
SALVADOR H. SANTA-CRUZ, Claimant
WCB Case No. 97-05991
ORDER ON REVIEW
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl and Moller.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Menashe's order that awarded claimant interim compensation. Claimant, pro se, cross-requests review of that portion of the ALJ's order that held that claimant's aggravation claim for a low back condition was untimely. On review, the issues are jurisdiction, aggravation and interim compensation. We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We adopt and affirm the ALJ's conclusion and opinion that claimant's aggravation claim was filed after the expiration of his aggravation rights. We reverse that portion of the ALJ's order that awarded interim compensation.

The ALJ relied on the court's opinion in Stone v. SAIF, 57 Or App 808 (1982). In Stone, the claimant filed an initial occupational disease claim more than five years after his last injurious exposure. The court concluded that, although the claim was barred under ORS 656.807(1) because it was not timely filed, claimant was entitled to interim compensation because the carrier did not issue a denial within fourteen days of the date the claim was filed.

The claim in Stone was not in "own motion" status because it had never been accepted. See ORS 656.273(4) and 656.278. By contrast, the present claim is in "own motion" status because more than five years have passed since the date of claimant's accepted nondisabling injury. See ORS 656.273(4)(b); Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988). Consequently, the ALJ had no authority to award interim compensation in this "own motion" claim. Bill D. Coleman, 48 Van Natta 2154 (1996).

ORDER

The ALJ's order dated November 7, 1997 is affirmed in part and reversed in part. That portion of the order that awarded interim compensation for the period June 12, 1997 to August 15, 1997 is reversed. The ALJ's order is otherwise affirmed.

In the Matter of the Compensation of
JAMES F. SHAUGHNESSY, Claimant
WCB Case No. 96-10382
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Scheminske, 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) Lipton's order that: (1) set aside its alleged "de facto" denial of claimant's left little finger "contusion" condition; (2) found that the employer's "partial" denial was limited to claimant's current condition; (3) set aside its current condition denial; (4) affirmed an Order on Reconsideration's award of 59 percent (3.54 degrees) scheduled permanent disability for the loss of use and function of the left little finger; and (5) awarded claimant assessed fees totaling $10,000 for prevailing against its current condition and alleged "de facto" denials and its request for hearing on the Order on Reconsideration. On review, the issues are "de facto" denial, compensability, scheduled permanent disability, and attorney fees. We reverse in part, affirm in part, and modify in part.

FINDINGS OF FACT

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

On February 3, 1996, claimant injured his left ring and little fingers at work when he struck them with a pipe wrench while attempting to secure a gate. On March 6, 1996, Dr. Brosch noted swelling and limited range of motion (ROM) in the left 5th finger at the DIP joint. (Ex. 2). Claimant continued to complain of swelling, pain and reduced ROM in May 1996 and was referred to Dr. Weirich, hand specialist. Weirich noted the presence of Bouchard's and Heberden's nodes bilaterally and x-rays revealed moderate degenerative changes affecting the entire hand and preexisting the compensable injury. (Ex. 4). Weirich diagnosed claimant's condition as degenerative arthritis exacerbated by claimant's crush injury on the job. On June 13, 1996, the employer accepted a nondisabling "left fifth finger strain," which it subsequently classified as disabling.

On September 3, 1996, Dr. Weirich performed a closing examination. He reported that claimant's little finger continued to be swollen and had limited ROM in all three finger joints and pain with radial and ulnar stress at the PIP level. Weirich stated that claimant's PIP sprain resulted in decreased ROM in his finger following the crush injury. Weirich noted claimant's underlying arthritic changes, but opined that they were not the major contributing cause of the PIP joint sprain or permanent impairment. (Ex. 7).

On October 2, 1996, Dr. Bald examined claimant for the employer. In addition to the loss of ROM at the PIP joint, which he attributed in major part to the injury, Bald identified lost ROM at the DIP joint, which, he opined, was due to the preexisting arthritis. (Ex. 8). Dr. Weirich concurred with Bald's opinion.

On November 8, 1996, the employer issued a pre-closure denial which provided in pertinent part:

> "Based on new medical evidence, it is our position that your accepted condition is now medically stationary. You have a pre-existing condition which combines with your work injury and is the major contributing cause of your current disability and need for treatment. For this reason, we must respectfully issue this partial denial of current disability and/or treatment as it no longer relates to your February 3, 1996 compensable injury." (Ex. 12).

Claimant requested a hearing challenging the denial.

A January 3, 1997 Determination Order awarded claimant 25 percent scheduled permanent disability for his left fifth finger. The award was based on lost ROM in the MP and PIP joints but not for the DIP joint. Each party requested reconsideration.

On February 18, 1997, claimant requested amendment of the Notice of Acceptance to include "crush injury." (Ex. 19). The employer responded by refusing to accept "crush injury" but offering to accept a "PIP strain of the left fifth finger." (Ex. 20). Claimant amended his request for hearing to include a "de facto" denial of the "crush injury" condition.

On March 12, 1997, claimant was examined by a panel of medical arbiters. The panel concluded that claimant had a diffuse preexisting arthritic condition affecting both hands, not significantly different in his left little finger than in any other digit of either the injured or the contralateral extremity. Based on that finding, the panel concluded that virtually all of the disability in claimant's left little finger could be attributed to the compensable injury. (Ex. 21). Based on the arbiters' examination, the Order on Reconsideration increased claimant's scheduled permanent disability award to 59 percent (3.54 degrees) for the loss of use and function of the left little finger. (Ex. 22). The employer requested a hearing on the Order on Reconsideration.

On May 30, 1997, Dr. Weirich was deposed regarding his concurrence with Dr. Bald's report. (Ex. 23).

CONCLUSIONS OF LAW AND OPINION

Scope of Acceptance/"De Facto" Denial

Claimant injured his left ring and little fingers at work when he struck them with a pipe wrench while attempting to secure a gate. Dr. Weirich diagnosed claimant's condition as degenerative arthritis exacerbated by claimant's crush injury on the job. The employer accepted a nondisabling "left fifth finger strain," which it subsequently classified as disabling. Claimant wrote to the employer pursuant to ORS 656.262(6)(d), manifesting his objection to the scope of its Notice of Acceptance by stating that a "crush injury" had been incorrectly omitted from the Notice. The employer timely responded, indicating that its acceptance of the left fifth finger strain was sufficient to apprise claimant of the acceptance of the entire soft tissue injury that was the result of claimant's February 3, 1996 injury to his left little finger.

The ALJ found that the most accurate identifier of claimant's injury was a "crush" or "contusion" of the left little finger and ordered the employer to accept a "left fifth finger contusion" in lieu of the previously accepted "left fifth finger strain." The ALJ then assessed a reasonable attorney fee for claimant's counsel's services in prevailing over the alleged "de facto" denial. On review, the employer contends that its Notice of Acceptance sufficiently apprised the parties of the scope of its acceptance and that, in any case, no attorney fee is warranted as claimant has not shown that the employer has failed to provide all compensation due.

Although we agree with the ALJ that the medical evidence indicates that the most accurate identifier of claimant's injury is "crush" or "contusion" of the left little finger (rather than an undiagnosed "strain"), we find that claimant has not established a "denied claim," and that, therefore, an assessed attorney fee is not warranted.

Under the law in effect at the time claimant requested acceptance of a "crush injury,"[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] We conclude in this case that there is no "denied claim" as defined in former ORS 656.386(1).

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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 current statute, 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).

Although claimant's attorney requested before hearing that the insurer accept the "crush injury," the insurer did not revise the acceptance. However, it made "other written clarification in response." This response does not indicate that it was denying the unaccepted condition on the ground it was not related to employment. Moreover, the record does not establish that the employer refused to pay compensation on the express ground that claimant's left little finger crush injury was not compensable or did not give rise to an entitlement to compensation. See, e.g., Kimberly Quality Care v. Bowman, 148 Or App 292 (1997). In addition, there is no evidence that benefits for claimant's left little finger crush injury have gone unpaid. Therefore, under these circumstances, no "denied claim" has been established, and no attorney fee is warranted under former ORS 656.386(1).[3]

November 8, 1996 Denial

The ALJ found that the employer's November 8, 1996 denial was a denial of claimant's current condition and should be set aside. On review, the employer contends that, in the context of the claim history, the denial concerned only claimant's preexisting degenerative arthritis. Alternatively, citing SAIF v. Ledin, 149 Or App 94 (1997), for the proposition that a carrier may amend its denial at hearing, the employer contends that it was entitled to limit the scope of its denial at hearing and did so during the opening colloquy of the parties and the ALJ. (Appellant's Brief at 14.)

In SAIF v. Ledin, the court 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;[4] however, extrinsic evidence may not be used to interpret the express language of a denial. See, e.g., Gregg Muldrow, 49 Van Natta 1866 (1997). Thus, in this case, 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. Therefore, extrinsic evidence regarding the history of the claim may not be used in interpreting the November 8, 1996 denial.

We accordingly look to the express language of the denial, which provides in pertinent part:

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[3] Former ORS 656.386(1) provides that claimant's attorney is entitled to an attorney fee at hearing in all cases involving denied claims where a claimant finally prevails against the denial.

[4] Here, the employer asserts that it had amended its denial at hearing during the opening colloquy between the attorneys and the ALJ. The record, however, does not support the employer's assertion.

At the beginning of the hearing, claimant framed the issue as follows:

"There is an issue of compensability of the current condition from a Denial dated November 8, 1996. It's a pre-closure combined-condition Denial.

"* * * * *

"Exhibit 20 indicates the basis for the Denial and does not include a denial of the underlying claim." (Tr. 3).

The employer stated:

"Claimant is challenging the Denial of November 8, 1996, which is Exhibit 12. There may, or may not, be a disagreement as to what the nature of that Denial is, and we can maybe deal with that in opening statements." (Tr. 5).

There was no further discussion of the "scope of denial" issue until closing arguments, when claimant contended that the denial was a denial of claimant's entire current condition (Closing Arguments at 3, 4) and the employer asserted that the insurer's conduct in accepting the claim and paying the compensation due to the PIP joint loss of ROM established that the denial was only a partial denial intended to deny the preexisting arthritic condition (Id. at 21).

These contentions during closing arguments fail to show that the employer amended its denial at hearing pursuant to OAR 438-006-0036. Rather, they relate only to the parties' ongoing disagreement as to the scope of the denial, and, as such, constitute no more than extrinsic evidence regarding that issue.

"Based on new medical evidence, it is our position that your accepted condition is now medically stationary. You have a pre-existing condition which combines with your work injury and is the major contributing cause of your current disability and need for treatment. For this reason, we must respectfully issue this partial denial of current disability and/or treatment as it no longer relates to your February 3, 1996 compensable injury." (Ex. 12, emphasis supplied).

The basis for the employer's denial is that the major contributing cause of claimant's combined condition has changed, and that claimant's preexisting condition, not the compensable injury, is now the major contributing cause of claimant's current disability and need for treatment. We agree with the ALJ that the unambiguous terms of the denial encompass a current condition denial, and that compensability of claimant's preexisting arthritis as a separable condition was not expressly raised by the employer's November 8, 1996 denial.

Extent of Scheduled Permanent Disability

We adopt and affirm the ALJ's opinion on this issue, with the following supplementation.

After our review of the medical record, we agree with the ALJ's evaluation of the medical evidence and his conclusion that the report of the medical arbiters is the most complete and persuasive evidence regarding claimant's left little finger impairment. Somers v. SAIF, 77 Or App 259 (1986) (in evaluating the medical evidence concerning causation, we rely on those opinions which are both well-reasoned and based on accurate and complete information).

The employer also argues that the arbiter panel should have apportioned the impairment due to the preexisting condition. The employer's argument is not well-taken.

Where, as here, there is a combination of a compensable injury and a preexisting condition, disability is "due to" the compensable injury whenever the compensable injury is the major cause of that disability. ORS 656.005(7)(a)(B); OAR 436-035-0010(2);[5] OAR 436-035-0007(3)(c).[6] Based on the medical arbiter panel's determination that the accepted injury was the major cause of the disability in claimant's left fifth finger, the panel correctly declined to apportion impairment.

Attorney Fees

For claimant's attorney's services in prevailing over the employer's current condition denial and the employer's unsuccessful challenge to claimant's permanent partial disability award, the ALJ awarded total assessed fees of $6,000, payable by the employer. The ALJ determined that the fee amount was reasonable after applying the factors set forth in OAR 438-015-0010(4).[7] The ALJ stated that he

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[5] OAR 436-035-0010(2) provides: "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. * * * ."

[6] OAR 436-035-0007(3)(c) provides:

"Where a worker's compensable condition combines with a preexisting condition, pursuant to ORS 656.005(7), the current disability resulting from the total combined condition shall be rated in accordance with these rules as long as the compensable condition remains the major contributing cause of the combined condition, i.e., a major contributing cause denial has not been issued pursuant to ORS 656.262(7)(b). Apportionment of disability is not appropriate."

[7] OAR 438-015-0010(4) provides that "[i]n any case where an [ALJ] or the Board is required to determine a reasonable attorney fee, the following factors shall be considered:

"(a) The time devoted to the case;

"(b) The complexity of the issue(s) involved;

"(c) The value of the interest involved;

"(d) The skill of the attorneys;

"(e) The nature of the proceedings;

"(f) The benefit secured for the represented party;

"(g) The risk in a particular case that an attorney's efforts may go uncompensated; and

"(h) The assertion of frivolous issues or defenses."

particularly considered "the length of the hearing, the deposition of Dr. Weirich, the benefit to claimant, the skill of counsel and the difficulty in obtaining a successful result in such cases."[8]

On review, the employer submits specific arguments regarding the rule-based factors of time devoted to the case and the benefit secured for claimant. In addition, the employer contends that consideration of the factors, either individually or collectively, does not justify a $6,000 fee in this case. Because the employer's arguments specifically address the factors, we provide the following supplementation and modification of the ALJ's decision.

Turning to the factors under OAR 438-015-0010(4), our review of the record reveals the following. Claimant's attorney successfully argued that claimant's current condition was compensable and that the extent of scheduled permanent disability should not be reduced. The file contained 23 exhibits, including one deposition of 24 pages. The hearing lasted approximately one hour and twenty minutes, resulting in a 22 page transcript. Claimant was the sole witness to testify and claimant's counsel presented oral closing arguments. Although the hearing was relatively brief, claimant's attorney expended additional time and effort on both the compensability issue in advance of that hearing, which included time spent in preparing for and participating in the deposition.

As compared to compensability and extent disputes normally reviewed by this forum, the issues in this claim were of average complexity and, given the application of the "major contributing cause" standard and the conflict in medical opinions, claimant's attorney assumed a moderate risk that he might go uncompensated for his services.

Finally, the value of the case and the benefit secured for claimant consisted of conservative medical services, no temporary disability, a portion of the scheduled permanent disability award, and potential future benefits for claimant's left little finger.

Based on our consideration of the factors in OAR 438-015-0010(4), particularly the aforementioned factors of time, value, benefit, and risk, we conclude that $3,300 is a reasonable attorney fee for claimant's services at hearing regarding the current condition and extent issues. Therefore, we modify the ALJ's attorney fee award.

Claimant's attorney is also entitled to an assessed fee for services on review. ORS 656.382(2). Claimant has submitted a Statement of Services in the amount of $3,283.75, but no less than $2,662.50,[9] documenting a total of 17.75 hours for all services exclusive of those related to attorney fee issues. The employer objects to these amounts, contending that the hourly fees and amount of time claimed are excessive. Claimant requests that we particularly consider the complexity of the issues, the value of the interest involved, the skill of the attorneys, the nature of the review proceeding involving compensability of a current condition and extent of disability, the number of arguments raised by the employer, and the benefit secured for the represented party.

After considering those factors, as we have explained in a prior section of the order, as well as reviewing the other factors in OAR 438-015-0010(4), and applying them to the compensability and extent issues, we find that a reasonable fee for claimant's attorney's services on review is $1,700, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's statement of services), the average complexity of the issues, and the below-average value of the interest involved. Claimant's attorney is not entitled to a fee for services related to the attorney fee issue.

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[8] We note that the record contains neither a specific attorney fee request nor argument as to how the rule-based factors should be weighed in determining a reasonable fee. Therefore, the ALJ's explanation for the fee award sufficiently complied with the Supreme Court's instruction in Schoch v. Leopold & Stevens, 325 Or 112, on remand 49 Van Natta 788 (1997), to set forth a "rational connection" between consideration of the factors and the fee awarded. See Russell L. Martin, 50 Van Natta 313 (1998).

[9] The first figure is based on an hourly fee of $185, the second on an hourly fee of $150.

ORDER

The ALJ's order dated July 8, 1997 is reversed in part, affirmed in part, and modified in part. Those portions of the ALJ's order that set aside the employer's "de facto" denial of claimant's "crush injury" and awarded a $4,000 attorney fee for prevailing over a "de facto" denial are reversed. That portion of the order that awarded a $6,000 assessed fee for claimant's attorney's services at hearing regarding the compensability and extent issues is modified to reduce the fee to $3,300. The remainder of the order is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,700, payable by the employer.

April 13, 1998 Cite as 50 Van Natta 739 (1998)

In the Matter of the Compensation of
CECELIA A. WAHL, Claimant
WCB Case No. 96-08247
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Baker's order that set aside its denial of claimant's L4-5 and L5-S1 disc conditions. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant suffered a compensable injury to her low back while working as a security guard for the employer on February 25, 1995. The injury occurred when claimant reached for a post to steady herself as she was going down some steps. Her ring caught on a hook, and she fell backward onto her back and left hip. (Ex. 26) Claimant's post-injury symptoms included low back pain, with radiating pain and occasional tingling down the left leg to the ankle. (Ex. 28, 30) Claimant's initial treating physician, Dr. Brazer, M.D., diagnosed acute lumbosacral strain with contusion and left sciatic radiation. (Ex. 30) The insurer accepted the injury as a "lumbar strain, left sciatica." (Ex. 31)

Claimant had a prior history of low back problems and functional overlay. In 1975, she was treated for low back and right leg pain, with a diagnosis of functional overlay and possible lumbar disc degeneration. (Ex. 2, 3) Claimant sustained a fall in June 1980 and received treatment for low back pain radiating into the right thigh, which was attributed to acute disc syndrome with hysterical features. (Ex. 9) A myelogram in December 1980 demonstrated a minimal anterior disc bulge at L4-5. (Ex. 10) In December 1986, claimant sustained a low back strain as a result of an injury with a prior employer. (Ex. 12, 14) Her claim for that injury was accepted and closed in November 1987 with an ultimate award of 10 percent unscheduled permanent partial disability (PPD) and 10 percent scheduled PPD for each leg. (Ex. 16) An MRI in December 1989 demonstrated degenerative changes at L4-5 and L5-S1. (Ex. 24)

Following the February 1995 injury at issue in this case, claimant sought follow-up care from Dr. Bert, orthopedic surgeon, in March 1995. Dr. Bert had treated claimant for prior back problems dating back to 1978. Dr. Bert's initial diagnosis was contusion of the lumbar spine and left sciatic nerve, and he read a March 20, 1995 MRI as demonstrating mild degenerative changes at L4-5 and L5-S1 and no disc herniation. (Ex. 33, 35) By April 24, 1995, claimant was also reporting right leg symptoms. (Ex. 36)

On September 15, 1995, Drs. Brooks and Arbeene examined claimant for the insurer. They noted functional overlay and reported that they could find no specific condition to account for claimant's continued complaints of low back pain. (Ex. 41) Dr. Bert concurred with this opinion. (Ex. 42)

Claimant's low back pain and bilateral lower extremity symptoms persisted. In February 1996, Dr. Bert referred claimant to Dr. Karasek, neurologist, for further testing and a second opinion. (Ex. 44)

On March 15, 1996, Drs. Potter and Gardner examined claimant for the insurer and diagnosed pain behavior and lumbosacral sprain/strain without evidence of radiculopathy. (Ex. 48) Dr. Bert concurred with this opinion.

A discography in April 1996 demonstrated degenerative changes with diffuse annular fissuring at L4-5 and L5-S1, without evidence of disc herniation or canal stenosis. (Ex. 49)

A June 13, 1996 Determination Order closed the February 1995 injury claim with no award of permanent disability. (Ex. 51) Claimant requested reconsideration, and Dr. Smith, orthopedist, performed an arbiter examination on August 13, 1996. Dr. Smith diagnosed lumbosacral sprain superimposed on minimal degenerative changes at the lumbosacral level, possible contusion of the left sciatic nerve, and functional overlay and pain behavior. (Ex. 53) A subsequent Order on Reconsideration affirmed the closure in all respects. (Ex. 56)

Meanwhile, in early August 1996, Dr. Bert proposed a surgical fusion from L4 to the sacrum. (Ex. 53-2) On August 21, 1996, Dr. Filarski, orthopedic surgeon, examined claimant to provide the insurer with a second opinion on the recommended surgery. Dr. Filarski diagnosed chronic degenerative arthrosis and chronic pain reaction. (Ex. 55) On October 31, 1996, the insurer issued a denial of degenerative arthrosis and chronic pain reaction, and all treatment for these conditions. (Ex. 59)

On November 8, 1996, Dr. Karasek related claimant's symptoms to a painful annular fissure on the left at L4-5. (Ex. 61)

On December 3, 1996, Dr. Bert performed surgery and discovered a very large, completely extruded fragment at L5, very degenerated and impinging severely on the right nerve root at L5. Dr. Bert concluded that this extruded fragment was the "obvious pain generator." Accordingly, he performed a laminectomy, discectomy and foraminotomy at L5-S1, rather than the previously planned two-level fusion surgery. (Ex. 62) Dr. Bert's final diagnosis was post-traumatic and degenerative disc disease at L4-5 and L5-S1. (Ex. 62)

CONCLUSIONS OF LAW AND OPINION

On review, the insurer contends that the ALJ erred in setting aside its denial of claimant's current L4-5 and L5-S1 disc conditions. We agree.

Resolution of this compensability 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). 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).

As a preliminary matter, we conclude that claimant's 1995 injury with the employer combined with preexisting degenerative changes within the meaning of ORS 656.005(7)(a)(B). Of the medical experts rendering an opinion on this issue, only Drs. Bert, Filarski and Smith had an opportunity to review the April 1996 discography. Those three doctors agreed that the 1995 injury had combined with the preexisting degenerative changes. (Ex. 53, 55, 63) We defer to the opinion of those experts and conclude that claimant must prove that the work injury was the major contributing cause of the current need for treatment or disability. ORS 656.005(7)(a)(B).

The insurer relies on the opinion of Dr. Filarski that the 1995 injury is not the major contributing cause of the annulus tearing or the recommended surgery. (Ex. 55) The insurer's denial is also consistent with the March 1996 opinion of Drs. Potter and Gardner that claimant's restrictions were due to long-standing degenerative processes in the lumbar spine rather than the 1995 injury. (Ex. 48).

Dr. Filarski's opinion is less persuasive because he did not have an opportunity to consider Dr. Bert's surgical findings; and we discount the opinion of Drs. Potter and Gardner because it was rendered without benefit of either the surgical findings or the April 1996 discography. Nevertheless, claimant cannot carry her burden of proof merely by discounting the medical opinions supporting the insurer's denial. Instead, claimant must offer medical opinion that affirmatively establishes the compensability of her claim by a preponderance of the evidence.

Here, claimant and the ALJ rely on the opinion of the treating surgeon, Dr. Bert, and the consulting physician, Dr. Karasek. Dr. Bert opined that the 1995 injury combined with claimant's preexisting degenerative changes and is the major cause of the annulus tearing at L4-5, the extruded disc at L5-S1, and the need for treatment and disability related to claimant's current low back condition. (Ex. 69, 70) Dr. Karasek opined that claimant's L4-5 annular tearing and extruded L5-S1 disc were probably related to her 1995 injury. (Ex. 67) Claimant's injury claim is also supported by: Dr. Brazer's June 1995 opinion (Ex. 38) that the 1995 injury was the major contributing cause of claimant's current low back symptoms; and Dr. Smith's August 1996 opinion (Ex. 53) that claimant's symptoms are "historically" due to the 1995 injury rather than the minimal degenerative changes demonstrated by MRI.

We conclude that this medical record does not satisfy claimant's burden of establishing compensability of her claim by a preponderance of the evidence.

Dr. Karasek's opinion that the current treatment/disability is related to the 1995 injury does not satisfy the major contributing cause standard; and Drs. Karasek, Smith and Brazer do not adequately address the relative contribution of claimant's preexisting degenerative changes. See Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev den 321 Or 416 (1995). Moreover, Drs. Bert and Smith expressly acknowledged that their opinions are dependent on claimant's own history regarding her symptoms both before and after the February 1995 injury. (Exs. 53, 70-35) This is a persuasive reason for discounting their opinions, given claimant's documented history of functional overlay.

Furthermore, Dr. Bert's opinion has been somewhat equivocal and suggestive of a "but for" analysis that does not support a "major contributing cause" finding. Id. Dr. Bert previously opined in November 1996 that the combination of the preexisting changes and the 1995 injury were the major contributing cause of the current need for surgery; and he reasoned that "[w]ithout the injury of 2-25-95, [claimant] would not have sought medical attention and the need for surgery would not have arisen." (Ex. 63) In his subsequent deposition testimony, Dr. Bert stated that, in retrospect, he did think surgery was necessary in 1989. (Ex. 70, pp. 12-13) Finally, at the end of his deposition, Dr. Bert agreed that post-injury diagnostic studies that did not demonstrate an L5-S1 herniation, suggest that it is more probable than not that the L5-S1 extrusion occurred sometime after the February 1995 injury. (Ex. 70, pp. 38-39)

In summary, we conclude that this medical record does not establish, by a preponderance of the evidence, that the 1995 injury is the major contributing cause of claimant's current need for treatment or disability. Accordingly, claimant has not carried her burden of establishing compensability of her L4-5 and L5-21 disc conditions under ORS 656.005(7)(a)(B).

ORDER

The ALJ's order dated November 13, 1997 is reversed. The insurer's July 19, 1995 denial is reinstated and upheld. The ALJ's assessed fee award is also reversed.

April 14, 1998 Cite as 50 Van Natta 741 (1998)

In the Matter of the Compensation of
RICKY V. BAUGHMAN, Claimant
WCB Case No. 97-05988
ORDER ON REVIEW
Mitchell & Associates, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that declined to award temporary disability benefits for the period from October 29, 1996 through July 11, 1997. On review, the issue is temporary disability.

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

We do not apply OAR 436-060-0020(5). See Jim R. Reed, 49 Van Natta 753 (1997).

ORDER

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

In the Matter of the Compensation of
DONALD G. GAUL, Claimant
WCB Case No. 97-06543
ORDER ON REVIEW
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Davis' order that dismissed his hearing request as having been withdrawn. On review, the issue is the propriety of the ALJ's dismissal order.[1] We affirm.

FINDINGS OF FACT

On July 29, 1997, claimant signed a retainer agreement with his former attorney(s) to represent him in connection with his workers' compensation claim. A provision of that agreement stated: "My attorneys are authorized to sign my name and in all other respects to act for me."

On August 14, 1997, claimant's former attorney filed a hearing request on claimant's behalf, contesting the insurer's compensability denial dated July 2, 1997 and seeking a penalty and attorney fee. A hearing was scheduled for November 12, 1997.

By letter dated November 7, 1997, claimant's former attorney withdrew the hearing request and requested issuance of a dismissal order. On November 24, 1997, the ALJ dismissed claimant's hearing request.

On December 23, 1997, we received claimant's December 15 handwritten request for Board review of the ALJ's dismissal order. By letter dated January 16, 1998, claimant's former attorney advised us that the case had been withdrawn, that claimant acted on his own behalf in requesting Board review, and that his law firm has not been representing claimant since issuance of the dismissal order.

By letter dated January 6, 1998, the insurer moved for dismissal of claimant's review request. We denied that motion on January 27, 1998.

CONCLUSIONS OF LAW AND OPINION

The dispositive issue is whether the ALJ properly dismissed claimant's hearing request as having been withdrawn. We conclude that it was.

The record shows that claimant, through his former attorney, withdrew his hearing request. Claimant does not dispute that his former attorney had the authority to act on his behalf when the hearing request was withdrawn, nor does claimant dispute that the ALJ dismissed his hearing request in

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[1] By letter dated March 6, 1998, the insurer's counsel moved both to deny claimant's request for review and to strike the factual allegations raised in claimant's handwritten request for review. Because, in support of its motion to deny, the insurer cites to prior Board orders that affirmed ALJ dismissal orders based on circumstances similar to those in this case, we interpret the insurer's motion to deny as argument, submitted in response to claimant's review request, that the ALJ's dismissal order should be affirmed on the merits. Moreover, inasmuch as we have concluded in this order that the ALJ properly dismissed claimant's hearing request, we need not address the insurer's motion to strike.

response to the withdrawal of his hearing request. Under these circumstances, we find no reason to alter the dismissal order. See Elvia H. Hillner, 49 Van Natta 1106 (1997); William A. Martin, 46 Van Natta 1704 (1994); Mike D. Sullivan, 45 Van Natta 900 (1993); Eul G. Moody, 45 Van Natta 835 (1993).

ORDER

The ALJ's order dated November 24, 1997 is affirmed.

In the Matter of the Compensation of
JANET F. BERHORST, Claimant
Own Motion No. 98-0129M
OWN MOTION ORDER
Malagon, Moore, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable lumbar strain, and chronic urinary tract infections, psychotic, related or due to the physical condition. Claimant's aggravation rights expired on January 23, 1989. SAIF agrees that claimant's current condition, need for laminectomy/diskectomy and foraminotomy at L2-3, is causally related to the compensable condition, that it is responsible for claimant's current condition and that the proposed surgery or hospitalization is reasonable and necessary. However, SAIF contends that claimant was not in the work force at the time of the current disability.

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

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 was not in the work force at the time of the current disability. Claimant responded to SAIF's contention by letter dated March 23, 1998. Claimant provided copies of two 1996 W-2 forms and a March 12, 1998 affidavit wherein she attests that "If my [claimant's] physical condition had been such that I [claimant] could work, and if it allowed me to work now and I [claimant] could find someone to hire me [claimant], I [claimant] would be working." The documentation provided by claimant evinces her willingness to work.

However, we have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction,[1] is the date she enters the hospital for the proposed surgery. Fred Vioen, 48 Van Natta 2110 (1996); John R. Johanson, 46 Van Natta 2463 (1994). The relevant time period for which claimant must establish she was in the work force is the time prior to her December 29, 1997 surgery, when her condition worsened requiring that surgery. See generally Wausau Ins. Companies v. Morris, 103 Or App at 273; Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990); Jeffrey A. Kyle, 49 Van Natta 1331 (1997); Michael C. Batori, 49 Van Natta 535 (1997); Kenneth C. Felton, 48 Van Natta 725 (1996).

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[1] The Board in its own motion jurisdiction can only authorize temporary disability from the time of surgery or hospitalization. See ORS 656.278(1)(a).

Claimant indicates that she was taken off work in December 1996 due to the compensable condition and that she spent "all of 1997 seeing various doctors." However, claimant does not provide medical documentation supporting her affidavit nor does she submit a medical opinion supporting her contentions. The record does not contain medical evidence that claimant was taken off work in December 1996 due to her compensable injury. Further, the medical documentation contained in the record fails to establish that in December of 1996 and all of 1997, claimant was unable to work and that it would have been futile for her to seek work due to her compensable condition.

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.

April 14, 1998 Cite as 50 Van Natta 744 (1998)

In the Matter of the Compensation of
WAVEL C. NELDON, Claimant
Own Motion No. 66-0235M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

On March 31, 1998, the SAIF Corporation submitted a request for additional medical benefits relating to claimant's compensable injury. Claimant was awarded permanent total disability benefits in 1955. SAIF recommends the reopening of this claim to provide for an electric wheel chair with hand controls and a home safety evaluation.

Inasmuch as claimant sustained a compensable injury prior to January 1, 1966, he does not have a lifetime right to medical benefits pursuant to ORS 656.245. William A. Newell, 35 Van Natta 629 (1983). However, for conditions resulting from a compensable injury occurring before January 1, 1966, the Board may authorize the payment of medical benefits. ORS 656.278(1)(b).

In a letter dated March 30, 1998, Dr. Lipsmeyer, claimant's treating physician recommended claimant be provided with an electric wheelchair "because he cannot maneuver a standard wheelchair. He has only one arm and because of the deterioration of his legs." Additionally, because of claimant's severe injury and current medical condition, SAIF's medical staff have recommended that a home safety evaluation be done.

Based on these opinions, we are persuaded that the requested electric wheelchair with hand controls and a home safety evaluation are reasonable and necessary for the compensable injury which has rendered claimant permanently and totally disabled. Accordingly, claimant's claim is reopened to provide for an electric wheelchair with hand controls and a home safety evaluation. This order shall supplement our April 28, 1992 order that previously reopened claimant's 1955 claim for the payment of medications, office visits, tests and prescriptions.

This authorization for compensable medical services shall continue on an ongoing basis for an indefinite period of time, until there is a material change in treatment or other circumstances. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
GILDA A. BORTHS, Claimant
WCB Case No. 97-13191
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Hall, Bock and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Brazeau's order that upheld the SAIF Corporation's denial of her claim for a stomach condition and resulting surgery. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant suffered a compensable cervical and thoracic strain while employed as a production assembler in October of 1988. SAIF accepted her claim on January 31, 1989. Just prior to her 1988 claim, claimant had undergone hiatal hernia surgery. A gastric ulcer was also diagnosed at that time.

On January 12, 1990, claimant reported to a hospital emergency room, complaining of gastric upset. Dr. Wollmuth noted claimant's long-standing history of gastrointestinal disease, including gallstones and a prior hiatal hernia repair. Wollmuth diagnosed upper GI bleeding, probably due to peptic disease and aggravated by claimant's use of medications. A subsequent endoscopy revealed marked erosive esophagitis. The symptoms of that condition continued thereafter, despite various therapies. Ultimately, Dr. Heinonen of Western Medical Consultants opined that claimant's GI bleeding was directly related to her use of aspirin. The aspirin was taken for the effects of claimant's compensable injury. Thereafter, SAIF accepted responsibility for claimant's esophagitis condition by way of a December 14, 1990 Stipulation and Order.

Claimant began treating with Dr. Deveney, Professor and Vice Chairman of Surgery at the Oregon Health Sciences University, in December of 1990. On December 27, 1990, Dr. Deveney performed a repeat Nissen fundoplication, during which a medium-sized hiatal hernia was found and repaired. Dr. Deveney also noted that a previously-performed 1986 fundoplication had slipped down to the point that it was wrapped around a tubularized portion of claimant's stomach. By letter dated September 17, 1991, SAIF denied claimant's claim for surgery on the basis that it was unrelated to her compensable conditions.

Claimant requested a hearing concerning SAIF's denial. By Opinion and Order dated September 30, 1994, then-Referee Michael V. Johnson set aside SAIF's denial insofar as it denied claimant's claim for reflux and the surgery performed by Dr. Deveney in late 1990. The Referee upheld SAIF's denial insofar as it pertained to claimant's hiatal hernia condition. The Referee's order was not appealed and became final as a matter of law. SAIF subsequently issued a formal acceptance of claimant's reflux condition.

In the meantime, claimant returned to her physicians in April of 1993, complaining of continuing GI distress. Radiological studies revealed a large hiatal hernia and a focal narrowing of the distal esophagus. In April 1993, Dr. Deveney did another surgery to revise claimant's Nissen fundoplication.

In September 1993, SAIF asked Dr. Deveney for a delineation of the various treatments provided to claimant for her gastric conditions. On September 24, 1993, Deveney responded that claimant's April 1993 surgery was to correct a previous operation that wrapped a portion of the stomach too tightly around her esophagus. The surgery was not designed to correct claimant's gastric reflux condition. A month later, Deveney clarified that claimant's then-current condition was unrelated to her esophagitis condition.

Claimant's gastric symptoms continued into 1995. In April of 1995, she visited her gastroenterologist, Dr. Mason, complaining of a "lump in her throat." Mason took a history that claimant was experiencing significant stress as a result of having to care for her invalid husband. Dr. Mason performed an endoscopy a month later, however, noting no frank esophageal obstruction, although there was a possibility of ongoing reflux problems.

In July of 1995, Dr. Deveney reported that it was probable that claimant sustained vagal nerve damage as a result of her several surgeries, given that the vagus nerve is in the area of her surgical sites.

In March 1996, Dr. Herrin, M.D., performed another endoscopic evaluation of claimant. Dr. Herrin found claimant's esophagus to be normal with no evidence of stricturing or esophagitis. The stomach also appeared normal. Because claimant had food in her stomach despite fasting, however, Herrin suggested that she might have a continuing lack of motility. Later testing confirmed that claimant's gastrointestinal motility was reduced. Because of that, Dr. Deveney recommended a pyloroplasty for the purpose of increasing her gastric drainage.

On June 6, 1997, SAIF denied the proposed surgery on the basis that it was unrelated to claimant's compensable conditions. On June 17, 1997, Dr. Deveney performed the recommended pyloroplasty.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant had failed to establish that her compensable conditions were the major cause of her need for surgery in 1996. We disagree.

Claimant asserts that her 1996 need for medical treatment is a compensable consequence of her accepted 1988 injury and its sequelae. In order to establish compensability, claimant must show that her 1988 injury or its sequelae, is the major contributing cause of her need for treatment. ORS 656.005(7)(a)(A). Where a worker sustains a "new injury" as the direct result of reasonable and necessary treatment for the compensable injury, the compensable injury is the major contributing cause of the consequential condition for purposes of ORS 656.005(7)(a). Barrett Business Services v. Hames, 130 Or App 190, rev den 320 Or 492 (1994).

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).

The only medical opinion addressing causation comes from Dr. Deveney, who has treated claimant since 1990 and performed the 1990, 1993, and 1996 surgical procedures. Dr. Deveney opined that claimant's current need for medical treatment was caused by damage to the vagal nerve that occurred during either the 1990 or 1993 surgeries. (Exs. 55, 60, 64, 67, 68). Dr. Deveney explained that the 1990 surgery was performed to relieve symptoms of claimant's reflux condition. (Ex. 68-14). He further explained that the 1993 surgery was necessary to loosen the fundoplication that had wrapped too tight during the 1990 surgery. (Exs. 34, 68-14).

Claimant's 1990 surgery was found compensable by a prior litigation order. (Ex. 40). That order was not appealed by SAIF and became final. According to Dr. Deveney, the 1993 surgery was performed to correct the fundoplication from the 1990 surgery. (Ex. 68-14). Inasmuch as the 1993 surgery was to repair a procedure that occurred during the 1990 compensable surgery, we find that there is a direct and inexorable causal connection between the two surgeries. See Barrett Business Services v. Hames, 130 Or App at 195. Accordingly, the 1993 surgery is a compensable consequence of the 1990 surgery.

Because both the 1990 and 1993 surgeries were compensable sequelae of claimant's accepted conditions, the fact that Dr. Deveney could not definitively state which of those surgeries caused the vagal nerve damage, necessitating the 1996 surgery, is not relevant. Rather, since both surgical procedures were compensably related to claimant's accepted condition, Dr. Deveney's opinion relating the 1996 surgery to either or both surgeries is sufficient to establish the compensability of the 1996 surgery. Consequently, based on Dr. Deveney's opinion, 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 concerning the compensability issue is $4,500, payable by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated November 7, 1997 is reversed in part and affirmed in part. That portion of the ALJ's order which upheld the SAIF Corporation's denial 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 counsel is awarded $4,500, as a reasonable assessed attorney fee, payable by SAIF. The remainder of the ALJ's order is affirmed.

Board Member Haynes dissenting.

The majority concludes that claimant's 1988 compensable injury and its sequelae are the major cause of claimant's current need for surgery. Because I believe that this record does not support that conclusion, I respectfully dissent.

In 1986, prior to claimant's 1988 compensable injury, she underwent a fundoplication procedure. (Ex. 7, 37a). In addition, claimant was diagnosed with a hiatal hernia and a gastric ulcer. (Id.) Her original compensable injury was a cervical/thoracic strain. (Ex. 3). As a result of aspirin intake for the compensable injury, claimant developed esophagitis which was also accepted as a consequence of the compensable injury. (Ex. 20). In 1990, claimant underwent further stomach surgery for a repeat fundoplication and hernia repair. (Exs. 20a, 21).

The subsequent litigation concerning claimant's condition and need for treatment was resolved by ALJ Michael Johnson's 1993 Opinion and Order. ALJ Johnson upheld SAIF's denial of claimant's hiatal hernia, but set aside SAIF's denial of claimant's reflux condition. (Ex. 40). In addition, ALJ Johnson found that SAIF was responsible for the 1990 surgery as a portion of that procedure was necessary in order to treat claimant's compensable esophagitis condition. (Id.). In 1993, claimant underwent surgery to revise the prior fundoplication. (Ex. 31).

While ALJ Johnson did find SAIF responsible for the 1990 surgery, that surgery also corrected claimant's noncompensable hernia condition. While it is the "law of the case" that SAIF was found responsible for the 1990 surgery, the subsequent surgery in 1993 has never been found compensable. The majority concludes that the 1993 surgery was caused in major part by the 1990 surgery and therefore, the 1993 surgery was a compensable consequence of the 1988 cervical injury. Although Dr. Deveney did indicate that the 1993 surgery was necessary to loosen the fundoplication that was wrapped to tight during the 1990 surgery, this is not sufficient to establish that the 1993 surgery was caused, in major part, by any of claimant's compensable conditions, i.e., cervical/thoracic strain, esophagitis, or reflux condition. Moreover, Dr. Deveney does not address the relative contribution of claimant's noncompensable hernia condition or the 1986 initial fundoplication procedure.

The majority essentially reasons that because the 1990 surgery was found compensable, the 1993 surgery must also be compensable and therefore, since the 1996 surgery was due to damage caused during either the 1990 or 1993 surgery, it must also be compensable. As noted above, I do not believe this record contains sufficient evidence to establish that the 1993 surgery is compensable. If the 1993 surgery is not compensable, then claimant has failed to prove that the 1996 surgery is compensable as Dr. Deveney cannot say which of the surgeries (1990 or 1993) necessitated claimant's 1996 surgery. Furthermore, Dr. Deveney has agreed that the 1996 surgery was due to claimant's preexisting noncompensable hiatal hernia condition and consequential repair surgeries. (Ex. 64).

Under these circumstances, I agree with the ALJ that while it is possible that the 1996 surgery was performed to correct damage that was caused by surgery performed for claimant's compensable conditions, it is equally possible that it was caused by surgical repairs to claimant's noncompensable hiatal hernia condition. Consequently, I would affirm the ALJ's conclusion that claimant failed to carry her burden of proof. For these reasons, I dissent.

In the Matter of the Compensation of
EDWARD A. BRODAHL, Claimant
WCB Case No. 97-07524
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that upheld the self-insured employer's denial of his claim for a right foot injury. On review, the issue is compensability.

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

On review, claimant argues that the ALJ erred in applying the "major contributing cause" standard. However, for the following reasons, we conclude that, under either a material contributing cause or the major contributing cause standard, claimant has not established compensability.

Although claimant argues that this case is not complex, we agree with the ALJ that an expert medical opinion is required. In Barnett v. SAIF, 122 Or App 279, 283 (1993), the court held that factors for determining whether expert testimony of causation is required include: (1) whether the situation is complicated; (2) whether symptoms appear immediately; (3) whether the worker promptly reports the occurrence to a superior; (4) whether the worker was previously free from disability of the kind involved; and (5) whether there was any expert testimony that the alleged precipitating event could not have been the cause of the injury.

Here, there was no specific incident at work which caused claimant's symptoms. Claimant reported the foot pain to his supervisors several days after the pain began. There is no evidence that claimant had previously experienced right foot symptoms, however, claimant had an off-work left foot injury approximately 10 days prior to the time his right foot symptoms first began. Finally, Dr. Yarusso, who first treated claimant, was unable to determine if claimant's injury was work related.

Under the circumstances, we conclude that the situation is complicated. Dr. Tilson noted that claimant had a prior left foot injury in 1995 which could have altered claimant's gait and predisposed his right foot to the stress fracture. (Ex. 13, 14). However, as noted by the ALJ, Dr. Tilson did not discuss claimant's more recent left foot injury. Although claimant contends that Dr. Tilson took a complete history and was aware of the 1997 left foot injury, there is no evidence to support this contention. In light of Dr. Tilson's discussion of the 1995 injury and the possible altered gait, we find it unlikely that Dr. Tilson would fail to note or discuss the more recent left foot injury. In any event, the failure to discuss the 1997 left foot injury has diminished the persuasiveness of Dr. Tilson's opinion.

Finally, Dr. Tilson reasoned that he believed claimant "in terms of his theory of causation, as at least by history there is no other potential explanation for the fracture." (Ex. 14). To the extent that Dr. Tilson's opinion is based on a temporal analysis, it is unpersuasive. See Allie v. SAIF, 79 Or App 284 (1986). Furthermore, claimant cannot rely solely on the deductive reasoning that, because his condition did not occur until after work exposure and cannot be proven to have been caused by another agent, it must have been caused by work. ORS 656.266; Bronco Cleaners v. Velazquez, 141 Or App 295, 299 (1996).

Consequently, in addition to the reasons provided by the ALJ, we find that Dr. Tilson's opinion does not persuasively establish compensability. Therefore, we affirm the ALJ's order.

ORDER

The ALJ's order dated December 30, 1997 is affirmed.

In the Matter of the Compensation of
MARLIE D. BRUCE, Claimant
WCB Case No. 93-07131
ORDER ON REMAND
Pozzi, Wilson, et al, Claimant Attorneys
Michael O. Whitty (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Bruce v. SAIF, 149 Or App 190 (1997). The court reversed the Board's prior order which held that claimant was not entitled to permanent total disability benefits. Marlie D. Bruce, 48 Van Natta 809 (1996). Finding that it could not determine whether we applied the correct legal standard when analyzing a vocational expert's reference to a "tight" labor market, the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant was compensably injured on May 23, 1988 when the log truck he was driving rolled off a cliff. As a result of the accident, claimant suffered facial injuries, a closed head injury, as well as injuries to his upper and lower back, right knee and right arm and partial loss of his vision. Due to the closed head injury, claimant suffers from post-traumatic stress syndrome, depression, severe memory loss and cognitive defects. These conditions render claimant unable to return to his prior work activities.

A vocational counselor identified claimant's post-injury transferable job skills as the ability to: (1) work in short cycle repetitive tasks; (2) work with things in a routine manner in a non-social environment; and (3) work with machines. The counselor concluded that there were some potential jobs that claimant could perform but found no such jobs available in claimant's geographical area.

A Determination Order awarded claimant, among other things, 88 percent (281.6 degrees) unscheduled permanent disability. An Order on Reconsideration reduced claimant's award to 86 percent (275.2 degrees). Claimant appealed the Order on Reconsideration and the Administrative Law Judge (ALJ) found claimant permanently and totally disabled (PTD). The SAIF Corporation sought Board review of the ALJ's order and on review we reversed the ALJ's order finding that claimant had not established that he was PTD and we affirmed the Order on Reconsideration's award of unscheduled permanent disability. In reaching our decision that claimant was not entitled to PTD benefits, we discounted the opinion of claimant's vocational expert, Mr. Ross, because we found that Ross' opinion was based on the fact that the labor market in the geographical area where claimant lived was "tight," rather than on whether claimant was employable.

Claimant appealed our decision to the Court of Appeals. Because it was unable to determine how we understood Ross' opinion that the labor market in the geographical area where claimant resided was "tight," the court reversed our order and remanded for reconsideration. The court interpreted former OAR 436-030-0055(1)(g) to require a determination of whether, assuming "normal" conditions in the pertinent labor market, work that a claimant could perform would ordinarily be available. The court reasoned that cyclical "boom or bust" conditions are immaterial to the inquiry. If, however, ordinarily there is a lack of suitable work in claimant's labor market, either because of chronically depressed conditions or a generic lack of available suitable positions, the "tight" state is material to the "odd-lot" analysis prescribed by OAR 436-030-0055.[1]

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[1] OAR 436-030-0055(1) provides, in pertinent part:

"(1) A worker is permanently and totally disabled if permanently incapacitated from regularly performing work in a suitable and gainful occupation. For the purpose of this rule:

* * * * * *

"(b) 'Suitable occupation' means those occupations that exist in a theoretically normal labor market, within a reasonable geographic distance, for which a worker has the training or experience, and abilities to realistically perform the job duties, with or without rehabilitation.

The court found that Ross' reference to the "tight" labor market was ambiguous in that it could be reasonably understood to refer either to a cyclical condition or to an ordinary state. Because the court could not determine whether we applied the correct legal standard, the court remanded for clarification or, if necessary, revision of our conclusions.

In light of the court's holding, we granted the parties' requests for supplemental briefs on remand. Having received the parties' supplemental briefs, we proceed with our reconsideration.

Included with claimant's supplemental brief is an affidavit from Mr. Ross in which Ross explains what he meant by his use of the term "tight" in reference to the labor market in the area where claimant resides. SAIF argues that the Board cannot consider extra-record evidence and moves to strike claimant's brief asserting that references to the extra-record material in the brief "poisons the entire document." SAIF opposes remand, arguing that there has been no showing that the information in the affidavit was unobtainable with due diligence at the time of hearing.

We treat the submission of the affidavit as a motion for remand. We may remand a case to the ALJ if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 n. 3 (1983). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must clearly be shown that material evidence was not obtainable with due diligence at the time of the hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986).

Based on this record, we find that claimant has not shown that the evidence from Mr. Ross was unobtainable with due diligence at the time of hearing. Because this evidence could have been offered at hearing, we deny the motion to remand. We likewise deny SAIF's motion to strike claimant's entire brief. However, we grant SAIF's motion to the extent that we do not consider those portions of the brief which refer to extra-record evidence. See Maria Leyva, 48 Van Natta 288 (1996) (Board will not consider any evidence that was not previously made a part of the record).

We next turn to the question of our understanding of Mr. Ross' testimony based on the existing record. In concluding that claimant was PTD, Ross stated:

> "I think in part it has to do with the labor market that he resides in. It is, as others describe it, tight, and that's described even in the file material that I reviewed. It's comprised primarily of mill work, logging, driving, and there's a trailer manufacturer and small retain operations. Given the lack of skills and the nature and degree of both his physical and cognitive impairments, I don't think he can find employment on a regular and sustained basis within that labor market."

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* * * * * *

"(e) A 'reasonable geographic distance' as used in this rule means either of the following unless the worker is medically precluded from commuting:

"(A) The area within a 60-mile radius of claimant's place of residence at the time of:

"(i) the original injury; or

"(ii) claimant's last gainful employment[.]

* * * * * *

"(B) The area in which a reasonable and prudent uninjured and unemployed person, possessing the same physical capacities, mental capacities, work skills and financial obligations as claimant does at the time of his rating of disability, would go to seek work.

* * * * * *

"(g) 'Theoretically normal labor market' as used in OAR 436-030-0055 and 436-030-0065 means a labor market that is undistorted by such factors as local business booms and slumps or extremes of the normal cycle of economic activity or technology trends in the long-term labor market."

After reconsidering this matter in light of the court's opinion, and having reviewed Ross' testimony in its entirety, we understand Ross' opinion to mean that there is ordinarily a lack of suitable work in the labor market where claimant resides. Thus, we conclude that Ross' opinion may not be discounted on the ground that it takes into account the conditions of the labor market. Such chronically depressed conditions are material to the question of whether claimant is employable in a theoretically normal labor market. However, as the parties point out, the resolution of this issue does not necessarily determine whether or not claimant is PTD. SAIF also submitted evidence from its own vocational expert, Stipe. Stipe, in contrast to Ross, does not believe that claimant is unemployable. Thus, in order to determine whether claimant is entitled to PTD benefits, we must determine which vocational expert is most persuasive.[2]

Claimant argues that Stipe's opinion is unpersuasive because he based his conclusion on a labor market other than the one in which claimant resides. We agree. Based on our review of the record, Stipe focused his analysis largely on geographical areas outside the labor market in which claimant resides. Specifically, Stipe focused on Boise and other communities which are more than 60 miles from the labor market in which claimant lives. (Ex. 68-61, 62).

SAIF next argues that under OAR 436-030-055(1)(e)(B), Boise is an area within a reasonable geographic distance to which a prudent person would relocate to find work. OAR 436-030-055(1)(e)(B) provides that a "reasonable geographic distance" includes the "area in which a reasonable and prudent uninjured and unemployed person, possessing the same physical capacities, mental capacities, work skills and financial obligations as claimant does at the time of his rating of disability, would go to seek work." We do not agree that a reasonable and prudent worker possessing claimant's mental capacities would relocate to Boise or the surrounding area. In this regard, the record establishes that claimant has difficulty in large urban areas such as Boise because of his head injury. We further note, as did the ALJ, that the labor market survey conducted by Stipe did not give potential employers complete information regarding the extent of the symptoms caused by claimant's head injury. Employers were only advised that claimant had some memory problems, but was able to perform simple to moderately complex instructions. According to the record, in addition to memory problems, claimant has other cognitive deficits from the head injury, including moderate impairments in attention and concentration, moderate reduction in new learning skills, mild to moderate decline in reasoning/divergent thinking ability, moderate compromise in executive function, and mild to moderate impairments in communication skills.

SAIF argues that we relied on Stipe's opinion in our prior order and asserts that the issue of the reasonableness of the geographic area considered by Stipe was finally resolved by our prior order. We disagree.

We did not rely on Stipe's opinion in our prior order and we did not address the persuasiveness of the labor market considered by Stipe. Rather, we found both of claimant's vocational experts unpersuasive. We then stated: "Given that the only other vocational evidence in the record indicates that claimant is employable, we conclude that claimant has not met his burden of proof to establish that he is unemployable." 48 Van Natta at 810. Thus, it was unnecessary for us to rely on Stipe's opinion since we had already concluded that there was no persuasive vocational evidence that claimant was unemployable. In any event, because this matter has been remanded for reconsideration, our prior order is a nullity. See Shawn P. Harold, 49 Van Natta 254, 255 (1997) (where court has remanded for reconsideration, prior Board order is a nullity and issues raised at hearing may be addressed on remand); Kim D. Wood, 48 Van Natta 482, 483 n. 1 (1996).

After reconsidering the vocational evidence in this case, we are more persuaded by the opinion of Ross. In rendering his opinion, Ross focused only on the relevant labor market. Moreover, he based his opinion on an accurate understanding of claimant's disabilities. In contrast, Stipe based his opinion partly on a consideration of a labor market outside of the one in which claimant resides and his labor market surveys were based on an incomplete description of claimant's injury-related cognitive deficits. For these reasons, on reconsideration of this matter, we find that the ALJ's order awarding claimant PTD benefits should be affirmed.

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[2] The record also contains a vocational opinion from Huckfeldt. However, in our prior order, we found Huckfeldt's opinion unpersuasive on the ground that he based his opinion on an incorrect belief that claimant was limited to sedentary work whereas the record established that claimant was capable of light work. The court found that our conclusions regarding the persuasiveness of Huckfeldt's opinion were supported by substantial evidence. We continue to give little weight to Huckfeldt's opinion.

Claimant has finally prevailed after remand. 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.

SAIF 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 is $4,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the permanent total disability issue (as represented by claimant's appellate briefs to the Board on review and remand), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated. We have not considered claimant's unsuccessful efforts to supplement the record. Finally, we have taken into consideration claimant's counsel's "out-of-compensation attorney fee," as described below.

Because claimant also appealed our prior decision to the court and that appeal has resulted in "increased" compensation (in that on remand we have found claimant to be entitled to PTD benefits), claimant's counsel is also entitled to an out-of-compensation attorney fee. See ORS 656.386(2); ORS 656.388(1). Consequently, we approve an "out-of-compensation" attorney fee, in lieu of the ALJ's out-of-compensation fee award, 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 exceed $6,000. See ORS 656.388(1); ORS 656.386(2); OAR 438-015-0055(1).

Accordingly, on reconsideration, we affirm the ALJ's order dated June 26, 1995. In lieu of the out-of-compensation attorney fee awarded by the ALJ, claimant's attorney is awarded 25 percent of the compensation created by this order. However, the total out-of-compensation attorney fee granted by the ALJ's order and this order shall not exceed $6,000. In addition, claimant's attorney is awarded an assessed fee of $4,000, for services before the Board and on remand, payable by SAIF.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROY N. HANSEN, Claimant
Own Motion No. 66-0200M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

On April 7, 1998, the SAIF Corporation submitted a request for additional medical benefits relating to claimant's compensable May 29, 1959 injury. Claimant has been found permanently and totally disabled as a result of his compensable injury. SAIF now recommends reopening of this claim to provide for the provision of compensable medical services received by any physician. In addition, SAIF recommends that claimant's claim remain open until medical services are no longer required.

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 for compensable injuries occurring before January 1, 1966. See ORS 656.278(1).

Here, SAIF contends that due to the severity of claimant's injury and current medical condition, claimant will require medical treatment from many different doctors. We find that the requested medical services are reasonable and necessary for the compensable injury which has rendered claimant permanently and totally disabled. Accordingly, claimant's claim is reopened to provide the above medical services. See OAR 438-012-0037. This order shall supplement our December 15, 1993 and August 10, 1992 orders that previously reopened claimant's 1959 claim for the payment of medications, office visits to and treatment by Dr. Toomey, tests and prescriptions.

This authorization for compensable medical services shall continue on an ongoing basis for an indefinite period of time, until there is a material change in treatment or other circumstances. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
DONALD L. HOLCOMB, Claimant
WCB Case No. 96-06330
ORDER ON REVIEW
David C. Force, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that declined to award a penalty and attorney fee for allegedly unreasonable delay in payment of compensation. On review, the issue is penalties and attorney fees. We vacate the ALJ's order and dismiss claimant's request for hearing.

FINDINGS OF FACT

On December 12, 1992, a Determination Order issued finding claimant no longer permanently totally disabled and awarding scheduled and unscheduled permanent disability. On April 28, 1994, ALJ Stephen Brown reinstated the permanent disability award and assessed a penalty. On March 6, 1995, the Board affirmed ALJ Brown's order. On April 10, 1996, the Court of Appeals affirmed the Board's order without opinion; the court stated that the "effective date" of the "appellate judgment" was July 19, 1996.

On August 15, 1996, the self-insured employer paid claimant $26,421.37. The parties' stipulated facts indicate that such money was "compensation stayed by the appeals by [the employer]." Claimant then requested a hearing, asserting that he was entitled to a penalty and attorney fee because the compensation was not timely paid.

CONCLUSIONS OF LAW AND OPINION

As the ALJ's order states, the only issue at hearing was whether the employer unreasonably delayed payment of compensation, thus entitling claimant to a penalty and attorney fee. Claimant contended that the employer was required to pay the stayed compensation within 30 days after April 10, 1996, the date of the court's decision. The employer responded that it timely paid compensation because it paid the money within 30 days of July 17, 1996, the effective date of the appellate judgment. The ALJ eventually agreed with the employer's position and declined to award a penalty or attorney fee.

The applicable statutes for deciding entitlement to a penalty and related attorney fee in this case are ORS 656.262(11)(a) and 656.382(1). The former statute in part provides that "the director shall have exclusive jurisdiction over proceedings regarding solely the assessment and payment of the additional amount described in this subsection." When the act of misconduct asserted for awarding a penalty under ORS 656.262(11)(a) is the same as alleged in support of an attorney fee under ORS 656.382(1), the sole issue is considered to be the entitlement of a penalty under ORS 656.262(11)(a) and the Director has exclusive jurisdiction. Corona v. Pacific Resources Recycling, 125 Or App 47, 50-51 (1993).

Here, the only act of misconduct alleged by claimant in support of a penalty and an attorney fee is untimely payment of stayed compensation. Because the same act of misconduct is asserted, the Director has exclusive jurisdiction of this matter.

ORDER

The ALJ's order dated August 1, 1997, as reconsidered on October 2, 1997 and October 24, 1997, and amended on November 20, 1997 and November 25, 1997, is vacated. Claimant's request for hearing is dismissed.

In the Matter of the Compensation of
MICHAEL C. LEGGETT, Claimant
WCB Case No. 96-04719
ORDER ON RECONSIDERATION
Popick & Merkel, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

On February 25, 1998 we abated our February 2, 1998 order that set aside the self-insured employer's "pre-closure" denial as procedurally invalid. We took this action to consider the employer's request for reconsideration. Having received the claimant's response, we proceed with our reconsideration.

The employer asserts that we erred in construing its May 13, 1996 current condition denial as an attempt to limit responsibility to a resolved condition. The employer also challenges the basis for our $3,800 attorney fee award.[1]

Even though the employer's pre-closure denial did not expressly assert that claimant's accepted conditions had resolved without permanent impairment, we adhere to our determination that the denial was procedurally invalid. As set forth in our prior order, although there is no prohibition against issuing a pre-closure denial of a condition clearly unrelated to the accepted condition, the employer may not, in the absence of an acceptance of a "combined condition," issue a pre-closure denial of a condition to which the accepted condition has contributed or combined. See, e.g., Elizabeth B. Berntsen, 48 Van Natta 1219, 1223 (1996).

In this case, prior to the closure of claimant's accepted strain claim, the employer denied claimant's current "cervical condition" asserting that the accepted strains were no longer a cause.[2] As this denial implies (and the medical evidence indicates[3]) while claimant's accepted claim for cervical and thoracic strains was in open status, his accepted condition contributed to his disability and need for treatment. Because the medical evidence fails to establish that the denied current cervical condition is completely separate from or unrelated to the accepted condition, the employer's pre-closure denial, to the extent it attempts to deny an inseparable condition, is procedurally impermissible.[4]

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[1] In his response to the employer's motion, claimant requests that we address the compensability of his current cervical disc condition. As set forth in our prior order, we decline to do so. Insofar as we have set aside the denial on procedural grounds, we find it unnecessary and inappropriate to consider the denial's substantive merit.

[2] Both at hearing and on review, however, the employer also supported its denial by arguing that the compensable strains had resolved prior to the denial and that claimant's preexisting C5-7 abnormalities were the sole cause of his current condition.

[3] For example, Dr. Thompson reported that claimant's January 27, 1995 injury may have caused a symptomatic, but not pathological, worsening of his preexisting cervical condition. (Ex. 23). Drs. Zivin and Thompson also opined that claimant's cervical strain symptoms had resolved by April 1995 and that his ongoing symptoms were attributable to his preexisting degenerative condition. (Ex. 18).

[4] Citing Carl L. Gruenberg, 49 Van Natta 750 (1997), the employer argues that its denial is not invalid, but merely "premature," because claimant has not made a written request for acceptance of his C5-7 abnormalities. To the extent the denial denies this specific condition (which is separate from the accepted strain) we agree with the employer's assertion. Thus, insofar as the denial purports to deny "unclaimed" C5-7 abnormalities, the denial is premature. Nevertheless, as noted above and as discussed in our prior order, a portion of the denial is also invalid because of the reference to claimant's "current disability and need for medical treatment" for his "cervical condition." Claimant's "cervical condition" did involve his accepted strain condition while the claim was in open status. Consequently, to the extent the denial attempts to deny claimant's accepted conditions prior to closure, it is impermissible (rather than premature).

With regard to the assessed attorney fee, the employer argues that no fee is warranted because the value of the interest involved is minimal. The employer is correct that, to the extent we have recognized that a portion of the denial may be "premature," claimant will not receive any benefits as a result of our holding and therefore no attorney fee is warranted. See, e.g., Robert W. Stephenson, 48 Van Natta 2442 (1997) (attorney fees are improper where Board determines the carrier's denial was a nullity because the claimant had not made a claim for the denied condition); Ramona E. Hamilton, 48 Van Natta 2438 (1996). On the other hand, to the extent we have found that a portion of the denial is impermissible because it attempts to deny accepted conditions prior to claim closure, claimant's counsel is entitled to a fee for preserving claimant's right to compensation related to his accepted conditions. See ORS 656.386(1). Furthermore, even if, as the employer argues, this accomplishment is of minimal monetary value, the "value of the interest involved" is only one factor to be considered in assessing a reasonable attorney fee; other factors include the time devoted to the issue, the complexity of the issue, and the risk that counsel may go uncompensated. See OAR 438-015-0010(4).

Consequently, considering the above factors, we modify the attorney fee award for claimant's counsel's services at hearing and on review. On reconsideration, we find that a reasonable fee for claimant's counsel's services at hearing, on review and on reconsideration concerning the impermissible pre-closure denial issue is $2,500, payable by the employer. Claimant is not entitled to a fee on reconsideration for services devoted to the attorney fee issue. See Dotson v. Bohemia Inc., 80 Or App 233 (1986). Accordingly, our February 2, 1998 order is withdrawn. On reconsideration, as supplemented and modified herein, we adhere to and republish our February 2, 1998 order in its entirety.[5] The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[5] The employer has asserted that, in the event we affirm the ALJ's order in WCB Case No. 96-07715, "there is nothing further for the carrier to do as the accepted condition has been processed." Because the issue presently before us pertains to the validity of the employer's "pre-closure" denial, it would be inappropriate for us to comment on the extent of a carrier's claim processing obligations resulting from our order (other than to remand the claim to the employer for processing according to law).

In the Matter of the Compensation of
CRAIG E. MARTIN, Claimant
WCB Case No. 97-04814
ORDER ON REVIEW
Bischoff, et al, 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) Brazeau's order that set aside its partial denial of claimant's right wrist condition. On review, the issue is compensability.

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

In the first paragraph of the findings of fact, we change the sixth sentence to read: "X-rays revealed an established non-union of the scaphoid, and claimant was diagnosed with an acute sprain of the right wrist." In the second paragraph on page 3, we change the date in the first sentence to "May 8, 1997."

On page 5, we replace the first full paragraph with the following:

> "In SAIF v. Nehl, 148 Or App 101, mod 149 Or App 309, 311 (1997), the court construed ORS 656.005(7)(a)(B) and held 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." The Nehl decision turned on the fact that there was a difference between the primary cause of the claimant's combined condition and the primary cause of his need for treatment. Id. at 313."

In the last paragraph on page 5, we change the fifth sentence to read: "Second, Dr. Appleby correctly noted that claimant's right wrist was essentially asymptomatic until the time of his November 1996 injury."

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

ORDER

The ALJ's order dated October 28, 1997 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by SAIF.

Board Member Moller dissenting.

In adopting and affirming the ALJ's order, the majority holds that claimant's right wrist condition is compensable. The ALJ and the majority rely on the opinion of Dr. Appleby to establish compensability. Because Dr. Appleby's opinion is not sufficient to satisfy claimant's burden of proof, I respectfully dissent.

Claimant has a long history of problems with his right wrist. He fractured the right wrist in 1983 and the fracture failed to heal completely. In December 1988, claimant injured his right wrist while roller skating and an x-ray revealed an "[e]stablished non-union scaphoid, right wrist." (Ex. 1). Claimant was diagnosed with an acute right wrist sprain. (Id.) He later returned to his regular work.

On November 12, 1996, claimant injured his right hand at work when he reached for a block of wood while operating a conveyor system. X-rays showed an old scaphoid fracture with significant spurring and arthritis. (Ex. 9). SAIF accepted a "crush injury to the dorsal aspect of the right 4th and 5th metacarpals." (Ex. 13). Claimant had continuing problems and was referred to Dr. Appleby.

Although the majority relies on Dr. Appleby's opinion to establish compensability, there are several reasons why his opinion is not persuasive. To begin, Dr. Appleby's opinion establishes only that the November 1996 work incident was the precipitating cause of claimant's need for treatment. On January 8, 1997, Dr. Appleby reviewed claimant's imaging studies and reported they showed "evidence of old radioschaphoid arthritis with overgrowth at the tip of the radial styloid" and "there is a chronic nonunited fracture of the scaphoid which has not changed it[s] configuration since the films taken in early October." (Ex. 15-5). He concluded that "[t]he injury which took place on November 12 is not associated with any change in the x-ray that I can see from November 12, comparing it to the October films." (Id.) Dr. Appleby explained that the "injury that was sustained on November 11 [sic] constituted the main cause for his being treated at this time, but the responsibility for the discomfort is equally shared between his old injury which predisposed him to this problem and the acute injury which changed his chronic asymptomatic wrist to an acute symptomatic wrist." (Ex. 15-6; emphasis added).

Dr. Appleby's reference to "main cause" indicates that the work injury was the immediate precipitating cause of claimant's need for treatment, but the preexisting condition was at least equally responsible for his symptoms. In Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev dismissed 321 Or 416 (1995), the court held that the determination of "major contributing 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. 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 401-02; see also SAIF v. Nehl, 149 Or App 309 (1997) (court agrees that reliance on "immediate cause" is incorrect test contemplated by ORS 656.005(7)(a)(B).)

Here, Dr. Appleby's opinion is based on precisely the type of reasoning rejected by the court in Dietz. That is, Dr. Appleby opines that the work injury is the "main cause" of claimant's need for treatment for the combined condition because it was the precipitating event that led claimant to seek medical treatment.

Dr. Appleby's other reports further indicate that he viewed claimant's work incident as only the precipitating cause for claimant's need for treatment, whereas the preexisting condition constituted the major contributing cause. On July 30, 1997, Dr. Appleby commented that when he first saw claimant "[i]t seemed at that point that the cause of the pain was primarily the underlying injury which had been aggravated by the injury in November. " (Ex. 29-1).

After reviewing Dr. Wilson's reports, Dr. Appleby concurred with Dr. Wilson's history and examination and did not dispute his impression that "this is a chronic scaphoid nonunion[.]" (Ex. 20-1). Dr. Appleby agreed with Dr. Wilson's conclusion that the "rollerskating injury in 1988 is the most important factor with regard to the ultimate development of his current condition." (Id.; emphasis added). He challenged only Dr. Wilson's conclusion that the work incident did not contribute at all to the need for treatment. Dr. Appleby commented that the November 1996 incident "materially changed the course" of claimant's condition. (Id.)

When medical opinions are 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). Dr. Appleby's opinion does not meet that standard. At best, Dr. Appleby's reports are ambiguous and inconsistent. On the one hand, he opines that the "main cause" for claimant's treatment was the November 1996 injury, but the responsibility for claimant's discomfort was "equally shared" between his preexisting condition and the work incident. (Ex. 15-6). However, Dr. Appleby also agreed with Dr. Wilson that the 1988 rollerskating injury "is the most important factor with regard to the ultimate development of his current condition." (Ex. 20-1). Dr. Appleby's final opinion does not help clear up the confusion. In that report, he simply stated that the November 1996 injury was the "cause for need for care in 1996 and 1997." (Ex. 31). Although Dr. Appleby was specifically asked about the "major cause" of claimant's need for care, he referred only to the "cause for need for care." On this record, claimant has not established that his right wrist claim is compensable. For these reasons, I respectfully dissent.

In the Matter of the Compensation of
LISA H. ROBERTS, Claimant
WCB Case No. 96-07969
ORDER ON REVIEW
Pozzi, Wilson & Atchison, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Biehl, Bock and Moller.

The insurer requests review of Administrative Law Judge (ALJ) Hazelett's order that set aside its denial of claimant's injury claim for a fainting episode. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

On July 7, 1996, claimant was at work cooking with a convection oven when she began to feel hot and lightheaded. Her job required her to stand while preparing products without the opportunity to sit. She stepped away from the oven and fell, bruising her tailbone. She was taken to a hospital emergency room by ambulance where the physician's impression was "near syncope." Claimant received follow up treatment from her regular physician, Dr. Behary.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that the sole reason for claimant's fall and injury to her tailbone was work. On this basis, the ALJ set aside the denial.

On review, the insurer argues that claimant's fainting spell was due to dehydration and that there is insufficient evidence that the dehydration was related to work. Claimant argues that the work activity was a material contributing cause of her fall and seeks to have the ALJ's order affirmed.

A compensable injury is "an accidental injury * * * arising out of and in the course of employment." ORS 656.005(7)(a). Where a fall is related to a fainting spell, the question is whether the fainting spell is sufficiently work-connected to satisfy the claimant's burden of proof. Tina Holliday, 48 Van Natta 1024 (1996); Katheryn L. Judd, 47 Van Natta 1645 (1995).

The cause of claimant's fainting spell is a complex medical issue; thus, expert medical evidence is required to establish causation. Uris v. Compensation Department, 247 Or 420, 427 (1967). The only physician to address the cause of claimant's fainting episode is Dr. Behary, who is claimant's treating physician.

Dr. Behary opined that the contributors to claimant's syncopal episode were dehydration and heat exposure. According to Dr. Behary, the dehydration was probably caused by nausea. The etiology of the nausea was unknown. However, Dr. Behary opined that the work conditions were a substantial factor in claimant's fainting spell and explained that because claimant had symptoms of nausea three to four days prior to the fainting episode and did not faint, the heat at work was the reason for the fainting episode.

Based on Dr. Behary's opinion, we find that claimant's fainting spell is sufficiently work-connected to satisfy claimant's burden of proof. In this regard, Dr. Behary opined that the work conditions were a substantial factor in causing the fainting spell and specifically implicated the heat at work as the cause of the fainting episode. Under such circumstances, we find that claimant has established that her fainting episode arose out of and in the course and scope of her employment.

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

ORDER

The ALJ's order dated July 15, 1997 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $1,200, payable by the insurer.

Board Member Moller dissenting.

I disagree with the majority's analysis and would find that ORS 656.005(7)(a)(B) applies to this claim and that claimant has failed to meet her burden of proof under that statute.

Based on the record, the parties litigated the issue of medical causation at hearing. As the majority correctly notes, the causation of claimant's fainting spell is a complex medical issue that requires expert medical evidence for its resolution. In this record, the only medical expert to address the cause of claimant's fainting episode is Dr. Behary.

Dr. Behary opined that the contributors to claimant's syncopal episode were dehydration and heat exposure. Dr. Behary believed that dehydration was key to the fainting episode in that, without the dehydration, claimant probably would not have fainted. According to Dr. Behary, the dehydration was probably caused by nausea prior to the date of the work incident. The etiology of the nausea is unknown, but could have been related to claimant's alcoholism or to something else. Dr. Behary indicated that heat alone can cause dehydration, but to conclude that the hot work environment caused the dehydration, she would need a history that claimant had been sweating a great deal. Such a history was not taken from claimant.

Dr. Behary opined that the work conditions were a substantial factor in claimant's fainting spell and explained that the heat was the "straw on the camel's back that led claimant to faint." Dr. Behary further explained that, possibly, if claimant had not been in the hot surroundings, she would not have fainted. Dr. Behary also noted that people who are dehydrated can faint in normal temperatures. However, because claimant had symptoms of nausea three to four days prior to the fainting episode and did not faint, Dr. Behary assumed that the heat at work was part of the reason for the fainting episode.

Based on Dr. Behary's opinion, the preexisting dehydration/nausea contributed so significantly to the fainting episode that claimant would not have fainted in its absence. On the basis of this medical evidence, I would find that claimant's exposure to heat at work combined with her preexisting dehydration to cause her disability and need for treatment. See ORS 656.005(7)(a)(B).[1] In spite of the significance of the dehydration to the fainting spell, there is no indication that Dr. Behary evaluated the relative contribution of the heat at work versus the preexisting dehydration to determine which was the primary cause of the fainting spell. Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev dismissed 320 or 416 (1995) (determination of the major contributing cause involves evaluating the relative contribution of different causes and determining which is the primary cause). Under such circumstances, Dr. Behary's opinion is unpersuasive and is insufficient to meet claimant's burden of proof.[2]

For these reasons, I respectfully dissent.

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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 conditions or the major contributing cause of the need for treatment of the combined condition."

[2] The ALJ relied, in part, on Benefiel v. Waremart, 112 Or App 480 (1992), in determining that claimant had established compensability. Claimant also relies on Benefiel on review. I find Benefiel distinguishable. In Benefiel, the claimant was ill with the flu and had requested the day off of work. However, the claimant's supervisor requested that she come to work. While working in a weakened state, the claimant became nauseated and light headed and collapsed onto her knees sustaining injuries. In finding the claimant's injuries compensable, the court held that there was no evidence to support the Board's finding that the claimant's work did not contribute to her injury. In the present case, unlike Benefiel, the parties litigated - and the medical evidence establishes - this claim as one for a "combined condition" under ORS 656.005(7)(a)(B). The medical evidence is insufficient to meet claimant's burden under that statute.

April 16, 1998 Cite as 50 Van Natta 759 (1998)

In the Matter of the Compensation of
DEBRA A. SHOUGH, Claimant
WCB Case No. 97-05707
ORDER ON REVIEW
J.R. Perkins III, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that upheld the SAIF Corporation's denial of her claim for a consequential mental disorder. On review, the issue is compensability.

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

Attached to her appellant's brief, claimant has submitted materials from Internet Mental Health including, among other things, the DSM IV diagnostic criteria for post-traumatic stress disorder (PTSD), public information on PTSD and the DSM IV diagnostic criteria for major depressive disorder. SAIF has moved to strike these attachments and any references to the attachments in claimant's brief, asserting that these documents were not part of the record at hearing.

Our review is limited to the record created at hearing. ORS 656.295(3) and (5). Generally, we treat submissions appended to a party's brief as a motion for remand. Judy A. Britton, 37 Van Natta 1262 (1985). We may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See ORS 656.295(5). To warrant remand, the moving party must show good cause or a compelling basis. A compelling basis exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988).

Here, we find no compelling basis to remand. Specifically, we find that information and analysis regarding the diagnostic criteria for PTSD already exists in the record. We further find that the attachments to claimant's brief are not reasonably likely to affect the outcome of the case. In addition, we find no explanation why these submissions were not obtainable with due diligence at the time of hearing. Accordingly, claimant's motion to remand is denied.

Furthermore, although we may, under limited circumstances, take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned," see Groshong v. Montgomery Ward Co., 73 Or App 403 (1985), we decline to take administrative notice of the documents appended to claimant's brief in this case. These submissions constitute evidence from a source not subject to confrontation and cross-examination. See, e.g., Michael A. Crause, 49 Van Natta 1022 (1997) (Board declined to take administrative notice of a submission from the DSM-IV manual because it was taken from a source not subject to confrontation and cross-examination); Richard H. Olsen, 41 Van Natta 1300 (1989) (Board did not have authority to consider the most recent version of a medical treatise where the evidence was not admitted at the hearing and not a part of the record). Consequently, we strike those portions of claimant's appellant's brief that refer to the extraneous material.

ORDER

The ALJ's order dated October 27, 1997 is affirmed.

In the Matter of the Compensation of
BONNIE J. ULRICH, Claimant
WCB Case No. C8-00499
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Burt, Swanson, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

On March 5, 1998, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We disapprove the proposed disposition.

On March 10, 1998, the Board wrote the parties noting that the CDA stated that the accepted condition is a "resolved cervical strain." (Emphasis added). The Board has interpreted CDAs pertaining to "resolved" conditions as limiting the continuing right to medical services under ORS 656.245. See Linda K. Perini, 46 Van Natta 2349 (1994). Consequently, the Board requested an addendum to the CDA to clarify that the CDA did not limit claimant's continuing rights to medical services.

On April 6, 1998, we received claimant's counsel's letter withdrawing the CDA. Within 30 days of submitting the disposition for approval, the Board may disapprove the disposition if the worker, the insurer or self-insured employer requests disapproval. ORS 656.236(1)(a)(C). Here, because more than 30 days has passed since submission of the CDA for approval, we are unable to disapprove the agreement under ORS 656.236(1)(a)(C).

However, pursuant to OAR 438-009-0020(4)(b), the Board may disapprove the agreement as unreasonable as a matter of law if the deficiency noted in the Board's addendum letter is not corrected within 21 days. To date, the parties have not submitted the addendum as requested on March 10, 1998. Under the circumstances, we disapprove the proposed disposition as unreasonable as a matter of law. See OAR 438-009-0020(4)(b).

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of any benefits that were stayed by submission of the proposed disposition. See OAR 436-060-0150(4)(i) and (6)(e).

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.

Alternatively, if the parties wish to resubmit a revised CDA (consistent with the matters discussed in our March 10, 1998 addendum letter) at a later date, they may do so. If and when such an agreement is received, we will proceed with our review of that particular CDA.

IT IS SO ORDERED.

In the Matter of the Compensation of
SHARON L. WREY, Claimant
WCB Case No. 97-04994
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Kekauoha's order that awarded an assessed attorney fee for allegedly unreasonable claims processing. 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

On March 17, 1997, claimant filed an 801 form for a neck and back injury. Claimant was treated by Dr. Freeman, chiropractor. On July 7, 1997, the insurer accepted the claim for a cervical/thoracic/lumbar strain.

The ALJ found that, because the insurer did not accept the claim within 90 days of claimant filing the 801, its acceptance was not timely. See ORS 656.262(6)(a). The ALJ further reasoned that the delayed acceptance resulted in the delayed payment of compensation based on evidence of unpaid medical bills as of a few days after acceptance. Thus, finding that there was unreasonable resistance to compensation, the ALJ awarded an assessed attorney fee of $300 under ORS 656.382(1).[1]

The insurer objects to the attorney fee award, first asserting that the issue was not raised at hearing. The insurer also contends that the award is not warranted because claimant did not show any "amounts then due" upon which to base an assessed attorney fee.

First, we agree with the ALJ that, based on claimant's attorney's statement of the issues at hearing, he raised the issue of entitlement to a penalty or attorney fee for the late acceptance. (Tr. 1). Furthermore, the insurer does not dispute that its acceptance was not within 90 days of the 801 form and, thus, was not timely.

ORS 656.382(1) provides that, if a carrier "unreasonably resists the payment of compensation," it shall be liable for a reasonable attorney fee. Based on such language, even if a carrier does not timely accept a claim, there is no unreasonable resistance to payment of compensation if it paid all compensation. See SAIF v. Condon, 119 Or App 194, rev den 317 Or 163 (1993). Here, the ALJ found that there was compensation owing at the time of the late acceptance based on a July 11, 1997 letter from Dr. Freeman to claimant's attorney stating that the balance of claimant's account was $411.50 and that no "payments have been made on this account." (Ex. 11). We agree with the insurer that such evidence is not enough to show that it unreasonably resisted payment of compensation.

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[1] Apparently, the ALJ did not assess a penalty under ORS 656.262(11)(a) for the untimely acceptance because he found that there were no "amounts then due."

Medical billings must be submitted to the insurer in the proper form. OAR 436-009-0010. Payment of medical bills that become due upon claim acceptance following a claim deferral period is within 14 days of acceptance or within 45 days of the insurer's receipt of the medical bill, whichever is greater. OAR 436-009-0030(3)(e). Although the record shows that no payments had been made on claimant's account with Dr. Freeman, it does not reveal whether medical bills had been submitted to the insurer or, if submitted, the date of submission. Consequently, the record is not sufficient to show whether or not medical bills were owing at the time of acceptance. Furthermore, because Dr. Freeman's letter is dated only four days after acceptance, even if medical bills had been submitted, the insurer continued to have at least an additional ten days before payment was required.

Thus, based on this record, we conclude that claimant failed to show that the insurer unreasonably resisted the payment of medical services. Consequently, we find a lack of proof upon which to base an attorney fee under ORS 656.382(1).

ORDER

The ALJ's order dated October 10, 1997, as reconsidered November 28, 1997, is reversed in part and affirmed in part. That portion of the order assessing an attorney fee under ORS 656.382(1) is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
VALERIE J. WEBER, Claimant
WCB Case No. 97-07603
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
G. Joseph Gorciak III, Defense Attorney

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) affirmed an Order on Reconsideration award of 23 percent (73.6 degrees) unscheduled permanent disability for claimant's psychological condition; and (2) awarded an assessed attorney fee. On review, the issues are extent of unscheduled permanent disability and attorney fees. We reverse.

FINDINGS OF FACT

Claimant was compensably injured on August 14, 1995 when her left little fingertip was amputated. (Ex. 1). On November 28, 1995, Dr. Davies performed a psychological evaluation on behalf of the employer. (Ex. 2). He diagnosed major depression, by history, in remission, and adjustment disorder with mixed emotional features, secondary to finger injury, in remission (resolved). (Ex. 2-5). Dr. Davies felt that claimant had an adjustment disorder superimposed on a preexisting depressive disease. (Id.) He concluded that claimant's amputation injury was unrelated to her depression, but was the major contributing cause of her adjustment disorder. (Ex. 2-6). He believed that both the depression and adjustment disorder were in remission. (Id.) Drs. Combs and Laderas concurred with Dr. Davies' report. (Exs. 4, 5).

On December 18, 1995, the employer issued a partial denial of claimant's current depression condition. (Ex. 3-1). In that letter, the employer said it had accepted a "disabling adjustment disorder, resolved." (Id.) Claimant did not appeal the partial denial.

The claim was closed by a Notice of Closure issued March 31, 1997, awarding temporary disability benefits and scheduled disability. (Ex. 10). Claimant requested reconsideration, asserting, among other things, that she was entitled to an award for the adjustment disorder. (Ex. 11). Dr. Bellville performed a medical arbiter examination. (Ex. 16). An Order on Reconsideration dated August 22, 1997 awarded claimant 23 percent unscheduled disability for the adjustment disorder. (Ex. 18).

CONCLUSIONS OF LAW AND OPINION

The ALJ relied on Dr. Bellville's report and affirmed the Order on Reconsideration award of 23 percent unscheduled disability for claimant's adjustment disorder.

The employer contends that the preponderance of medical opinion establishes that claimant is not entitled to an unscheduled disability for her adjustment disorder. The employer argues that Dr. Bellville's opinion is not persuasive because he interchanged depression, major depression and adjustment disorder.

Claimant's claim was closed on March 31, 1997. (Ex. 10). Therefore, the rating of permanent disability in this case is governed by the disability standards set forth in WCD Admin. Order 96-072 (effective February 15, 1997).

OAR 436-035-0007(13) provides, in part:

> "On reconsideration, where a medical arbiter is used, impairment is established by the medical arbiter, except where a preponderance of the medical opinion establishes a different level of impairment."

On November 28, 1995, Dr. Davies diagnosed major depression, by history, in remission, and adjustment disorder with mixed emotional features, secondary to finger injury, in remission (resolved). (Ex. 2-5). Dr. Davies felt that claimant had an adjustment disorder superimposed on a preexisting depressive disease. (Id.) He concluded that claimant's amputation injury was unrelated to her depression, but was the major contributing cause of her adjustment disorder. (Ex. 2-6). He felt that both the depression and adjustment disorder were in remission and claimant's problems had resolved with appropriate treatment of the underlying depression. (Id.) Drs. Combs and Laderas concurred with Dr. Davies' report. (Exs. 4, 5).

There is no indication from Drs. Davies, Combs or Laderas that claimant had any permanent impairment due to the compensable adjustment disorder. Thus, claimant's entitlement to permanent disability rests on the opinion of the medical arbiter, Dr. Bellville.

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, rev den 325 Or 438 (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).

Before the arbiter examination, Dr. Bellville was asked to report "objective permanent impairment resulting from the accepted psychological condition only[.]" (Ex. 15-2; emphasis in original). Dr. Bellville was instructed that claimant's accepted conditions included a "disabling adjustment disorder, resolved" and he was told that depression was a denied condition. (Id.)

In his report, Dr. Bellville referred to an accepted condition of "disabling adjustment disorder, resolved" and a denied condition of depression. (Ex. 16-1). He reported that claimant's more severe symptoms of depression began after the finger injury. (Ex. 16-3). With medication and the passage of time, claimant's crying spells diminished, her mood lifted and her concentration and attention improved. (Ex. 16-4). However, Dr. Bellville reported that claimant had recently begun having trouble again with her mood and sleep. (Id.) He explained:

> "Part of [claimant's trouble sleeping] may be related to change in her position at work, part of it may also be related to anticipation of this examination process which involved a previous panel examination on Friday, August 15, 1997." (Ex. 16-3).

Later in the report, Dr. Bellville commented that it was "only in the last few weeks, with the change in her job status and these impending interviews and evaluations, that she has had some return of mood disturbance and sleep disturbance." (Ex. 16-5). He reported:

> "As far as the accepted condition of adjustment disorder, she has been relatively stable now for sometime except for the last few weeks which may be a waxing and waning of her conditions. It is also possible that it could be a sign that the effectiveness of the anti-

> depressant is wearing off and those need to be raised. In any case, her current symptom picture appears to best fit within a Class II minimal category until you take into consideration the fact that she is, in fact, currently taking an anti-depressant medication which is helping to control her symptoms. With that in mind she is felt best to fall into the Class II mild category." (Ex. 16-5, -6).

Dr. Bellville concluded that, "[a]t this point, diagnosis would be that she has the residuals of her adjustment disorder or depression, whichever you want to call it." (Ex. 16-6; emphasis added).

> Under "Axis I" in the "Final Diagnoses" section of the report, Dr. Bellville reported:
>
> "History of adjustment reaction following initially a back injury which occurred on-the-job in December 1994, but was exacerbated by amputation of the tip of the left little finger in August 1995. Because of the length of the time of symptom duration, on technical basis, adjustment disorder is no longer called for according to the diagnostic guidelines. Rather, she would fall into a category diagnostically of major depression with remission of most of her symptoms following anti-depressant medication. Nicotine use is also noted." (Id.; emphasis added).

Under "Axis IV," Dr. Bellville noted that claimant's psychosocial stressors were: "Most immediately the examination process and the change in a new production line at work may account for some recent return of sleep and mood disturbance." (Id.)

We find Dr. Bellville's opinion to be, at best, inconsistent and confusing. It is clear from Dr. Bellville's report that he was aware that claimant's accepted condition was a "disabling adjustment disorder, resolved" and that depression was a denied condition. (Ex. 16-1). He was asked to report objective permanent impairment resulting from the "accepted psychological condition only" and he felt she had function in the Class II mild category. (Exs. 15-2, 16-6). Nevertheless, he concluded that, "[a]t this point, diagnosis would be that she has the residuals of her adjustment disorder or depression, whichever you want to call it." (Ex. 16-6). Dr. Bellville's report does not establish that claimant's current level of impairment is due to her adjustment disorder. Rather, his report indicates that her impairment is related to the denied condition of depression. In the diagnostic section of his report, he said: "Because of the length of the time of symptom duration, on technical basis, adjustment disorder is no longer called for according to the diagnostic guidelines." (Ex. 16-6). Instead, he felt that claimant fell into "a category diagnostically of major depression." (Id.)

Moreover, Dr. Bellville commented in several portions of his report that claimant's change in mood and sleep habits was related to a change in her work duties and the arbiter examination. (Exs. 16-3,-5, -6). Those findings attribute claimant's impairment to causes other than the compensable injury. The portion of claimant's current psychological condition caused by her reaction to claims processing is not considered to be caused by the compensable injury. See Barr v. Fairview Training Center, 139 Or App 196, 202-04, rev den 323 Or 690 (1996); Roseburg Forest Products v. Zimbelman, 136 Or App 75, 79 n.2 (1995). We conclude that Dr. Bellville's report does not establish that claimant's impairment was due to the accepted adjustment disorder. There are no other medical opinions that establish that claimant has permanent impairment resulting from the accepted psychological condition. Rather, the preponderance of persuasive medical opinion establishes that claimant has no permanent impairment resulting from the compensable injury. Under these circumstances, we find that claimant is not entitled to an unscheduled permanent disability award.[1]

ORDER

The ALJ's order dated December 4, 1997 is reversed. Claimant's 23 percent (73.6 degrees) unscheduled permanent disability award is reversed. The ALJ's attorney fee award is also reversed.

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[1] In light of our conclusion, we need not address the employer's argument that claimant's attorney is not entitled to an assessed attorney fee.

In the Matter of the Compensation of
ROBERT D. ANDERT, Claimant
WCB Case No. 97-05909
ORDER ON REVIEW
Richard F. McGinty, Claimant Attorney
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Moller and Hall.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) affirmed an Order on Reconsideration awarding 11 percent (16.5 degrees) scheduled permanent disability for loss of use or function of the left leg; and (2) awarded an assessed attorney fee of $1,600. On review, the issues are extent of scheduled permanent disability and attorney fees.

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

Claimant has an accepted left lateral meniscus tear. A Notice of Closure awarded 5 percent scheduled permanent disability. Based on a medical arbiter's report, an Order on Reconsideration increased claimant's award to 11 percent. The ALJ affirmed this award. The insurer challenges this portion of the ALJ's order, contending that claimant is entitled to only the 5 percent awarded by the Notice of Closure.

The only evidence of impairment is from the medical arbiter, Dr. Hunt. He measured range of motion for claimant's left leg, commenting that, "[a]s far as the left leg is concerned, [claimant] has more findings, including decreased extension especially. Flexion is equal on both sides and therefore is probably normal for him." (Ex. 37-7, 37-8). Dr. Hunt also stated that claimant "should have some permanent limitations based on the left knee * * *. Those include obvious things such as no kneeling or squatting on the left." (Id. at 8). Finally, Dr. Hunt found that "evidence of medical [sic] compartment arthritis in both knees which to date is only symptomatic in the left knee make other restrictions based purely on the injury difficult to apportion." (Id.)

The Order on Reconsideration based its award on limited extension, a chronic condition, and surgery. (Ex. 38-2). The insurer asserts that claimant is not entitled to values for limited extension or a chronic condition.

We agree with the ALJ that Dr. Hunt's report establishes entitlement to a value for lost range of motion. Dr. Hunt distinguished between the compensable and noncompensable left leg conditions, and stated that claimant had "decreased extension." In referring to claimant's arthritis, Dr. Hunt found that "other restrictions" could not be apportioned. We find the report is best construed as showing that claimant's range of motion for extension is due to the compensable injury. Furthermore, the Department correctly rounded the value up to 1 percent. See OAR 436-035-0007(14)(b).

In sum, we agree with the ALJ that, based on Dr. Hunt's report, claimant is entitled to 11 percent scheduled permanent disability for his left leg.

The insurer also contests the ALJ's award of $1,600 for services at hearing. Claimant moves to remand the case to the ALJ for consideration of the attorney fee award in light of the factors in OAR 438-015-0010(4).

We may remand a case to the ALJ if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 n 3 (1983). In order to satisfy this standard, a compelling reason must be shown for remanding, including a showing that evidence was not obtainable at the time of hearing. Here, we find no basis, and there is no assertion, that any evidence concerning the attorney fee was not obtainable at the time of hearing. Furthermore, we find the record sufficiently developed for us to consider the matter on review. Thus, we deny claimant's motion to remand.

Under OAR 438-015-0010(4), we consider the following factors:

"(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."

Here, as the insurer points out, there was no hearing and claimant's submission to the ALJ was untimely and, therefore, not considered at hearing. Furthermore, the nature of the proceeding and the complexity of the issue were routine because the case involved the single issue of extent of scheduled permanent disability (although two body parts were at issue). The value of the interest involved also was routine. Claimant's attorney, however, secured the benefit of permanent disability for the compensable conditions and there was a risk that counsel's efforts could go uncompensated. Finally, there was no assertion of frivolous issues or defenses. Based on a review of these factors, we agree with the ALJ's award of $1,600.

Claimant's attorney also 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 permanent disability issue is $400, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 13, 1997 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $400, to be paid by the insurer.

In the Matter of the Compensation of
MAUREEN L. COFFMAN, Claimant
WCB Case No. 96-09006
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order which dismissed her request for hearing, concerning an appeal of an Order on Reconsideration, as untimely. On review, the issue is jurisdiction.

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

Subsequent to the ALJ's order, we issued our decision in Jenny L. Boydston, 50 Van Natta 691 (1998). In Boydston, we held that former ORS 656.268(6)(d)[1] provided a statutory limitation on the time

[1] ORS 656.268(6)(d) was amended in 1997. Or Laws 1997, ch 111, sec. 1; ch. 382, sec. 1. The amendments, however, assuming they are applicable, do not affect the issue presented in this case.

in which the Director has been granted to issue an Order on Reconsideration. Specifically, that provision required the Director to issue an Order on Reconsideration within 18 working days from the date of receipt of the request for reconsideration (or within 75 working days if a medical arbiter was appointed) or the reconsideration will be deemed denied. We concluded that former ORS 656.268(6)(d) was a statutory limitation on the Director's plenary authority to withdraw or reconsider an Order on Reconsideration.

Here, claimant's request for reconsideration was filed on October 15, 1996. (Ex. 42). An Order on Reconsideration issued on November 6, 1996. (Ex. 44C). The statutory time period in which the Department had to issue a reconsideration order expired on November 12, 1996. On that date, the Department withdrew and abated the November 6, 1996 Order on Reconsideration. (Ex. 45A). Claimant did not request a hearing within 30 days from the November 6, 1996 Order on Reconsideration, or within 30 days of the November 12, 1996 expiration of the statutory time limit. Accordingly, we agree with the ALJ that claimant's subsequent request for hearing was untimely and, therefore, the ALJ correctly concluded that claimant's request for hearing should be dismissed.[2] Boydston, 50 Van Natta at 691.

ORDER

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

[2] As we noted in Boydston, we agree that ORS 656.268(6)(b) grants the Department the authority to postpone the reconsideration. However, as in Boydston, the Department did not postpone the reconsideration process in this matter. Consequently, ORS 656.268(6)(b) has no application.

April 17, 1998 Cite as 50 Van Natta 767 (1998)

In the Matter of the Compensation of
LAURA R. FRANKE, Claimant
WCB Case No. 96-04464
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Herman's order that upheld the self-insured employer's denial of claimant's current cervical condition. On review, the issue is compensability.[1]

We adopt and affirm the ALJ's order.

ORDER

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

[1] In her Reply Brief, claimant argues for the first time that the employer's denial is procedurally improper. However, claimant agreed to litigate the merits of the denial at hearing, without raising an alleged procedural defect. (See Tr. 1). Under these circumstances, claimant waived any procedural defect regarding the denial, and we do not address the argument on review. See Thomas v. SAIF, 64 Or App 194 (1983); see also Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

In the Matter of the Compensation of
ANTHONY F. MERSINO, Claimant
WCB Case No. 96-03687
ORDER ON REVIEW
John C. DeWenter, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) set aside its denial of a "new injury/aggravation" claim for claimant's current low back condition; and (2) awarded an assessed attorney fee of $6,000. On review, the issues are compensability, aggravation and attorney fees. We reverse.

FINDINGS OF FACT

On July 23, 1991, claimant injured his back at work while working in California and was diagnosed with an acute lumbar strain. (Ex. 1). On August 12, 1991, Dr. Gomberg reported that claimant remained totally disabled. (Ex. 3). Thereafter, claimant moved to Oregon and began treating with Dr. Potter.

On August 26, 1991, Dr. Potter diagnosed "[w]ell-compensated pre-existing minimal lumbar scoliosis," moderate degenerative disc disease at L5-S1 and Bertolotti's syndrome, left side. (Ex. 4-3). On September 9, 1991, Dr. Potter reported that claimant could return to full duty work. (Exs. 5, 6). On October 14, 1991, Dr. Potter reported that claimant was medically stationary. (Ex. 7).

On August 12, 1993, claimant was treated by Dr. Lemley for lower back pain. (Ex. 8). Dr. Lemley reported that since 1991, claimant had been continually careful getting up from chairs, and he noted that claimant had a "[h]erniated disc left lower back per x-ray in 1991." (Id.) He reported that claimant had "Pain down both legs. Severe on left down to the foot." (Id.)

In 1991, claimant began working for the employer as a sprayer of cabinet parts. (Tr. 11). He testified that on April 12, 1995, he started getting leg and low back pain while he was at work. (Tr. 13, 14). He finished work and sought medical treatment that day. (Tr. 15). An x-ray on April 12, 1995 showed narrowing of the L4-5 and L5-S1 disc spaces and an "asymmetric lumbo-sacral junctional anomaly resulting in slight list of the lumbar spine to the right." (Ex. 9). Claimant was diagnosed with a lumbar soft tissue strain. (Ex. 10).

On May 3, 1995, claimant was examined by Dr. Renaud. In reporting claimant's history, Dr. Renaud referred to claimant's 1991 injury four years ago:

> "He had a diagnosis of a ruptured disc at that time, and he improved with time, his claim was closed, and he went about a year without symptoms. Since then he's had a bout of symptomatology approximately every year. He states that these recurrences have never been as severe as they are at this time." (Ex. 19-1).

Dr. Renaud diagnosed a herniated nucleus pulposus at either L5 or S1, as well as a congenital transitional vertebrae at L5 and "[m]ultiple areas of diminished disc interspace indicative of some degenerative disc disease which is not industrially related." (Ex. 19-4). Dr. Renaud recommended light duty and indicated that claimant would "return to his usual state of health with the passage of time." (Id.)

On May 26, 1995, Dr. Renaud indicated claimant was feeling better and "now has a pain in the left sacroiliac region, but no lower extremity aching or pain." (Ex. 19-5). He diagnosed herniated nucleus pulposus, resolving. (Ex. 19-6). He noted that an x-ray showed severe degenerative arthritis of the hip. (Id.)

On June 19, 1995, the employer accepted a nondisabling lumbosacral strain. (Ex. 20).

On January 11, 1996, Dr. Renaud reported that claimant had done "very well" until December 26, 1995 when he started having increased pain in his back. (Ex. 21-1). Claimant indicated that he thought a new bed had aggravated his symptomatology. (Id.) He reported back pain with radiation into both buttocks, both thighs and down into the left lower extremity to the ankle. (Ex. 21-2). Dr. Renaud diagnosed a "[l]ikely herniated nucleus pulposus" and recommended physical therapy. (Ex. 21-4). On the authorization form for physical therapy, Dr. Renaud's diagnosis was degenerative spondylosis with radiculopathy. (Exs. 22, 23). Claimant was later taken off work. (Ex. 25).

On January 30, 1996, Dr. Renaud reported that claimant had an "aggravation of his previously present herniated nucleus pulposus" and he recommended an MRI. (Ex. 29A). On the same date, Dr. Renaud signed a "Notice of Claim for Aggravation of Occupational Injury or Disease" form. (Ex. 31). Dr. Renaud wrote to the employer, stating that claimant had an aggravation of his April injury or "possibly even a new injury." (Ex. 36). However, he thought that "it may actually be impossible to state at this time." (Id.)

On February 16, 1996, the employer denied claimant's "new injury/aggravation" claim for back complaints. (Ex. 39).

An MRI on March 19, 1996 showed a "large, left posterior focal disc protrusion of the L4-5 disc with significant distortion of the thecal sac" and slight to moderate congenital central spinal stenosis of the lumbar spine. (Ex. 42). Dr. Renaud diagnosed a herniated nucleus pulposus at L4-5. (Ex. 37).

In March 1996, claimant began treating with Dr. Ermshar, who continued conservative therapy. (Ex. 40A). On July 22, 1996, Dr. Ermshar reported that claimant had an abrupt onset of symptoms that had been present for two weeks. (Ex. 45B). He diagnosed recurrent acute lumbosacral pain with radiculopathy at L3-4. Dr. Ermshar was later deposed by the parties. (Ex. 60).

On June 7, 1996, claimant was examined by Dr. Farris, neurologist, and Dr. Dinneen, orthopedist, on behalf of the employer. (Ex. 44). They concluded that the preexisting degenerative lumbar disc disease was the major contributing cause of claimant's current condition. (Ex. 44-6). Dr. Farris provided another report after reviewing claimant's March 1996 MRI. (Ex. 59).

On August 6, 1996, claimant was examined by Dr. Kirkpatrick, who diagnosed a severe left L4-5 herniated disk with radiculopathy, "chronic and recurring." (Ex. 48-3). He recommended a left L4-5 diskectomy. On November 22, 1996, Dr. Kirkpatrick opined that the major cause of claimant's condition was the original lifting injury in 1991. (Ex. 58). Dr. Kirkpatrick was later deposed by the parties. (Ex. 61).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant was a thorough and consistent historian, although he noted some inconsistencies between claimant's testimony and the medical record. The ALJ concluded that the "application" of Dr. Kirkpatrick's reasoning to the facts led to the conclusion that the April 12, 1995 incident was the major contributing cause of the herniated disc at L4-5.

The employer argues that claimant was not a reliable historian and contends that claimant failed to establish a compensable aggravation of his accepted lumbosacral strain.

Although the ALJ found claimant was a reliable historian, he made no express credibility findings based upon claimant's demeanor. When the issue of credibility concerns an evaluation of the substance of a witness' testimony and other inconsistencies in the record, the Board is equally qualified to make its own determination of credibility. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). After our de novo review of the record, we find the contemporaneous medical records to be more reliable than claimant's testimony. Consequently, where there are inconsistencies, we rely on the contemporaneous medical records.

Because of the multiple possible causes of claimant's disability or need for treatment, this issue presents a complex medical question that must be resolved on the basis of expert medical evidence. Uris v. Compensation Dept., 247 Or 420 (1967); Barnett v. SAIF, 122 Or App 279 (1993).

Under ORS 656.273(1), a worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings. Two elements are necessary to establish a compensable aggravation: (1) a compensable condition; and (2) an "actual worsening." Gloria T. Olson, 47 Van Natta 2348, 2350 (1995). If the allegedly worsened condition is not a compensable condition, compensability must first be established under ORS 656.005(7)(a). Id.

We begin our analysis with a determination of whether claimant's current condition is a compensable condition. As a result of the April 1995 injury, the employer accepted a nondisabling lumbosacral strain. (Ex. 20). Drs. Ermshar and Kirkpatrick diagnosed claimant's current condition as a disc herniation at L4-5. (Exs. 48, 55). Claimant's L4-5 disc herniation is not an accepted condition.

Therefore, in order to establish a worsened condition resulting from the original injury, claimant must first establish that the L4-5 disc herniation is a compensable condition. See Gloria T. Olson, 47 Van Natta at 2350.

Claimant contends that the L4-5 herniation is compensable whether the applicable standard is material or major contributing cause. As a fact finder, it is our obligation to apply the appropriate legal standards to determine the compensability of a worker's claim. Daniel S. Field, 47 Van Natta 1457 (1995) (citing Hewlett-Packard v. Renalds, 132 Or App 288 (1995)).

The medical evidence shows that claimant had degenerative disc disease in his lumbar spine before the April 12, 1995 injury. In 1991, Dr. Potter reported that claimant had moderate degenerative disc disease at L5-S1, preexisting lumbar scoliosis and Bertolotti's syndrome. (Ex. 4-3). Dr. Ermshar began treating claimant in March 1996 and he agreed that claimant had preexisting degenerative disc disease before his treatment of him. (Ex. 60-8). He agreed that because claimant had degenerative disc disease in his lower back, he could suffer a bulging or ruptured disk without trauma. (Ex. 60-11). Dr. Kirkpatrick agreed that claimant's L4-5 disc condition was the cumulative total of everything that has happened to his back. (Ex. 61-29).

Based on those medical opinions, we conclude that claimant's current low back condition combined with his preexisting low back conditions, including degenerative disc disease, to cause or prolong his disability or need for treatment. Under these circumstances, claimant is subject to the "major contributing cause" standard of proof. See ORS 656.005(7)(a)(B). Therefore, in order to establish compensability, claimant must prove that the April 1995 work incident is the major contributing cause of his disability or need for medical treatment of the combined condition.

Claimant relies on the opinions of Drs. Ermshar and Renaud to establish compensability. In evaluating the medical evidence concerning causation, we rely on opinions that are well-reasoned and based on accurate and complete information. Somers v. SAIF, 77 Or App 259 (1986). We generally rely on the opinion of a claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). For the following reasons, we are not persuaded by the opinions of Drs. Ermshar and Renaud.

Dr. Renaud began treating claimant approximately three weeks after the April 12, 1995 work incident. (Ex. 19). On May 26, 1995, he reported that claimant was feeling better and he diagnosed a herniated nucleus pulposus, "resolving." (Ex. 19-6). On February 15, 1996, Dr. Renaud reported that claimant had done "fairly well" until January 1996 when he had a recurrence of back pain. (Ex. 36). He concluded that claimant had an aggravation of his April injury or "possibly even a new injury[,]" but he thought that "it may actually be impossible to state at this time." (Id.) We are not persuaded by Dr. Renaud's opinion because he was unable to say whether claimant sustained an aggravation or a new injury. His opinion is entitled to little probative weight because it establishes, at most, the possibility of a causal connection between claimant's April 1995 injury and his current L4-5 disc herniation. See Miller v. SAIF, 60 Or App 557 (1982); Gormley v. SAIF, 52 Or App 1055 (1981).

Furthermore, we are not persuaded by Dr. Ermshar's opinion because it is not well-reasoned and has numerous inconsistencies. On October 28, 1996, Dr. Ermshar agreed with the opinions expressed by Drs. Farris and Dinneen, who had concluded that the claimant's preexisting degenerative lumbar disc disease was the major contributing cause of his current condition. (Exs. 44-6, 55-2). However, on November 15, 1996, Dr. Ermshar changed his earlier concurrence with Drs. Farris and Dinneen because claimant had "no evidence of preexisting back injury objectively documented." (Ex. 57). Thus, although Dr. Ermshar initially agreed that the preexisting degenerative lumbar disc disease was the major contributing cause of claimant's current condition, he changed his concurrence because claimant had no evidence of a "preexisting back injury." Nevertheless, in a deposition, Dr. Ermshar agreed that claimant had preexisting degenerative disc disease before he began treating him. (Ex. 60-8). Dr. Ermshar's opinion is not persuasive because it lacks adequate explanation for these variations. See Kelso v. City of Salem, 87 Or App 630 (1987).

Although Dr. Ermshar said that more than 50 percent of claimant's back problems in spring 1996 were caused by the April 1995 injury. (Exs. 60-30, -31), he testified that he would defer to Dr. Kirkpatrick's opinion in determining the etiology of claimant's L4-5 disc herniation. (Ex. 60-18). Dr. Ermshar is a family practice physician. Dr. Kirkpatrick, neurosurgeon, opined that the major cause of

claimant's current condition was the original lifting injury in 1991. (Exs. 58, 61). In light of Dr. Ermshar's acknowledged deference to Dr. Kirkpatrick's opinion, Dr. Ermshar's opinion that the majority of claimant's current back problems were caused by the April 1995 injury is not persuasive.

The remaining medical opinions do not establish that claimant's April 1995 injury was the major contributing cause of his current L4-5 disc herniation. As we discussed earlier, Dr. Kirkpatrick believed that the major cause of claimant's current condition was the original lifting injury in 1991. (Ex. 58). He testified that, based on the facts, rather than hypotheticals, he did not believe the 1995 injury was the major cause of claimant's current condition. (Exs. 61-30, -31). Dr. Kirkpatrick's opinion does not establish compensability.

Similarly, the reports from Drs. Farris and Dinneen do not support claimant's position. They concluded that the claimant's preexisting degenerative lumbar disc disease was the major contributing cause of his current condition. (Ex. 44-6). After reviewing the March 1996 MRI, Dr. Farris opined that claimant's symptoms were most reasonably attributed to preexisting degenerative lumbar changes. (Ex. 59-3).

We conclude that claimant has failed to prove that the April 1995 work incident is the major contributing cause of his disability or need for medical treatment of his current L4-5 disc herniation. Because he has not established a compensable condition, we need not address whether he has established an "actual worsening" pursuant to ORS 656.273.[1] See Gloria T. Olson, 47 Van Natta at 2351.

ORDER

The ALJ's order dated November 14, 1997 is reversed. The employer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

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[1] In light of our conclusion that the claim is not compensable, we do not address the employer's argument that the ALJ's attorney fee award should be reduced. For the same reason, we need not address the employer's objections to claimant's attorney's affidavit in support of award of attorney fees, which was submitted on review.

April 17, 1998 Cite as 50 Van Natta 771 (1998)

In the Matter of the Compensation of
EDISON L. NETHERTON, Claimant
WCB Case No. 97-05537
ORDER ON REVIEW
Sara L. Gabin, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Galton's order that increased claimant's scheduled permanent disability award from 18 percent (8.64 degrees) for loss of use or function of the right thumb, as awarded by a Determination Order and affirmed by an Order on Reconsideration, to 37 percent (55.5 degrees) for loss of use or function of the right forearm (wrist). In its brief, the insurer also argues that the ALJ abused his discretion in reopening the hearing record to allow claimant an opportunity to present new arguments. On review, the issues are abuse of discretion and extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

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

After closing arguments, by letter dated October 14, 1997, the ALJ asked claimant's attorney for clarification of her authorities and position. Specifically, the ALJ referenced WCD Admin. Order 96-072 (eff. February 15, 1997) and asked claimant's attorney to "state exactly on what [administrative rules she is] relying and exactly what aggregate [permanent partial disability] award claimant is requesting." The ALJ stated that his request, "by necessity, results in re-opening of the record." The ALJ sent a copy of

the letter to the insurer's attorney. By letter dated October 17, 1997, and copied to the insurer's attorney, claimant's attorney responded by listing the various impairments claimant was claiming and the corresponding administrative rules. By letter dated October 20, 1997, and copied to claimant's attorney, the ALJ wrote the insurer's attorney and asked if she wished to respond to claimant's attorney's October 17, 1997 letter. By FAX dated October 27, 1997, the insurer's attorney advised the ALJ that she did "not find it necessary to respond."

CONCLUSIONS OF LAW AND OPINION

Abuse of Discretion

On review, the insurer argues that the "ALJ abused his discretion in reopening the record to give claimant's counsel an opportunity to make new arguments" and identifying for claimant's counsel WCD Admin. Order 96-072 as the applicable administrative order. Appellant's Brief, page 5. We need not address whether the ALJ abused his discretion because, even if we found he did, the result would not change under the facts of this case.

At hearing and on review, the sole issue is extent of claimant's scheduled permanent disability related to his accepted right wrist fracture. As such, the hearings record is limited by statute to the record developed on reconsideration.[1] ORS 656.283(7). Thus, for all practical purposes, the record was frozen at hearing. Furthermore, no new evidence was solicited or submitted after the hearing record closed. Moreover, to the extent that new arguments were raised after the record closed, the insurer was provided an opportunity to respond and explicitly declined.

More importantly, the Board has de novo review, which includes determining which law applies to the facts of a particular case, including identifying any applicable administrative rules. The Board applies the law as the record/evidence leads it. See Daniel S. Field, 47 Van Natta 1457 (1995) (citing Hewlett-Packard Co. v. Renalds, 132 Or App 288 (1995)); Dibrito v. SAIF, 319 Or 244, 248 (1994) (it is our obligation as a fact finder to apply the appropriate legal standards to determine the compensability of a worker's claim). Our de novo review also requires us to determine the persuasiveness of the evidence. While the parties' arguments may help in our review, those arguments are not controlling and cannot require us to go where the law and evidence do not lead. Thus, even if the ALJ abused his discretion in seeking "post-hearing" clarification from claimant's attorney, the insurer suffered no harm. In this regard, the record was frozen, the insurer was given the opportunity to respond, and the insurer timely requested de novo review by the Board.

Accordingly, under the circumstances of this case, we do not find it necessary to determine whether the ALJ abused his discretion and proceed with our de novo review.

Extent of Scheduled Permanent Disability

The applicable standards are those in effect on the date of the Notice of Closure or Determination Order. OAR 438-010-0010; OAR 436-035-0003(1). In this case, the applicable standards are contained in WCD Admin. Order 96-072, the standards in effect on April 14, 1997, the date of the Determination Order. OAR 436-035-0010 through 436-035-0260 apply to the rating of claimant's scheduled permanent disability. ORS 656.283(7) and 656.295(5) provide that the evaluation of the worker's disability shall be as of the date of issuance of the reconsideration order.

Pursuant to OAR 436-035-0007(13), where a medical arbiter is used on reconsideration, "impairment is established by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment." After our de novo review, we adopt the ALJ's reasoning and conclusions that a preponderance of the medical evidence does not establish a different level of impairment from that established by Dr. Witczak, orthopedist, who served as the medical arbiter. Therefore, we rely on Dr. Witczak's report in determining claimant's permanent disability. Id.

Dr. Witczak indicated that there were two types of impairment due to claimant's compensable broken right wrist: (1) loss of range of motion in the right wrist; and (2) loss of strength in the right wrist. (Ex. 16-3).

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[1] The parties stipulated that all exhibits admitted at hearing were part of the record on reconsideration.

Where, as here, the uninjured contralateral joint has no history of injury or disease, impairment due to loss of range of motion in a joint is determined by comparing the range of motion in the injured joint to the uninjured contralateral joint. OAR 436-035-0007(22). However, if the motion of the contralateral joint exceeds the values for ranges of motion established under the standards, the values established under the standards apply to establish impairment. OAR 436-035-0007(22)(a); 436-035-0080.

Here, the motion of the uninjured contralateral joint (the left wrist) exceeds the values under the standards for dorsiflexion, radial deviation, and ulnar deviation. Therefore, the values in OAR 436-035-0080 apply to rate those losses of range of motion in the right wrist. Those losses are rated as follows: dorsiflexion of 48° equals 2.2 percent, radial deviation of 17° equals 0.6 percent, and ulnar deviation of 23° equals 1.4 percent. OAR 436-035-0080(1), (5), and (7). However, the uninjured left wrist range of motion for palmer flexion is 42°, which is less than the "normal" value of 70° for that range of motion. OAR 436-035-0080(3). Therefore, the value for the right wrist palmer deviation of 25° is determined in comparison with the left wrist measurement of 42° and results in a value of 4.6 percent. OAR 436-035-0007(22). These range of motion values are added for a total loss of range of motion of 8.8 percent, which is rounded up to 9 percent. OAR 436-035-0007(14) and (21)(a).

To determine impairment due to loss of strength, the physician reports the worker's strength using a 0 to 5 grading system, which is converted into a percentage value pursuant to OAR 436-035-0018(a). Loss of strength in the forearm or hand is valued as if the peripheral nerve innervating the weakened muscle(s) was impaired. OAR 436-035-0110(8)(a). The table at OAR 436-035-0110(8) provides the maximum percentage impairment values for each peripheral nerve in the upper extremity. The peripheral nerve supplying certain muscles may be identified by referencing the AMA Guides to the Evaluation of Permanent Impairment, 3rd Ed. (Revised), 1990. OAR 436-035-0007(18)(b). After identifying the peripheral nerve(s) involved, the percentage of loss of strength is multiplied by the maximum percent impairment allowed for the identified nerve(s). OAR 436-035-0110(8). If multiple nerves have impairment findings, those impairment values are combined. OAR 436-035-0007(20).

Dr. Witczak measured claimant's strength as grade 4/5 for the right palmer flexors and dorsiflexors and grade 5/5 for the corresponding muscle groups on the left. Pursuant to OAR 436-035-0007(18)(a), grade 4/5 is valued at 20 percent. The AMA Guides indicate that the right palmer flexors and dorsiflexors are innervated by the median and ulnar peripheral nerves. The median nerve (below mid-forearm) and the ulnar nerve (below mid-forearm) have a maximum value of 44 percent and 31 percent, respectively. OAR 436-035-0080(8). These values are multiplied by the 20 percent loss of strength rated by Dr. Witczak for values of 8.8 percent and 6.2 percent, respectively. Id. These values are rounded to 9 percent and 6 percent, then combined for a total loss of strength value of 14 percent. OAR 436-035-0007(20).

The loss of range of motion value (9 percent) is combined with the loss of strength value (14 percent) for a total scheduled permanent disability of 22 percent.

We note that claimant argues that he is also entitled to the loss of range of motion in his right thumb measured by Dr. Yarusso, attending physician, at the time of his closing examination. (Ex. 14). However, as addressed above, we have found Dr. Witczak's medical arbiter report establishes claimant's permanent disability. Dr. Witczak did not indicate claimant had any loss of range of motion in his right thumb.

Finally, because we have reduced the scheduled permanent disability awarded by the ALJ, claimant is not entitled to an assessed attorney fee on review. ORS 656.382.

ORDER

The ALJ's order dated October 29, 1997 is modified. In lieu of the ALJ's award and the Order on Reconsideration's award, claimant is awarded 22 percent (33 degrees) scheduled permanent disability for loss of use or function of the right forearm (wrist), which is his total award to date. Claimant's out-of-compensation attorney fee shall be adjusted accordingly.

In the Matter of the Compensation of
CALUM E. REED, Claimant
Own Motion No. 98-0147M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable right separated olecranon injury. Claimant's aggravation rights expired on December 6, 1994. SAIF agrees that claimant's current right epicondylitis is causally related to his accepted condition and that SAIF is responsible for claimant's current condition. However, SAIF opposes reopening of claimant's claim for the payment of temporary disability compensation, contending that claimant was not in the work force at the time of the current worsening.

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). Here, claimant must prove that he was in the work force on December 1, 1997, when his condition worsened requiring hospitalization. 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).

SAIF contends that claimant was not in the force at the time of his current disability. We disagree. In response to our March 31, 1998 letter requesting work force information, claimant contends his "aggravation" occurred around July 21, 1997, "at which time I was working at Northgate Auto Parts." Claimant further contends that the job was terminated on October 16, 1997 and that subsequent to his termination he has been receiving unemployment benefits. In support of his contentions, claimant submitted copies of his 1996 W-2, 1997 tax form and a Claim Summary Display obtained from the Employment Department.

We need not address claimant's work force status in July of 1997 or October of 1997. We have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction,[1] is the date he enters the hospital for the proposed surgery. Fred Vioen, 48 Van Natta 2110 (1996); John R. Johanson, 46 Van Natta 2463 (1994). The relevant time period for which claimant must establish he was in the work force is the time prior to when his compensable condition worsened requiring surgery and/or inpatient hospitalization. See generally Wausau Ins. Companies v. Morris, 103 Or App 270, 273 (1990); Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990); Jeffrey A. Kyle, 49 Van Natta 1331 (1997); Michael C. Batori, 49 Van Natta 535 (1997); Kenneth C. Felton, 48 Van Natta 725 (1996).

Here, in a December 1, 1997 chart note, claimant's attending physician, Dr. Thayer, recommended that claimant undergo a right elbow epicondylar release. Claimant submitted a payment history from the Employment Department which shows that he was receiving unemployment benefits in December of 1997 and continues to receive said benefits to date. The receipt of unemployment benefits is *prima facie* evidence that claimant is willing to work and is making reasonable efforts to obtain employment. See Carol L. Conaway, 43 Van Natta 2267 (1991); John T. Seiber, 43 Van Natta 136 (1991). There is no rebuttal evidence. Therefore, we find that claimant was in the work force at the time of his current worsening which required surgery.

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[1] The Board in its own motion jurisdiction can only authorize temporary disability from the time of surgery or hospitalization. See ORS 656.278(1)(a).

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning March 4, 1998, the date he was hospitalized for surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
LADELL Y. SCHWAB, Claimant
WCB Case No. 97-04287
ORDER ON REVIEW
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) Hazelett's order that dismissed her request for hearing as untimely filed. On review, the issue is whether there was good cause to excuse untimely filing of the hearing request.

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

On review, claimant contends that she has established good cause to excuse her untimely request for hearing concerning the SAIF Corporation's December 17, 1996 denial of her cervical spine condition. We disagree. "Good cause" means "mistake, inadvertence, surprise or excusable neglect," as those terms are used in ORCP 71B. Hempel v. SAIF, 100 Or App 68 (1990). Claimant has the burden of establishing good cause. Id.

Claimant alleges that, after SAIF issued its denial of her cervical condition claim, she spoke to SAIF's claims examiner, Ms. Sabatini, and they reached an agreement regarding future processing of the claim. Claimant testified that, under their agreement, claimant would seek surgical treatment under her accepted carpal tunnel syndrome (CTS) claim, which was in "own motion" status, and if the treatment did not relieve her symptoms, then SAIF would "reopen" the cervical condition claim. (Day 1, Tr. 25-28, 40). Claimant further testified that Ms. Sabatini indicated that treatment for the wrist (CTS) condition probably would resolve her symptoms and eliminate the need for "reopening" of the cervical claim. (Day 1, Tr. 39). Claimant also testified that Ms. Sabatini told her not to worry about her denied claim and that "everything should probably be okay." (Day 1, Tr. 39).

Claimant argues, based on her testimony, that she has shown good cause for her untimely appeal of the denial. She asserts that there was more than confusion that led to her untimely appeal; rather, she alleges that she was mislead by Ms. Sabatini to believe that her denied cervical claim would be reopened at a later date in the event that CTS treatment did not relieve her symptoms.

We do not need to address the issue of whether the facts alleged by claimant would be sufficient to establish good cause for an untimely appeal, because we agree with the ALJ's conclusion that claimant has not established those facts by a preponderance of the evidence in this record. Claimant's allegation that she reached an agreement with Ms. Sabatini regarding the processing of her claim was flatly denied by Ms. Sabatini. Ms. Sabatini testified that she did not tell claimant that her denied cervical claim could be "reopened," explaining that "it's just not done." (Day 2, Tr. 8). Ms. Sabatini also denied telling claimant not to worry about the denial or that "everything would be taken care of." (Day 2, Tr. 9). Rather, Ms. Sabatini testified that, when claimant expressed interest in pursuing surgery through the "own motion" (CTS) claim, she referred claimant to the "own motion" claims adjuster. (Id.) Ms. Sabatini denied offering any advice regarding the denial process or requesting a hearing, other than informing claimant of her 60-day appeal rights on the denial and her right to an attorney. (Day 2, Tr. 8, 33). She also denied suggesting to claimant that she pursue treatment under her CTS claim, instead of the cervical claim, or that having treatment for CTS would likely resolve her cervical symptoms. (Day 2, Tr. 31-32).

Thus, the record contains directly contradictory testimonies by claimant and Ms. Sabatini as to whether Ms. Sabatini told claimant that her denied cervical claim could be "reopened" if treatment for

CTS did not relieve her cervical symptoms. Claimant's testimony on this point is not corroborated by documentary evidence or by the testimony of other witnesses.[1] As the party bearing the burden of proof in this matter, claimant must prove her allegations by a preponderance of the evidence. Based on this record, we conclude that the evidence in the record is, at most, in equipoise. Because good cause has not been proven, the ALJ properly dismissed the hearing request as untimely filed.

ORDER

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

[1] Claimant testified that, after her telephone conversation with Ms. Sabatini regarding the denial, she informed her husband and mother of "what was said." (Day 1, Tr. 41). However, neither claimant's husband nor her mother was called as a witness to corroborate claimant's version of the conversation.

In the Matter of the Compensation of
DAVID E. STUTZMAN, Claimant
WCB Case No. 96-06436
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Otto's order that set aside its denial of claimant's current low back condition. In his respondent's brief, claimant contests that portion of the ALJ's order that determined that SAIF was not precluded from denying his current condition. On review, the issues are claim preclusion, compensability and responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact in the Order on Reconsideration with the following changes.

On page 2, we change the second sentence in the second paragraph of the findings of fact to read: "Aetna Casualty & Surety Company accepted claimant's condition. (Ex. 0)."

In the fifth full paragraph on page 3, we change the last sentence to read: "On April 22, 1993, Dr. Robertson reported that claimant had exaggerated responses and his current problems were largely functional. (Ex. 7). He agreed with the work recommendations of Drs. Henson and Bowman."

In the fifth paragraph on page 4, we replace the last sentence with the following:

> "On August 27, 1996, Dr. Dahlin referred to a March 1994 MRI that showed post-operative fibrosis, status post lumbosacral fusion and multi-level degenerative lumbar disc disease proximal to the fusion area. Dr. Dalhin further indicated that claimant had significant low back pathology related to those factors. (Ex. 27). Dr. Dahlin described claimant's present low back problems as 'multi-factorial' and he was 'unable to determine the relative impact of the industrial injury of some ten years ago.' (Id.)"

In the second paragraph on page 5, we change the date to "October 10, 1996."

We do not adopt the findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Claim Preclusion

We adopt and affirm the portion of the ALJ's order that concluded that SAIF was not precluded from litigating compensability of claimant's current condition.

Current Condition Denial

Claimant has two previous accepted low back injuries. On July 21, 1969, he injured his low back while working for Aetna's insured. Aetna accepted claimant's condition (Ex. 0), although the record does not include a specific acceptance. As a result of that injury, claimant underwent a lumbar laminectomy and spinal fusion at L4-5 and S1. (Ex. 5). The claim was closed with a 112 degree unscheduled permanent partial disability award for the low back. (Ex. 0).

Claimant's second compensable low back injury occurred on July 17, 1986, while he was working for SAIF's insured. Claimant injured his low back when he slipped while stepping from a ladder to a truck. (Ex. 2). SAIF accepted a back strain. (Ex. 3). There is no indication that this injury resulted in permanent disability.

On June 17, 1996, SAIF denied compensability of claimant's current low back condition on the ground that the July 17, 1986 injury was not the major contributing cause of his current condition, disability and need for treatment. (Ex. 26).

The ALJ found that, although claimant's 1969 and 1986 injuries did not involve the same condition, they involved the same body part. The ALJ reasoned that ORS 656.308 did not apply, but the last injurious exposure rule and the rebuttable presumption in Industrial Indemnity v. Kearns, 70 Or App 583 (1984), did apply. The ALJ found that the 1969 injury remained the major contributing cause of claimant's low back condition and because SAIF failed to rebut the second prong of the Kearns presumption, the ALJ set aside SAIF's compensability denial. We disagree.

To begin, this is not a responsibility dispute. SAIF and claimant are the only parties to the dispute. Moreover, SAIF does not contend, either by its express denial or by its arguments, that claimant's current condition is not "compensable" because the condition is related to the 1969 injury. Rather, in denying claimant's current condition, SAIF asserted that its accepted 1986 low back strain was not the major contributing cause of claimant's current disability and need for treatment. In other words, rather than conceding compensability of the claim and attempting to shift responsibility to a prior carrier, SAIF was availing itself of its statutory right to deny the claim under ORS 656.262(6) and require claimant to establish the compensability of his current condition and need for treatment.[1] See ORS 656.266. Consequently, Kearns applies to this matter.[2]

Although the ALJ phrased the compensability issue as whether claimant had shown "work-relatedness," the correct inquiry is whether claimant has established the requisite causal relationship between the 1986 compensable injury and his current condition. Because claimant has a prior 1969 compensable injury to his low back, the causation issue in this case is a complex medical question that must be resolved by expert medical opinion. Uris v. Compensation Department, 247 Or 420 (1967); Barnett v. SAIF, 122 Or App 279, 283 (1993). Although we generally defer to a claimant's attending physician, Weiland v. SAIF, 64 Or App 810, 814 (1983), we do not rely on Dr. Dahlin's opinion because of numerous unexplained inconsistencies.

Dr. Dahlin began treating claimant in November 1993. On May 22, 1995, Dr. Dahlin reported that claimant had a chronic back condition. (Ex. 19). He believed that claimant's present symptoms were directly and primarily related to the July 17, 1986 injury. (Ex. 20).

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[1] Like the ALJ, we do not find that claimant's current condition involves the "same condition" that was processed as part of both the 1969 injury and the 1986 injury. In addition, SAIF has never assumed responsibility, either by litigation or by application of ORS 656.308, for any part of claimant's 1969 injury. Consequently, ORS 656.308 is inapplicable, and this case is distinguishable from prior Board cases that held that ORS 656.308(1) barred a second carrier (with an accepted claim involving the same condition) from issuing a current condition denial pursuant to ORS 656.262(6)(c). See, e.g., Daral T. Morrow, 49 Van Natta 1979, recon 49 Van Natta 2105 (1997).

[2] We note that although the ALJ applied Kearns to set aside SAIF's compensability denial, the only issue in the Kearns case was responsibility. 70 Or App at 585. The ALJ also relied on Raymond H. Timmel, 47 Van Natta 31 (1995), in which the only issues were responsibility and attorney fees. Compensability of a condition must be proven as a threshold matter before proceeding to a determination of responsibility. See Jack W. Swinford, 49 Van Natta 1519 (1997); Andrew R. Comeau, 42 Van Natta 1630 (1990); Joseph L. Woodward, 39 Van Natta 1163 (1987). Thus, before the Kearns "rebuttable presumption" analysis can be applied, claimant must first establish the compensability of his claim. See Andrew R. Comeau, 42 Van Natta at 1631. To do so, claimant must establish that his accepted 1986 low back strain with SAIF is a material contributing cause of his current condition. Id.

In March 1996, Dr. Dahlin was shown a videotape of claimant engaging in various activities. (Ex. 23). After watching the video, Dr. Dahlin reported on June 6, 1996 that claimant exhibited not only the ability to carry out very demanding physical tasks but also a level of endurance that was incompatible with his diagnosis of a failed back syndrome. (Ex. 24-1). In a questionnaire from SAIF, Dr. Dahlin agreed that claimant had misrepresented his condition and physical capacities. (Ex. 24-3). He reported that claimant had no need for treatment and he agreed that claimant's "July 17, 1986 injury has resolved and his current need for medical treatment is unrelated to his accepted conditions[.]" (Id.)

On August 27, 1996, Dr. Dahlin referred to an MRI performed in March 1994 that showed "post-operative fibrosis, status post lumbosacral fusion and multi-level degenerative lumbar disc disease proximal to the fusion area" and he said that claimant had "significant low back pathology" related to those factors. (Ex. 27). Dr. Dahlin described claimant's present low back problems as "multi-factorial" and he was "unable to determine the relative impact of the industrial injury of some ten years ago." (Id.)

In a deposition on September 25, 1996, Dr. Dahlin identified claimant's condition as lumbar spine derangement with chronic pain syndrome and said that, although he had not seen claimant for quite awhile, he would make the same diagnosis now. (Exs. 28-4, -5). Dr. Dahlin continued to agree with his May 22, 1995 report, which stated that claimant's present symptoms were directly and primarily related to the July 17, 1986 injury. (Exs. 28-6, -7). However, later in the deposition, Dr. Dahlin could not say whether the 1986 injury was playing some role in claimant's need for treatment in 1993. (Ex. 28-8).

Although in May 1995, Dr. Dahlin believed that claimant's present symptoms were directly and primarily related to the July 17, 1986 injury (Ex. 20), he agreed in June 1996 that claimant's "July 17, 1986 injury has resolved and his current need for medical treatment is unrelated to his accepted conditions[.]" (Ex. 24-3). On August 27, 1996, Dr. Dahlin was "unable to determine the relative impact" of the injury ten years ago in 1986. (Ex. 27). Nevertheless, in a deposition on September 25, 1996, Dr. Dahlin continued to agree with his May 22, 1995 report, which stated that claimant's present symptoms were directly and primarily related to the July 17, 1986 injury. (Exs. 28-6, -7). However, later in the same deposition, Dr. Dahlin could not say whether the 1986 injury was playing some role in claimant's need for treatment in 1993. (Ex. 28-8).

Dr. Dahlin's opinion is, at best, confusing. Because of numerous unexplained inconsistencies, we do not rely on his opinion in determining whether claimant's current condition is causally related to the 1986 compensable injury.

The only other medical opinion concerning claimant's current low back condition is from Dr. Strukel, who reviewed the surveillance videotape and claimant's medical records. (Ex. 30). Based on his review in October 1996, Dr. Strukel felt that it was inconsistent that claimant had continuing problems from the 1986 low back strain. (Ex. 30-3). He said that a strain occurring ten years ago would not have long lasting side effects and did not appear to cause any pathologic changes. (Ex. 30-4). Rather, Dr. Strukel felt that claimant's current symptoms were related to the previous disc herniation, spinal laminectomy and surgery for the herniation and subsequent spinal fusion. (Exs. 30-3, -4).

We are persuaded by Dr. Strukel's opinion because it is well-reasoned and based on accurate and complete information. See Somers v. SAIF, 77 Or App 259 (1986). Based on his opinion, we conclude that claimant's current condition is not causally related, either in material or major part, to the 1986 injury accepted by SAIF. Accordingly, SAIF's denial must be upheld.

ORDER

The ALJ's order dated November 15, 1996, as reconsidered on February 6, 1997, is reversed in part and affirmed in part. 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.

In the Matter of the Compensation of
JEANE A. THORNBURG, Claimant
WCB Case No. 97-05809
ORDER ON REVIEW
Heiling, Dodge & Associates, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

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

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of the last sentence.

We briefly summarize the findings of fact as follows.

Claimant is a registered nurse who manages the intensive care unit at a hospital. She weighs approximately 130 pounds.

On March 19, 1997, claimant fell down some stairs at home and had hip, neck and low back pain as a result of the fall. She sought treatment on March 25, 1997 from Dr. Johnson, a chiropractic physician, for the pain related to the fall.

On about March 29, 1997, a heavy patient was admitted to the intensive care unit where claimant worked. The patient's weight at admission was 175 pounds, but increased to 203 pounds between March 29 and April 11, 1997.

Claimant worked two 12-hour shifts per week and was required to move or lift the heavy patient several times during her shift. During the course of caring for the patient, claimant developed back and neck pain.

On April 15, 1997, claimant complained to Dr. Johnson of "new" neck pain after lifting the heavy patient several times during her shift. Dr. Johnson diagnosed acute traumatic cervical sprain/strain with disc degeneration as well as acute traumatic thoracic strain.

Claimant filed a workers' compensation claim on April 17, 1997. Claimant was examined, on behalf of the employer, by Dr. Gambee, an orthopedic surgeon.

The employer denied claimant's claim on June 19, 1997 on the ground that claimant suffered only an increase in symptoms and that the major contributing cause of any disability or medical treatment was her preexisting degenerative disc disease and osteoarthritic conditions.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant had established that she suffered a cervicothoracic strain as a result of her work activities and set aside the denial. On review, the employer first argues that the onset of claimant's condition was gradual rather than sudden since the patient who allegedly caused claimant's symptoms was in the intensive care unit for three weeks. On this basis, the employer argues that the claim is appropriately analyzed as an occupational disease. The insurer further argues that, even if the claim is analyzed as an industrial injury, the major contributing cause standard of ORS 656.005(7)(a)(B) is applicable. We agree, for the following reasons, that whether the claim is analyzed as an injury or as an occupational disease claim, the major contributing cause standard applies to this claim.

Two medical experts address the cause of claimant's upper back and cervical condition. Dr. Johnson treated claimant for the upper back and cervical condition. He opined that the lifting of the heavy patient at work is the major contributing cause of the right neck pain with radiating shoulder and trapezius pain. Dr. Johnson opined that the degenerative condition was "part of the normal aging process" and "not part of the injury." However, Dr. Johnson agreed that degenerative joint disease such as claimant has suggests that the spine may be weak and may predispose one to injury. See ORS 656.005(24) ("preexisting condition" defined to include a condition that "predisposes a worker to disability or need for treatment.")

Dr. Gambee examined claimant on behalf of the employer and diagnosed claimant's condition as neck strain superimposed on preexisting degenerative arthritis. Dr. Gambee opined that claimant's work exposure caused the preexisting condition to be symptomatic, but did not pathologically change the underlying process. Dr. Gambee also opined that the preexisting condition was the major contributing cause of claimant's need for treatment. At his deposition, Dr. Gambee became aware of claimant's fall down the stairs at home on March 18, 1997 and claimant's treatment for the fall by Dr. Johnson. Dr. Gambee reviewed Dr. Johnson's records of the treatment for the fall and opined that the areas of pain claimant reported were basically the same as those claimant reported from the work exposure to the heavy patient. After reviewing Dr. Johnson's chart notes regarding the fall, Dr. Gambee opined that more than 51 percent of claimant's problems were the result of a combination of claimant's degenerative process and the fall down the stairs.

After reviewing the medical evidence, we do not find Dr. Johnson's opinion persuasive. In this regard, Dr. Johnson did not explain or elaborate on his apparent opinion that the degenerative condition did not contribute to claimant's injury. Such an explanation is particularly lacking in light of Dr. Johnson's March 25, 1997 assessment of "chronic [degenerative joint disease] of the cervical region involving C4-5-6 with attendant subluxation complex." Thus, we find Dr. Johnson's opinion to be conclusory and lacking in explanation and medical analysis. See Moe v. Ceiling Systems, 44 Or App 429 (1980); see also, Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev dismissed 321 Or 416 (1995) (persuasive medical opinion must evaluate the relative contribution of the different causes and explain why one condition, activity or exposure contributes more to the claimed condition than all other causes or exposures combined).

In determining the cause of claimant's neck and upper back condition, we rely on the opinion of Dr. Gambee. See Somers v. SAIF, 77 Or App 259, 263 (1986) (when there is a dispute between medical experts, we rely on those opinions which are both well-reasoned and based on complete information).[1] Based on Dr. Gambee's opinion, we find that claimant's preexisting degenerative condition combined with the injury or exposure at work and that the degenerative condition was the major contributing cause of claimant's disability and need for treatment. Accordingly, whether the claim is for an injury or for an occupational disease, we find that the major contributing cause standard applies. See ORS 656.005(7)(a)(B); 656.802(2)(a). Based on this record, claimant has not established that her work exposure, as opposed to her preexisting condition, was the major contributing cause of her cervical and upper back condition.

ORDER

The ALJ's order dated November 2, 1997 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

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[1] Claimant argues that Dr. Gambee is unpersuasive since he was critical of Dr. Johnson for failing to include his chart notes of treatment prior to the work exposure. We do not find the fact that Dr. Gambee was critical of Dr. Johnson or Dr. Johnson's office practices to be relevant to the persuasiveness of either medical opinion. Claimant also argues that Dr. Gambee incorrectly read the MRI as indicating that claimant's degenerative condition was "moderate." In fact, Dr. Gambee was not referring to the MRI report, but was instead giving his own interpretation of plain x-rays taken by Dr. Johnson's office which Dr. Gambee indicated he personally reviewed. (Ex. 23-4; 29-6).

In the Matter of the Compensation of
DUSTIN L. CROMPTON, Claimant
Own Motion No. 97-0523M
OWN MOTION ORDER OF ABATEMENT
Glen J. Lasken, Claimant Attorney

The self-insured employer requests reconsideration of our March 19, 1998 Second Own Motion Order on Reconsideration, in which we authorized reopening of claimant's claim to provide temporary total disability compensation beginning March 12, 1997, the date he was hospitalized for surgery.

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
GLORIA J. WILEY, Claimant
WCB Case No. 97-03589
ORDER ON REVIEW
Coughlin, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Moller and Bock.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Otto's order that awarded claimant 30 percent (96 degrees) unscheduled permanent disability for a low back injury, whereas an Order on Reconsideration did not award claimant any unscheduled permanent disability. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We adopt the "Conclusions of Law and Opinions" set forth in the ALJ's order concerning the values given for age, education, and impairment. We modify the ALJ's reasoning concerning the adaptability value as set forth below.

Relying on claimant's affidavit, the ALJ concluded that claimant's description of her lifting activities established that claimant's Base Functional Capacity (BFC) was in the medium strength category. We disagree.

Pursuant to OAR 436-035-0310(4)(a), a worker's BFC is determined by identifying the Dictionary of Occupational Titles (DOT) code which most accurately describes claimant's the most physically demanding job that the worker has successfully performed in the five years prior to determination. While we consider the record as a whole, including the job duties and physical demands of the relevant job, the fact remains that the most applicable DOT determines the strength category for that job. See OAR 436-035-0005(17); 436-035-0310(4)(a); Thomas D. Porter, 45 Van Natta 2218 (1993). While a claimant's sworn statement is relevant to a determination of the most appropriate DOT code, it cannot be used to determine that no DOT accurately describes the job duties. Kathyrn D. Parsons, 45 Van Natta 954 (1993).

Here, the ALJ found, and we agree, claimant's affidavit (Exhibit 47) is the most persuasive evidence of her job duties in the last 5 years. In her sworn statement, claimant indicates that the DOT descriptions for Invoice Control Clerk (DOT # 214.662-026) and Sorter Agriculture Produce (DOT # 529.687-186) accurately describe most of her job duties. (Ex.47). The strength category assigned to those two job descriptions is sedentary and light respectively. Pursuant to OAR 436-035-0310(4)(a) when a combination of DOT codes most accurately describes a worker's duties, the highest strength category for a combination of codes applies. As noted above, the DOT indicates that a Sorter Agriculture Produce is in the light strength category. Accordingly, we concluded that claimant's BFC is light.

As found by ALJ, and not contested by the parties, claimant's Residual Functional Capacity (RFC) is in the light-sedentary category. A comparison of claimant's BFC, which we have herein found to be in the light category, and her RFC, yields an adaptability value of 2. OAR 436-035-310(6).

Claimant's age and education value (4) is multiplied by the adaptability value of (2) for a total value of 8. That value is added to claimant's impairment value of 14 for a total award of 22 percent unscheduled permanent disability. The ALJ's order is modified accordingly.

Finally, because we have reduced claimant's award of unscheduled permanent disability on appeal, claimant's counsel is not entitled to an assessed attorney fee pursuant to ORS 656.382(2).

ORDER

The ALJ's order dated September 17, 1997 is modified in part and affirmed in part. In lieu of the ALJ's award of 30 percent (96 degrees) unscheduled permanent disability, claimant is awarded 22 percent (70.4 degrees) unscheduled permanent disability. The ALJ's "out-of-compensation" attorney fee award is modified accordingly. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
MISTY HAYWARD, Claimant
WCB Case No. 97-05286
ORDER ON REVIEW
G. Joseph Gorciak III, Claimant Attorney
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

The insurer requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) set aside its denial of claimant's occupational disease claim for a headache and cervical strain condition; and (2) awarded an assessed fee of $3,000 for claimant's attorney's services at hearing. On review, the issues are compensability and attorney fees.

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

The insurer argues that there was "no basis for a claim under ORS 656.005 or otherwise" because claimant required no medical services. The insurer contends that, because the medical treatment provided claimant was not effective in relieving her headache and cervical strain symptoms, claimant required no medical services and, therefore, did not sustain a compensable occupational disease. In other words, the insurer apparently argues that medical treatment must be successful in order to support a compensable occupational disease claim. We disagree.

Claimant's claim is an occupational disease claim, which is governed by ORS 656.802. An "occupational disease" is defined, in part, as "any disease or infection arising out of and in the course of employment caused by substances or activities to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein, and which requires medical services or results in disability or death." ORS 656.802(1). Thus, a compensable occupational disease claim either requires medical services or results in disability or death.[1] In addition, ORS 656.802(2)(c) provides that occupational diseases are subject to the same limitations and exclusions as accidental injuries under ORS 656.005(7). Finally, ORS 656.005(7)(a) defines a "compensable injury" in similar terms, stating, in part, a compensable injury is "an accidental injury * * * arising out of and in the course of employment requiring medical services or resulting in disability or death."

ORS 656.005 does not define "medical services." The court in Finch v. Stayton Canning Co., 93 Or App 168 (1988), while pointing out that there is no definition for the term "medical services" in former ORS 656.005(8)(a),[2] held that a claimant who had symptoms, and sought the assistance of a

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[1] At hearing, claimant testified that she missed "some time at work" because of her headaches. (Tr. 18). However, we need not address whether this testimony arises to the level of "disability" under ORS 656.802(1), because we find that claimant has established that her headache and cervical strain conditions required medical services.

[2] Former ORS 656.005(8)(a) is now found at ORS 656.005(7)(a). The relevant language defining a compensable injury in terms of requiring "medical services" remains the same.

physician for treatment even though no actual treatment was recommended, had received the required "medical services" and suffered a compensable occupational disease. The court said "[t]hat no treatment is available for an injury or disease does not mean that a claimant is not injured or sick." Id. at 173; David M. Crymes, 45 Van Natta 267 (1993); Linda L. Smith, 41 Van Natta 2114 (1989).

Here, claimant sought medical treatment from Dr. McLarty, treating physician, who diagnosed and treated claimant for severe cervical strain and headache. (Exs. A, B, 1A, 2). Dr. McLarty's medical treatment, which included medication and injections, was not successful in relieving claimant's symptoms and he referred claimant to Dr. Crumpacker, neurologist, for treatment of her headaches and neck pain. (Exs. 2, 4). Claimant's symptoms resolved with ergonomic changes in her work station and reduced work hours before she was examined by Dr. Crumpacker, who advised claimant to consult him if her headaches returned. However, the fact remains that claimant required medical treatment for her headache and cervical strain conditions. Furthermore, both Drs. McLarty and Crumpacker related those conditions and claimant's need for treatment to her work activities, with Dr. McLarty opining that claimant's work activities were the major contributing cause of claimant's need for treatment. (Exs. 4-2, 6, 7). There is no contrary evidence.

We find that the medical services claimant received from Drs. McLarty and Crumpacker constitute medical services within the meaning of ORS 656.802(1) and ORS 656.005(7)(a). Finch v. Stayton Canning Co., 93 Or App at 173; David M. Crymes, 45 Van Natta at 267; Linda L. Smith, 41 Van Natta at 2115.

Attorney Fees

Stating that he relied on the general principles in OAR 438-015-0010(4),[3] the ALJ determined that $3,000 was a reasonable attorney fee for claimant's attorney's services. The insurer argues that the ALJ's award of $3,000 is "grossly excessive." We disagree.

The record contains no specific attorney fee request (or statement of services), nor does it appear that the parties submitted to the ALJ any argument as to how the rule-based factors should be weighed in determining a reasonable fee. We have recently determined that, under such circumstances, the ALJ is not obligated to make specific findings regarding the rule-based factors, in order to have a reviewable order. Russell L. Martin, 50 Van Natta 313 (1998) (finding that the absence of a fee request or argument on the rule-based factors distinguishes a case from Schoch v. Leupold & Stevens, 325 Or 112, on remand 49 Van Natta 788 (1997), which required a "sufficient explanation" of how the rule-based factors were weighed in deciding that a "reasonable" fee was substantially less than the amount requested).

However, on review, the insurer submits, apparently for the first time, specific arguments regarding the rule-based factors of time devoted to the case, complexity of the issue, and value of the interest involved. The insurer argues that consideration of those factors does not justify a $3,000 fee in this case. Because the insurer has now advanced arguments specifically addressing the factors, and considering that further appellate review of our decision would be subject to the "range of discretion" criteria discussed in Schoch, we provide the following supplementation to the ALJ's decision.

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[3] OAR 438-015-0010(4) provides that "[i]n any case where an [ALJ] or the Board is required to determine a reasonable attorney fee, the following factors shall be considered:

"(a) The time devoted to the case;

"(b) The complexity of the issue(s) involved;

"(c) The value of the interest involved;

"(d) The skill of the attorneys;

"(e) The nature of the proceedings;

"(f) The benefit secured for the represented party;

"(g) The risk in a particular case that an attorney's efforts may go uncompensated; and

"(h) The assertion of frivolous issues or defenses."

Turning to the factors under OAR 438-015-0010(4), we find that the compensability issue was of average complexity and that the proceedings were relatively limited, with no depositions or expert witnesses. Prior to hearing, however, claimant's attorney expended additional time and effort seeking medical evidence to support claimant's claim. All ten exhibits in the record were submitted by claimant's attorney. Thus, contrary to the insurer's argument, claimant's attorney's time devoted to this case was not limited to the time before the ALJ at hearing. In addition to the time devoted to this case, there was the significant value of claimant's interest in obtaining acceptance of the headache and cervical strain condition. Given the application of the "major contributing cause" standard, claimant's attorney assumed a risk that he might go uncompensated for his services. In the face of that risk, claimant's attorney secured significant benefits (actual and potential benefits for the headache and cervical strain conditions) for claimant, including payment for medical services. Based on our consideration of the factors in OAR 438-015-0010(4), particularly the aforementioned factors of time, value, benefit, and risk, we conclude that $3,000 is a reasonable attorney fee. Therefore, as supplemented herein, we affirm the ALJ's fee award.

Claimant's attorney is entitled to an assessed fee for services rendered in defending against the insurer's request for review regarding the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $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. In addition, because attorney fees are not "compensation" within the meaning of ORS 656.382(2), claimant's attorney is not entitled to an assessed fee for defending the ALJ's attorney fee award. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated October 31, 1997 is affirmed. For services on review, claimant's attorney is awarded a fee of $750, payable by the insurer directly to claimant's attorney.

In the Matter of the Compensation of
SUE A. KONIAK, Claimant
WCB Case Nos. 97-06647 & 97-05869
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Beaverton City Attorney Office, Attorney

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Herman's order that enforced a penalty awarded by a prior ALJ's order. In her respondent's brief, claimant contends that the ALJ should have awarded a penalty for the employer's allegedly unreasonable failure to pay the first penalty. On review, the issue is penalties. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Stipulation of the Parties" and Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Enforcement of Penalty

We adopt the ALJ's conclusions on this issue, with the following supplementation.

On review, the employer contends that the ALJ erred by enforcing the prior ALJ's order. Specifically, the employer argues that the prior ALJ's order was incorrect because it assessed a penalty on amounts due up through the time of hearing rather than on amounts due at the time of the denial.

The employer acknowledges that the prior ALJ's order is final as a matter of law. Furthermore, it "does not contend the final order issued by [the prior ALJ] is void." Reply brief, pg. 3. Rather, the employer argues that the prior order was incorrect and the penalty assessed in that order should not have been enforced by ALJ Herman.

We have previously held that, although a carrier's apparent belief that an award of interim compensation was made in error might be grounds for an appeal of the ALJ's order, it was not a legitimate basis for the failure to comply with that order. See Karen S. McKillop, 44 Van Natta 2473 (1992). Similarly, where a carrier failed to comply with an ALJ's order because it did not believe that the claimant was substantively entitled to temporary disability, we concluded that, because the ALJ's order was a valid, final order, the carrier did not have a legitimate doubt regarding its duty to comply with the ALJ's order. See Imre Kamasz, 47 Van Natta 332 (1995).

Consequently, in the present case, we conclude that if the employer believed that the first ALJ's order was in error, its remedy was to appeal that order. Because it did not do so, ALJ Herman correctly assessed a penalty based on the time period specified by the prior ALJ's order.[1]

Entitlement to an Additional Penalty

We adopt the ALJ's reasoning on this issue. Moreover, because the employer's appeal in this case involves a penalty, we are unable to award claimant's counsel an attorney fee for services on review. See Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The ALJ's order dated November 13, 1997 is affirmed.

[1] We do not agree with the employer's assertion that the first ALJ's statement regarding amounts due up through the time of hearing was "dicta." It is both routine and proper for an ALJ to define the time period upon which the penalty is being based.

April 22, 1998 Cite as 50 Van Natta 785 (1998)

In the Matter of the Compensation of
RAFAEL LEON, Claimant
Own Motion No. 97-0421M
OWN MOTION ORDER ON RECONSIDERATION
Ernest Jenks, Claimant Attorney
Saif Legal Department, Defense Attorney

On November 18, 1997, we denied claimant's request for temporary disability compensation. We found that we were not authorized to reopen claimant's claim because the SAIF Corporation had not accepted claimant's current herniated disc L5-S1. SAIF is now requesting reconsideration of the November 18, 1997 order contending that the parties have entered into a stipulation wherein SAIF agrees that claimant's current condition and ensuing surgery are compensably related to the accepted condition.

This request, made more than 120 days after our November 18, 1997 order is untimely. However, in extraordinary circumstances, the Board may, on its own motion, reconsider any prior Board order. OAR 438-012-0065(3). Here, the parties did not enter into an agreement regarding the compensability of claimant's current condition and ensuing surgery until March 26, 1998, when Administrative Law Judge (ALJ) Hoguet approved a "Stipulation and Order" which resolved the parties' dispute pending before the Hearings Division. The parties agreed that SAIF would process the claim for medical treatment, including surgery, under claimant's 1989 injury claim. Further, SAIF agreed to recommend a Board's Own Motion Order reopening under claimant's 1989 injury claim for the payment of temporary disability compensation. Given this change in the status of claimant's condition as described in the parties' approved stipulation and as explained in the parties' mutually satisfactory request for Own Motion relief, we find that extraordinary circumstances exist to allow reconsideration of our November 18, 1997 order. See OAR 438-012-0065(2).

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 a June 6, 1997 chart note, Dr. Tahir, claimant's attending physician, recommended claimant undergo a hemilaminectomy and diskectomy at L5-S1. Thus, we conclude that claimant's compensable injury worsened requiring surgery.

Accordingly, we authorize the reopening of claimant's 1989 injury claim for the payment of temporary disability compensation beginning the date he enters the hospital 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
DAVID R. MALONE, Claimant
WCB Case No. 97-03667
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that: (1) upheld the self-insured employer's denial of his new injury claim for a low back condition; and (2) determined that the employer properly processed the low back condition under claimant's 1984 injury claim. Prior to briefing, claimant requested that we "abate any time limitations or further processing of the closure of the claimant's September 12, 1984 condition." On review, the issue is claim processing.

We adopt and affirm the ALJ's order with the following response to claimant's abatement request.

The employer denied that claimant sustained a new compensable injury on January 7, 1997 involving an L2-3 disc condition and, instead, processed claimant's current back condition under a previously accepted 1984 injury claim. According to claimant, the employer has issued a Notice of Closure referencing the 1984 date of injury. Although claimant contends that further processing of the claim under the 1984 injury claim should be abated pending resolution of claimant's appeal of the ALJ's order, we decline to grant claimant's abatement request. See SAIF v. Maddox, 295 Or 448 (1983) (compensability of a claim need not be finally determined before the extent of disability may be determined and litigated); Diana L. Brett, 46 Van Natta 23 (1994) (regardless of which carrier was ultimately found responsible in pending responsibility litigation, the claim was properly processed to closure by the carrier who was responsible for the claim at the time of closure); see also Nina J. Butler, 46 Van Natta 523 (1994) (the carrier which was responsible for the claimant's current condition, was also responsible for processing the claim, including the determination of permanent disability resulting from the claim, and could not join other carriers in the extent litigation).

ORDER

The ALJ's order dated January 6, 1998 is affirmed.

In the Matter of the Compensation of
BRUCE R. PALANUK, Claimant
WCB Case No. 97-06874
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) McWilliams' order that set aside its partial denial of claimant's injury claim for a right knee condition. SAIF also objects to the amount of the attorney fee requested by claimant for his attorney's services on review. On review, the issues are compensability and attorney fees.

We adopt and affirm the ALJ's order regarding the compensability issue. In addition, we offer the following findings and discussion concerning the attorney fee on review.

Claimant requests a $2,500 attorney fee for services on review. ORS 656.382(2). SAIF contends that the requested fee is "clearly excessive." Because claimant's counsel was the same attorney who developed the record and tried the case at the hearings level, SAIF questions the necessity of the legal time claimed on review.

Based on our review of the record and the parties' submissions regarding the attorney fee issue, we make the following findings.

Claimant's attorney asserts that she devoted "approximately" 16 hours to legal research, reviewing the record, and drafting the brief on review regarding the compensability issue. She further states that she has twelve years of experience as a workers' compensation attorney. In submitting a 10 page respondent's brief (with approximately 7 pages devoted to argument regarding the compensability issue), claimant's attorney skillfully and successfully defended against SAIF's appeal regarding the compensability of claimant's right knee condition.[1] The complexity of the compensability issue presented for our resolution is at a level slightly greater than that normally considered by this Board. The value of the claim is substantial in that claimant will likely undergo surgery for his compensable condition. Considering the divided medical evidence and SAIF's vigorous defense against the claim, there was a significant risk that claimant's counsel might go uncompensated. There were no frivolous claims or defenses asserted.

Accordingly, after considering claimant's request, SAIF's objection, and the factors set forth in OAR 438-015-0010(4),[2] and applying the factors to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $2,500 payable by SAIF. In reaching

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[1] Claimant's attorney was previously awarded a $3,400 attorney fee for services at hearing.

[2] OAR 438-015-0010(4) provides that "[i]n any case where an [ALJ] or the Board is required to determine a reasonable attorney fee, the following factors shall be considered:

"(a) The time devoted to the case;

"(b) The complexity of the issue(s) involved;

"(c) The value of the interest involved;

"(d) The skill of the attorneys;

"(e) The nature of the proceedings;

"(f) The benefit secured for the represented party;

"(g) The risk in a particular case that an attorney's efforts may go uncompensated; and

"(h) The assertion of frivolous issues or defenses."

this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by claimant's respondent's brief and his attorney's statement of services[3]), the complexity of the compensability issue, and the value of the interest involved.

ORDER

The ALJ's order dated December 24, 1997 is affirmed. For services on review, claimant is awarded a $2,500 attorney fee, payable by the SAIF Corporation.

[3] We note that claimant is not entitled to an attorney fee for time spent on the attorney fee issue.

In the Matter of the Compensation of
DAROLD E. PERRY, Claimant
WCB Case Nos. 97-03813 & 97-02352
ORDER ON REVIEW
Richard F. McGinty, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

Liberty Northwest Insurance, on behalf of employer Goodwill Industries, requests review of those portions of Administrative Law Judge (ALJ) Poland's order that: (1) set aside its denial of claimant's "new injury" claim for his cervical, thoracic and lumbar condition; and (2) upheld the aggravation denial of the SAIF Corporation for the same conditions. On review, the issues are compensability and responsibility. We reverse.

FINDINGS OF FACT

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

Claimant was compensably injured on December 1, 1993 when he tipped over while driving a logging skidder. The treating doctors diagnosed cervical and lumbar strains and SAIF accepted claimant's claim for these conditions. Post injury x-rays and MRIs indicated a normal cervical and lumbar spine. In July 1994, claimant's then treating physician, Dr. Laubengayer, opined that claimant was medically stationary with mild permanent disability related to a chronic lumbar strain, although his lumbar range of motion was probably normal for claimant. The claim was closed pursuant to an August 30, 1994 Notice of Closure which awarded temporary disability only. Pursuant to a Claim Disposition Agreement (CDA) approved by the Board in January 1995, claimant relinquished all further rights to benefits under the claim, with the exception of medical services.

Claimant then began working as a bartender. He continued to experience periodic episodes of neck, mid-back and low back pain. In November 1996, he began working for Liberty's insured, Goodwill Industries. His job involved unloading and loading trucks carrying bins of clothing and housewares. On or around December 18, 1996, claimant experienced the gradual onset of pain in his neck and back, which increased to the point that he was unable to perform his job.

On January 7, 1997, after three weeks of self-treating with pain medication and massages, claimant sought treatment with Dr. Stringham. Dr. Stringham diagnosed chronic low back syndrome with acute exacerbation. An x-ray of the lumbar spine showed marked narrowing of the L5-S1 disc space.

Claimant filed an aggravation claim with SAIF, which was denied, and a current condition claim with Liberty. Liberty denied responsibility only.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's current condition was compensable but did not represent an actual worsening of the conditions accepted by SAIF. The ALJ further found that Liberty was responsible for claimant's current disability and need for treatment pursuant to ORS 656.308(1). On review, Liberty argues that claimant's current condition is not compensable and, alternatively, even if compensable, responsibility for claimant's current condition remains with SAIF. For the reasons set forth below, we conclude that claimant's condition is compensable and that SAIF is responsible for claimant's current need for treatment.

As the ALJ noted, the record contains two medical opinions addressing the cause of claimant's current condition. Dr. Stringham, who treated claimant and reviewed his past medical records, opined that claimant's work activities for Liberty's insured constituted an exacerbation of his original 1993 injury but that the original injury remained the major cause of claimant's musculoskeletal symptoms of the neck and back in December 1996. Dr. Stringham also opined that claimant did not suffer any "new injury" while working for Liberty's insured.

On the other hand, Dr. Mayhall, who reviewed claimant's medical records at SAIF's request, opined that the major contributing cause of claimant's current need for treatment was his work for Liberty's insured on December 18, 1996. Dr. Mayhall found no objective evidence that claimant's current condition was related to his original 1993 injury and concluded that claimant's new condition involved a combination of a sprain occurring on or about December 18, 1996 and degenerative disc disease at L5-S1 which had developed sometime after claimant's 1993 injury.

Where, as here, the medical evidence 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, we find no persuasive reason not to rely on Dr. Stringham's assessment that claimant has a chronic back condition related to his December 1993 injury. Dr. Stringham's opinion is based on a complete and accurate history and is consistent with claimant's clinical course. Further, unlike Dr. Mayhall, Dr. Stringham had the opportunity to examine claimant and evaluate his low back condition over time. Consequently, we conclude that claimant's December 1996 exacerbation and need for treatment is compensably related to his December 1993 injury.

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."

ORS 656.308(1) 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). 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.

In this case, the evidence fails to establish that claimant sustained a "new compensable injury" (or a new occupational disease) while working for Liberty's insured. Dr. Stringham specifically opined that claimant suffered no new injury but only a temporary exacerbation of his underlying chronic back condition. Dr. Mayhall assumed that claimant experienced an acute lumbosacral strain in December

1996 with a lifting maneuver, but this assumption is not consistent with claimant's testimony that his worsened pain developed gradually as he was going about his regular duties and without any specific inciting incident. Consequently, on this record, we conclude that responsibility for medical services related to claimant's December 1996 exacerbation of neck and back symptoms remains with SAIF.[1]

Because we have found that SAIF remains responsible for claimant's need for treatment, we reverse that part of the ALJ's order which assessed a $1,000 attorney fee against Liberty under ORS 656.308(2)(d). Instead, we find that claimant's attorney is entitled to an assessed fee payable by SAIF under ORS 656.308(2)(d) for prevailing over SAIF's responsibility denial. We further conclude that a $1,000 fee is warranted, considering the value of the interest involved, the results achieved, the risk that claimant's counsel might go uncompensated and the time spent in litigating the issue.[2]

Claimant's attorney is also entitled to an attorney fee for services at hearing concerning the issue of compensability.[3] 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 compensability issue at hearing is $1,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel might go uncompensated.

ORDER

The ALJ's order dated October 28, 1997 is reversed. Liberty's March 6, 1997 responsibility denial is reinstated and upheld. The SAIF Corporation's compensability and responsibility denials of claimant's current cervical, thoracic and lumbar strains are set aside, and the claim is remanded to SAIF for processing according to law. In lieu of the ALJ's $1,000 assessed fee against Liberty, SAIF shall pay claimant a $1,000 assessed fee for prevailing over its responsibility denial. In addition, claimant's counsel is awarded $1,000 for services related to the compensability dispute, payable by SAIF.

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[1] Because of the parties' CDA, claimant has relinquished all rights to benefits under the SAIF claim except medical services. See ORS 656.236(1); Jeffrey B. Trevitts, 46 Van Natta 1767 (1994), aff'd Trevitts v. Hoffman-Marmolejo, 138 Or App 455 (1996).

[2] Claimant has not requested an extraordinary attorney fee, nor have we found extraordinary circumstances warranting an increased award under ORS 656.308(2)(d). See Foster-Wheeler Constructors, Inc., v. Smith, 151 Or App 155 (1997) (absent extraordinary circumstances, the $1,000 attorney fee limit of ORS 656.302(2)(d) applicable to the portion of the proceeding involving responsibility regardless of whether responsibility is the only issue).

[3] Because our order has reversed the ALJ's determination that claimant sustained a "new compensable injury" while working for Liberty's insured, and has instead found that SAIF remains responsible (for medical services only) related to claimant's condition, our order results in a reduction of claimant's compensation. Therefore, claimant is not entitled to an attorney fee under ORS 656.382(2) for services on review. See, e.g., James D. Ortner, 50 Van Natta 29, 31 (1998).

In the Matter of the Compensation of
GEORGE E. SIMS, Claimant
WCB Case Nos. 96-11333 & 96-09345
ORDER ON REVIEW
Kasia Quillinan, Claimant Attorney
Hoffman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Poland's order that: (1) set aside its denials of claimant's low back injury claims; and (2) assessed penalties and/or an attorney fee for its allegedly unreasonable and/or untimely claim processing. On review, the issues are compensability and penalties. We reverse in part, modify in part, and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," through page 3.

CONCLUSIONS OF LAW AND OPINION

Claimant has long-standing progressive low back spondylolisthesis, first diagnosed at L5-S1 in 1974.

Claimant began working for the employer in 1990 as an industrial refrigeration maintenance worker. On June 12, 1994, he sustained a compensable injury when he slipped and fell onto his left side. Claimant's post-injury symptoms included left hip and leg pain, low back pain, and paraspinal muscle spasms.

On August 5, 1994, the employer accepted the injury as a left hip strain and left thigh bruise. On August 15, 1994, the employer received a letter from claimant which noted that "low back vertebrae and nerve damage was left out of the [acceptance] letter." (Ex. 9A).

Claimant began treating with Dr. Miller in September 1994. On October 17, 1994, Dr. Miller performed an L5 decompressive laminectomy and medial facetectomy; on January 24, 1995, Dr. Miller performed a repeat L5 decompressive laminectomy with posterolateral fusion from L4 to S1.

On July 7, 1995, during physical therapy, claimant felt a pop in his low back, followed by a sensation of extreme fatigue. Hours later, claimant experienced significant pain and stiffness in his low back, a return of left leg pain, left leg weakness, and numbness in both feet.

On September 4, 1996, the employer issued a denial of "disc herniation at L5-S1 and disk derangement at L3-L4." On February 27, 1997, the employer issued a denial of spondylolisthesis, foraminal stenosis, degenerative disc disease, left hip bursitis, disc bulge at L4-5 with disc space narrowing, L4-5 deficit, and neurogenic claudication. Claimant requested a hearing.

Compensability

The ALJ set aside the employer's denials, finding the opinion of Dr. Miller, treating surgeon, to be the most persuasive.

We agree with the ALJ that Dr. Miller's opinion regarding causation is the most persuasive, as explained in the Opinion and Order. In addition, we find that Dr. Miller's conclusion that claimant's June 12, 1994 fall at work is the major cause of his need for the October 1994 and January 1995 low back surgeries (to relieve nerve compression due to spondylolisthesis, or slippage, of the lumbar spine bones) is the most consistent with claimant's clinical course. In this regard, we note that claimant performed fairly strenuous work for 16 years after his 1974 and 1975 back injuries (without medical treatment for his back).

Claimant did have a long-standing history of chronic low back pain before the 1994 injury. However, he first experienced acute left leg symptoms after the work injury. (Tr. 17-18). Moreover, although claimant also has preexisting degeneration (which has contributed to his spondylolisthesis), Dr. Miller explained that the nerve impingement caused by the work injury's effect on the spondylolisthesis was the specific and primary cause of the need for treatment for the combined condition. (See Ex. 40-12-20). Dr. Miller also explained that claimant's left leg symptoms need not have occurred immediately after the work injury, for their cause to be trauma-induced. (Ex. 40-51-52). Thus, even though such symptoms were not medically documented until July 27, 1994, we conclude that Dr. Miller's opinion is consistent with claimant's history and well-reasoned. (See Ex. 40-54).

Accordingly, based on Dr. Miller's persuasive opinion, we conclude that claimant has established that his 1994 work injury was the major contributing cause of his need for surgery for low back spondylolisthesis. See ORS 656.005(7)(a)(B); SAIF v. Nehl, 148 Or App 101, on recon, 149 Or App 309 (1997). In addition, again based on Dr. Miller's persuasive opinion, we agree with the ALJ that claimant's work injury and treatment therefore (including physical therapy) were the major cause of his disability and need for treatment for his low back disc derangement(s) (at L3-4, L4-5, and/or L5-S1) after his surgeries. (See Ex. 40-38-43). See ORS 656.005(7)(a)(A).

However, we modify the ALJ's order, based on the following reasoning. Claimant has established a compensable low back spondylolisthesis condition and a (post-surgery, L3-4, L-4-5, and/or L5-S1) disc derangement condition. He has not proven compensable degenerative disease, bursitis, or neurogenic claudication. Accordingly, we modify the ALJ's order to indicate that the denials are set aside only to the extent that they deny spondylolisthesis (the condition which required surgery) and low back disc derangement(s) (the cause of claimant's post-surgery disability and/or need for treatment).

Penalties and Attorney Fees

We agree with the ALJ that claimant's May 29, 1996 and July 25, 1996 letters do not support a penalty because there is no evidence establishing when (or whether) the employer received them. Thus, because we cannot say when the 90-day statutory period for investigating claims commenced running in this case, the employer's failure to respond does not support a penalty for untimely processing. See Cameron D. Scott, 44 Van Natta 1723, 1724 (1992); Terrance A. Benboe, 42 Van Natta 298, 302 (1990). Accordingly, because we agree that claimant has not established entitlement to a penalty on this basis, we adopt the ALJ's opinion in this regard, in the section entitled "Penalties," from page 7 through the first full paragraph on page 8.

The employer argues that claimant's August 12, 1994 letter, (Ex. 9A), was insufficient to constitute a request for an amended claim acceptance. We disagree.

When claimant wrote the letter, the employer had only accepted a "left hip strain and left thigh bruise" (Ex. 9), and evidence of low back injury was available to the employer. (Exs. 3, 4, 6). Under these circumstances, the employer's failure to timely respond to claimant's August 12, 1994 letter referencing an unaccepted low back claim (which we find compensable) constituted an "unreasonable delay" under ORS 656.262(11)(a). Accordingly, we adopt the ALJ's opinion in this regard (the last 2 paragraphs on page 8).

The ALJ also assessed a $500 "penalty-related" attorney fee based on a finding that the employer failed to timely processing claimant's claims for mileage, aquatic therapy, and medication expenses (and/or reimbursement for these expenses).

The employer argues that the record does not establish that it received claims for these expenses more than 90 days before its September 4, 1996 denial. (See Exs. 19 F, 19G, 20A, 22B, 24B, 29A, 42, 43). We agree and conclude that no processing infraction is proven on these bases. See Cameron D. Scott at 1724; Terrance A. Benboe at 302. Accordingly, we reverse the portion of the ALJ's order that assessed a penalty-related attorney fee on this basis.

Claimant's attorney is entitled to an assessed fee for services on review devoted to successfully defending against the employer's appeal regarding the spondylolisthesis and disc derangement 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 these issues is $1,500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interests involved.

ORDER

The ALJ's order dated October 31, 1997 is reversed in part, modified in part, and affirmed in part. That portion of the order that assessed a $500 "penalty-related" attorney fee is reversed. That portion of the order that set aside the self-insured employer's denials is modified. The denials are set aside only insofar as they denied claimant's low back spondylolisthesis and disc derangements at L-3-4, L-4-5 and/or L5-S1. The remainder of the order is affirmed. For services on review regarding the compensability issues, claimant is awarded a $1,500 attorney fee, payable by the employer.

In the Matter of the Compensation of
LAURA A. ARRANT, Claimant
WCB Case Nos. 97-00399 & 97-00398
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Hall and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that: (1) upheld Giesy, Greer & Gunn's (Giesy's) denial of her occupational disease claim for a right elbow condition; and (2) upheld the SAIF Corporation's denial of her occupational disease claim for the same condition. On review, the issues are compensability and, potentially, responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, which are summarized below.

Claimant, whose job duties primarily involved telephone and computer data entry work, first developed right elbow pain after striking the elbow against her refrigerator at home in December 1994. After she began working overtime in January 1995, her right elbow pain increased and she sought treatment from her family physician, Dr. Sanford, in March 1995. He diagnosed right lateral epicondylitis and provided conservative treatment.

Claimant continued to work and regularly wore an elbow brace, but her right elbow pain increased. In September 1995, Dr. Sanford injected the elbow with cortisone, and claimant took a week of vacation from work to rest the elbow. She continued to take anti-inflammatories through November 1995. Thereafter, her right elbow pain subsided and the elbow was asymptomatic for approximately nine months.

Effective January 1, 1996, the employer transferred its insurance coverage from SAIF to Giesy. Claimant's job duties remained the same.

After performing some overtime work in June 1996, claimant's right elbow pain reappeared in July 1996. The pain was similar to, and in the same location as, the earlier elbow pain in 1995. Claimant returned to Dr. Sanford and was referred to Dr. Wilson, a hand surgeon. Treatment was conservative. Claimant filed a claim for the right elbow condition with the employer, which was denied by SAIF and Giesy.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant was an unreliable historian and disbelieved her testimony that she had the onset of right elbow pain before the refrigerator incident in December 1994. Finding, instead, that claimant's elbow pain began with the refrigerator incident, the ALJ concluded that claimant had a right elbow pain condition which preexisted her work activities and that her right elbow "disease" claim was based on the worsening of that preexisting condition. Applying ORS 656.802(2)(b), the ALJ concluded that claimant did not carry her burden to prove that her work activities were the major contributing cause of the "combined condition" and pathological worsening of the preexisting disease. The ALJ therefore concluded that claimant's right elbow claim was not compensable.

While we agree with, and adopt, the ALJ's conclusions and opinion with regard to the right elbow condition that required treatment from March 1995 through November 1995, we disagree with his conclusions and opinion with regard to the "recurrent" right elbow condition that began in about July 1996. For the reasons stated below, we conclude that claimant proved an occupational disease claim based on the recurrent elbow condition.

The medical experts who rendered causation opinions in this case, Drs. Tesar and Wilson, both opined that claimant had a complete resolution of her right lateral epicondylitis in about November 1995, following the cortisone injection by Dr. Sanford in September 1995. (Exs. 15B-7, 17). In deposition, Dr. Wilson adhered to his opinion that the right elbow condition had "completely resolved"

in 1995, based primarily on the history that the right elbow was asymptomatic for approximately nine months. (Ex. 18-24). Drs. Tesar and Wilson also agreed that the recurrence of claimant's right lateral epicondylitis in July 1996 constituted a "new" condition. (Exs. 15B-7, 17, 18-14, 18-15). Dr. Tesar went on to opine that, given the complete resolution of claimant's 1995 right elbow condition, the 1995 condition had "absolutely no bearing on [claimant's] current condition." (Ex. 15B-9).

On review, Giesy contends that Dr. Tesar's and Dr. Wilson's opinions that there was a complete resolution of the 1995 elbow condition, were premised on the incorrect assumption that claimant's right elbow was asymptomatic for approximately nine months. Giesy argues that, according to claimant's statement to Giesy's investigator in October 1996, her right elbow pain disappeared for only a few weeks in October and November 1995. Giesy further argues that claimant reported having elbow pain in late 1995 and early 1996 but did not seek treatment. We disagree with Giesy's arguments.

After reviewing claimant's statement to Giesy's investigator, we find claimant's statements regarding her "post-November 1995" right elbow condition to be ambiguous and somewhat confusing. Claimant stated that her elbow symptoms disappeared "for several weeks" and that her symptoms through October and November 1995 "weren't bad." (Ex. 9A-25). Claimant did not say, however, that she continued to have right elbow symptoms after November 1995. (Id.)

Because claimant's statement is unclear regarding her symptomatic course after November 1995, we rely on her earlier history to Dr. Wilson that the cortisone injection "almost completely relieved the [elbow] pain for almost nine months" and that in July 1996 "she began having [elbow] pain again." (Ex. 8). Claimant's history to Dr. Wilson is entirely consistent with the history she provided to Dr. Tesar, (Ex. 15B-2), and her testimony at hearing, (Tr. 21-23). Therefore, based on the greater weight of the evidence in this record, we find that claimant had a complete resolution of the initial onset of right lateral epicondylitis for approximately nine months. Accordingly, we conclude that the second onset of right lateral epicondylitis in June 1996 represented a new and distinct disease.

To establish the compensability of the "new" disease, claimant must prove that her work activities were the major contributing cause of the recurrent right lateral epicondylitis in 1996. See ORS 656.802(2)(a).[1] On this issue, the medical evidence is divided. Dr. Tesar opined that the right lateral epicondylitis in 1996 "developed spontaneously." (Ex. 15B-9). Though acknowledging that the work exposure after December 1995 "may be" the major contributing cause, Dr. Tesar could not relate the condition to claimant's work activities because her level of work activity apparently had not changed in 1996. (Id.)

Dr. Wilson wrote: "[Claimant's] work exposure after December 31, 1995 does appear to be the major contributing cause for her current condition and need for treatment." (Ex. 17). Dr. Wilson adhered to that opinion in his deposition. (Ex. 18, pp. 20-21).

After reviewing the medical opinions, we find Dr. Wilson's opinion to be more persuasive. Dr. Tesar appeared to base his causation opinion on the absence of a change in claimant's work activity in 1996. (Ex. 15B-9). However, claimant testified that she worked overtime in June 1996. (Tr. 23). Her testimony on the particular point was not rebutted by her former supervisor, Ms. Webb, who also testified at hearing. (Tr. 52). Based on claimant's unrebutted testimony, we find that there was a change in work activity prior to the recurrence of the epicondylitis condition. Because Dr. Tesar had an inaccurate history, the probative value of his opinion must be discounted. Instead, we rely on Dr. Wilson's opinion, which was well reasoned and based on complete information.[2] See Somers v. SAIF, 77 Or App 259, 263 (1986). Therefore, we conclude that claimant has established an occupational disease claim under ORS 656.802(2)(a) based on her right lateral epicondylitis condition that required

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[1] Based on our finding that claimant's prior episode of epicondylitis in 1995 had completely resolved, we do not find that claimant's 1996 episode of epicondylitis was "based on the worsening of a preexisting condition." Therefore, the 1996 disease claim is subject to ORS 656.802(2)(a), rather than ORS 656.802(2)(b).

[2] Giesy argues that Dr. Wilson's opinion regarding the cause of the second episode of epicondylitis is unpersuasive because he was provided history that claimant's first episode of epicondylitis was caused by overtime work in December 1994, rather than the refrigerator incident. We disagree. Inasmuch as Dr. Wilson assumed (correctly) that claimant's first episode of epicondylitis had completely resolved, we find that the circumstances surrounding the onset of the first episode had virtually no relevance to the issue of causation of the second episode.

treatment beginning in July 1996. Because Giesy was the carrier on the risk during claimant's employment after 1995, and the "post-1995" work activities have been implicated as the major contributing cause of the recurrent epicondylitis condition, claimant has established that her employment conditions while Giesy was on the risk were the "actual cause" of her condition. Accordingly, Giesy is the responsible carrier and its denial shall be set aside.

Claimant's attorney is entitled to an assessed fee for prevailing over Giesy's denial. See ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review regarding the compensability of claimant's second episode of epicondylitis is $3,500, to be paid by Giesy. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearing record and appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney's services may have gone uncompensated. Claimant's attorney is not entitled to an assessed fee for services devoted to the issue of the compensability of the first episode of epicondylitis in 1995.

ORDER

The ALJ's order dated December 10, 1997 is reversed in part and affirmed in part. The portion of the ALJ's order that upheld Giesy's denial of claimant's occupational disease claim is reversed. Giesy's denial is set aside to the extent that it denied claimant's occupational disease claim for recurrent right lateral epicondylitis in 1996, and the claim for that condition is remanded to Giesy for processing according to law. The ALJ's order is otherwise affirmed. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $3,500, payable by Giesy.

April 23, 1998 Cite as 50 Van Natta 795 (1998)

In the Matter of the Compensation of
DAVID E. HORTON, Claimant
WCB Case No. 97-01863
ORDER ON RECONSIDERATION
Daniel M. Spencer, Claimant Attorney
Zimmerman, et al, Defense Attorneys

The insurer requests reconsideration of our March 27, 1998 Order on Review that set aside its denial of claimant's current right knee condition on the ground that the denial was an improper pre-closure denial. In response, claimant asserts that the insurer's denial was procedurally improper.

The insurer first argues that we failed to explain the basis of our finding that the denial was pre-closure. In this regard, relying on Chaffee v. Nolt, 94 Or App 83 (1988), the insurer argues that because the denial issued the same date as the Notice of Closure, the denial cannot be considered a pre-closure denial. Based on the following reasoning, we find Chaffee distinguishable and we adhere to our conclusion that the denial was an improper pre-closure denial.

As the insurer argues, the claim was closed on the same date it was denied. The worksheet attached to the February 25, 1997 Notice of Closure indicates that the claim was denied. Based on the worksheet, we find that the denial preceded the closure. We further note that the worksheet attached to the Notice of Closure gives no medically stationary date. Normally, a worker must be medically stationary prior to claim closure. One exception to this general rule is contained in ORS 656.268(1)(a). That statute provides, in relevant part:

> "(1) * * * Claims shall not be closed if the worker's condition has not become medically stationary unless:
>
> "(a) The accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005(7) * * *."

Based on this record, we are persuaded that the claim was closed following issuance of a pre-closure denial pursuant to ORS 656.268(1)(a).

Furthermore, the pre-closure denial was improper under the circumstances of this claim. As we noted in our initial order, ORS 656.262(7)(b) allows a "pre-closure" denial when the denial is based on the combined condition no longer being compensable under ORS 656.005(7)(a)(B). See Marianne L. Sheridan, 48 Van Natta 908 (1996). As we found in our original order, ORS 656.262(7)(b) is not applicable to this claim because the employer did not accept a combined condition.[1] See Robin W. Spivey, 48 Van Natta 2362 (1996) (ORS 656.262(7)(b) is applicable only when the carrier has accepted a combined condition). In this case, the insurer accepted a right knee "strain," not a combined condition involving claimant's preexisting right knee condition.

The insurer argues that under Chaffee v. Nolt, the denial should not be considered pre-closure. In Chaffee, the employer issued a claim denial three days before claim closure. The court held that, in view of the employer's prompt closure of the claim immediately after the issuance of the denial, it did not appear that the employer's conduct was intended to shortcut the ordinary process of claim closure or was otherwise unreasonable. Chaffee, 94 Or App at 85. Thus, although the denial was considered to be an improper prospective denial, the court concluded that the Board had not erred in addressing the merits of the denial. We find Chaffee distinguishable.

Here, in contrast to Chaffee, we are persuaded that the insurer's conduct in issuing its denial prior to its Notice of Closure did shortcut the claim closure process. In this regard, by improperly issuing a denial under ORS 656.262(7)(b) and by then closing the claim under ORS 656.268(1)(a), the employer was able to close the claim prior to claimant becoming medically stationary. Cf. Chaffee, 94 Or App at 85 (court affirms Board's finding that the claimant's condition was medically stationary at the time of closure). As explained above, since no combined condition had been accepted, the claim had to be closed following the normal procedures for closure under ORS 656.268 for claimant's accepted strain claim. See Spivey. In other words, since there was no indication that claimant was medically stationary, this claim would not have qualified for claim closure under the normal provisions of ORS 656.268 . See ORS 656.268(1). The issuance of the pre-closure denial in this case allowed the insurer to bypass the normal process of claim closure. Under the circumstances of this claim, where no combined condition had ever been accepted by the insurer and the record does not support a conclusion that claimant's accepted strain is either separable from his current condition or medically stationary, a denial of the current condition was improper until the claim qualified for claim closure.

As we concluded in our initial order, while a "pre-closure" denial may be appropriate when the worker's current condition is completely separate from, or unrelated to, the accepted condition, this case does not present that scenario. Rather, as the employer's denial states, while the accepted strain claim was in open status, the injury claim contributed to claimant's disability and need for treatment. Therefore, on this record, we cannot find that claimant's current condition is completely separate from, or unrelated to, the accepted open low back strain claim. Compare Zora A. Ransom, 46 Van Natta 1287 (1994) (preclosure denial was proper where the medical evidence "unequivocally" indicated that the claimant's current condition was not related to the accepted condition). Accordingly, we continue to find the employer's pre-closure denial procedurally invalid and it shall remain set aside.

The insurer notes that claimant's appeal from a "post-hearing" Order on Reconsideration which affirmed the Notice of Closure was ultimately dismissed by an ALJ in a separate proceeding. The insurer argues that the Board has no jurisdiction over the closure notice and cannot "go behind" the closure notice by finding the denial to be an improper "pre-closure" denial. We agree with the insurer that the claim closure is not before us in this proceeding. The specific issue raised by the parties in this case was the propriety of the denial. We have limited our decision to that issue. Issues or questions regarding how our decision may or may not affect the closure or processing of the claim are not before us and we do not comment on them. See Richard L. Elsea, 47 Van Natta 262 (1995) (Board declined to address the implications of its decision in a responsibility dispute on the future processing of the claim since those issues were outside the scope of the Board's review).

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[1] For this same reason, ORS 656.262(6)(c) (which allows a carrier to deny the claim when the combined condition ceases to be the major contributing cause) is also inapplicable to the employer's denial. See Richard L. Markum, 48 Van Natta 2204 (1996) (ORS 656.262(6)(c) is premised on the carrier's "acceptance" of a combined or consequential condition under ORS 656.005(7), whether that acceptance is voluntary or results from a judgment or order).

Our March 27, 1998 order is withdrawn. As supplemented herein, we republish our March 27, 1998 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
ROBERT B. KAPPA, Claimant
WCB Case No. 97-04343
ORDER ON REVIEW
Hollander, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by the Board en banc.

Claimant requests review of Administrative Law Judge (ALJ) Herman's order that upheld the insurer's denial of claimant's claim for damage to his eyeglasses. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

The parties stipulated that claimant's eyeglasses were damaged as a result of his work activities with the employer. The parties further stipulated that, while claimant was using his glasses at the time they were damaged, claimant himself sustained no injury to his body.

On July 18, 1997, claimant's optician reported that he had examined claimant's glasses and found them to be chemically damaged and not repairable.

CONCLUSIONS OF LAW AND OPINION

The ALJ held that the claim for damage to claimant's eyeglasses was not a "compensable injury." Relying on our decision in Martin J. McKeown, 42 Van Natta 1053 (1990), the ALJ reasoned that the claim was not compensable because the law requires that a claimant sustain a physical injury requiring medical treatment or resulting in disability in order for damage to a prosthetic appliance to be compensable. Here, claimant did not suffer a physical (*i.e.*, bodily) injury. For the reasons discussed below, we conclude that claimant need not suffer a bodily injury in order to establish a compensable claim. Moreover, we conclude that, under the facts of this case, claimant has established a compensable claim for damage to his eye glasses.

Our analysis begins with ORS 656.005(7), which defines a "compensable injury" in part as "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[.]" (Emphasis supplied). The text of the statute is clear. A compensable injury includes either an "accidental injury" or an "accidental injury to prosthetic appliances" so long as the other provisions of the definition are established. Because the statute is stated in the disjunctive, either event is sufficient to produce a compensable injury. Further, assuming that an "accidental injury" implies some form of bodily harm, see Mathel v. Josephine County, 319 Or 235, 240 (1994) (Court references ordinary meaning of the term "injury" as "an act that damages, harms, or hurts"), then an accidental injury to prosthetic appliances would refer to damage, harm or hurt to such an appliance. Here, there is no dispute that claimant experienced damage to a prosthetic appliance. Therefore, we conclude that the term "accidental injury to prosthetic devices" does not, in itself, expressly require accompanying bodily harm.

However, it is possible that other provisions of the statutory definition create an implicit requirement of bodily injury. In order for an accidental injury or an accidental injury to prosthetic devices to be compensable, the injury must either require medical services or result in disability or death. "Disability or death" suggests physical injury. However, because there is no claim of disability or death in this case, the issue is narrowed to whether the requirement of medical services impliedly

necessitates some form of bodily injury. Therefore, we next address the issue whether, absent an accompanying bodily injury, the injury to claimant's eye glasses in this case requires medical services as that term appears in the statute.

There is no statutory definition of "medical services." However, ORS 656.245(1)(a) provides, in part, that for every "compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions caused in material part by the injury for such period as the nature of the injury or the process of the recovery requires...." Additionally, ORS 656.245(1)(b) provides that compensable medical services include "prosthetic appliances." Similarly, ORS 656.245(1)(c)(D) and (E) provide that "[p]rosthetic devices, braces and supports" as well as "[s]ervices necessary to monitor the status, replacement or repair of prosthetic devices, braces and supports" remain "compensable medical services" beyond an injured worker's medically stationary date. Based on this statutory language, we conclude that replacement or repair of prosthetic devices, including eye glasses, constitute medical services.

Finally, we turn to the question whether the circumstances of the injury in this case are such that the injury arose out of and in the course of claimant's employment. In this regard, in McKeown, the claimant's glasses were damaged when they fell out of his pocket while he was bending over to pick up a file at work. We concluded that the claim was not compensable. In doing so, we cited to the relevant administrative rule which provided that:

> "If such a prosthetic appliance is damaged when in use at the time of a compensable injury the cost is a compensable medical expense, regardless of whether the worker actually received a physical injury at the time of the compensable injury." Former OAR 436-60-050(2).[1]

Thus, the applicable administrative rule required that, to be compensable, the prosthetic appliance must be damaged when in use at the time of and in the course of a compensable injury. Relying on the rule, we found that, because the glasses were not in use at the time they were damaged, the claim was not compensable under the rule.

It may be that the requirement that eye glasses be "in use" is consistent with the statutory definition which necessitates that an injury "arise out of and in the course of employment." However, we need not decide that issue in this case because the parties have stipulated that claimant's glasses were damaged as a result of his work activities and that claimant was using his glasses at the time they were damaged. Accordingly, we conclude that claimant has established that the accidental injury to his eye glasses arose out of and in the course of his employment.

In reaching our decision in McKeown, we also cited Larson 3, Workmen's Compensation Law (1987), sec. 42.12, and alternatively reasoned that the claim was not compensable because the claimant did not require medical treatment or suffer disability to his person. To the extent our decision in this case is inconsistent with our alternative reasoning in McKeown, we disavow that rationale.

Consequently, we conclude that, because damage to a prosthetic device (claimant's eyeglasses) is a compensable injury, the insurer must provide medical services for conditions (damage to the glasses) caused by the injury. Accordingly, the claim is compensable under the applicable statutes.

In sum, we hold that a compensable injury can be established by damage to the prosthetic device, regardless of whether the claimant sustains an accompanying physical injury. Moreover, in this case, there is no dispute that claimant was using or wearing his glasses at work when the glasses were damaged and that the damage resulted from the performance of claimant's work activities. Consequently, we conclude that the glasses were damaged at the time of and in the course of a compensable injury. Therefore, the costs of repair or replacement of the eyeglasses is a compensable medical expense.

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[1] The rule has since been renumbered and now provides that:

"The costs of repair or replacement of prosthetic appliances damaged when in use at the time of and in the course of a compensable injury is a compensable medical expense, whether the worker actually received a physical injury. For purposes of this rule, a prosthetic appliance is an artificial substitute for a missing body part or any device by which performance of a natural function is aided, including but not limited to hearing aids and eye glasses." OAR 436-010-0230(10).

Because claimant has established compensability of the claim for replacement or reimbursement for the damage occurring to his eyeglasses at work, we set aside the insurer's denial. Claimant's counsel is entitled to an assessed attorney fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on review regarding the compensability issue is $4,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record, claimant's appellate briefs, and claimant's counsel's statement of services), the complexity of the issue, the value of the interest involved, and the risk that counsel might go uncompensated.

ORDER

The ALJ's order dated November 3, 1997 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant's counsel is awarded an assessed attorney fee of $4,000, to be paid by the insurer.

In the Matter of the Compensation of
LLOYD A. TERPENING, Claimant
WCB Case No. 97-02842
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Moller and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Tenenbaum's order that set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

We do not adopt the ALJ's finding that claimant's job involved repetitive use of his hands for hammering. Instead, we find that claimant's job required use of a hammer, but it is unclear whether the hammer use was repetitive or involved both hands. (Tr. 17).

We also do not adopt the ALJ's findings that claimant's use of pneumatic staple guns required squeezing the trigger repetitively or that two of the three staple guns used by claimant had safety features (that did not require manual triggering to operate). Instead, we find that two of the pneumatic staple guns used by claimant required single triggering to operate; the rest of the (unspecified number of) staple guns used by claimant had a safety feature. (Tr. 18). Use of a staple gun with the safety feature required claimant to hold the trigger down and push the safety plunger to operate the gun. (Id.)

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant had carried his burden of proving, by a preponderance of the evidence, that his work activities were the major contributing cause of his bilateral CTS. In reaching this conclusion, the ALJ found that the opinion of Dr. Gifford was more persuasive than the opinions of Drs. Radecki and Carpenter. On review, the employer argues that the opinion of Dr. Gifford is conclusory and that Dr. Radecki's opinion is more persuasive. We agree and reverse.

To establish his occupational disease claim, claimant must prove that employment conditions were the major contributing cause of the bilateral CTS. See ORS 656.802(2)(a). Determining the "major contributing cause" involves evaluating the relative contribution of different causes of the disease and deciding which is the primary cause. Dietz v. Ramuda, 130 Or App 397, 401 (1994). Based on the

medical record, we find that there are multiple potential causal factors involved in claimant's CTS; therefore, the causation issue presents a complex medical question which must be resolved on the basis of expert medical evidence. See Uris v. Compensation Dept., 247 Or 420, 426 (1967); Barnett v. SAIF, 122 Or App 279, 283 (1993). Claimant has the burden of proving his claim by a preponderance of the evidence. See ORS 656.266.

The medical evidence on causation is divided between the opinion of Dr. Gifford, who supports compensability, and those of Drs. Radecki and Carpenter, who do not. Where the medical evidence is divided, we generally give more weight to those opinions that are both well-reasoned and based on complete information. See Somers v. SAIF, 77 Or App 259, 263 (1986); Michael R. Dowell, 49 Van Natta 1289, 1291 (1997).

After reviewing the record, we find that Dr. Radecki's opinion is the better reasoned opinion and based on complete information. He took a thorough history of claimant's prior injuries and conditions involving the upper extremities and the symptomatic course of claimant's current upper extremity condition. (Ex. 8, pp. 1-3). Dr. Radecki described in detail claimant's current work activities as ceiling builder for a travel trailer manufacturer, and took a thorough history of claimant's prior employment activities. (Id.) He also discussed the force, positioning, and motion required of claimant's fingers, hands and wrists while performing the current work activities. (Id.)

Based on the information obtained during the examination, Dr. Radecki concluded that claimant's current employment activities were not of sufficient force or duration to cause CTS as severe as claimant's. (Ex. 8-5). In particular, he stated that claimant did not perform work activities requiring repetitive flexion and extension of the wrists against high force and that the stapling activity was a low-force activity with much of it accomplished without any wrist or finger movement at all. (Id.) Furthermore, given the symmetry and severity of claimant's median nerve slowing, Dr. Radecki was convinced that the median nerve injuries preexisted claimant's current employment. (Ex. 8-6). Looking to pre-employment causal factors, Dr. Radecki opined, based on his review of medical literature, that claimant's anatomically "very square" wrists were the primary cause of the bilateral median nerve slowing. (Id.) He also opined that claimant's prior history of multiple fractures to the forearms and hands while rodeoing, and his past excessive drinking, were additional factors that could have contributed to the median nerve injury. (Id.) Dr. Carpenter concurred with Dr. Radecki's report. (Ex. 13).

Dr. Gifford received a copy of Dr. Radecki's report and was asked by claimant's attorney whether claimant's CTS was caused in major part by his work activities for the employer. Dr. Gifford marked the "yes" blank and explained "[i]ncreased trauma to area." (Ex. 12-1). Dr. Gifford also answered "yes" when asked whether work activities caused claimant's immediate need for treatment, explaining that, with increased trauma, there is a greater chance of permanent symptoms from swelling and pressure on the median nerve. (Ex. 12-2).

While Dr. Gifford's ultimate opinion supports the claim, he offered little in the way of explanation for his opinion. He indicated that claimant suffered "increased trauma" due to his employment, but he did not respond to Dr. Radecki's explanation of why the particular work activities performed by claimant could not have caused the CTS. He also did not discuss what, if any, impact claimant's prior history of multiple fractures had on his current condition. In short, Dr. Gifford did not persuasively rebut the better reasoned opinion of Dr. Radecki. For this reason, we conclude that claimant did not carry his burden of proof.

The ALJ found several reasons to discount Dr. Radecki's opinion. (O&O p. 5). First, the ALJ stated that Dr. Radecki was unaware that only one of the three pneumatic staplers used by claimant did not require repetitive triggering. However, there is no evidence that claimant used only three pneumatic staplers or that only one of the staplers did not require repetitive triggering. Rather, claimant testified that two of the staplers "were just single triggers," while the "rest of them" had safety features that involved holding the trigger down and "pushing" the safety down. (Tr. 18). Therefore, claimant did not specify how many staplers he used at his current employment. Moreover, his testimony concerning the type of staplers he used is ambiguous. Claimant's unclear testimony is not sufficient to rebut Dr. Radecki's history that "[m]uch of the stapling" was accomplished without wrist or finger movement. (Ex. 8-5).

Second, the ALJ correctly stated that Dr. Radecki did not make reference to claimant's use of a hammer at work, but there is no evidence of how much, or how repetitively, claimant used a hammer at work. Moreover, there is no indication that claimant used a hammer in both hands; therefore, the lack of reference to hammering does not undercut Dr. Radecki's ultimate conclusion that claimant's work activities were not of sufficient force or duration to cause his bilateral CTS.

Third, the ALJ stated that Dr. Radecki did not discuss how claimant's past alcohol abuse could have contributed to the CTS and that the doctor had an inaccurate history regarding claimant's prior injuries. However, neither of those matters was an important factor in the doctor's ultimate conclusion that the current work activities were not of sufficient force or duration to cause claimant's bilateral CTS. It was that particular conclusion that Dr. Gifford failed to rebut. For these reasons, we reverse the ALJ's order and reinstate the denial.

ORDER

The ALJ's order dated November 20, 1997 is reversed. The self-insured employer's denial of claimant's occupational disease claim for bilateral CTS is reinstated and upheld. The ALJ's assessed fee award is reversed.

April 24, 1998 Cite as 50 Van Natta 801 (1998)

In the Matter of the Compensation of
MARSHA ANDERSON, Claimant
WCB Case No. C800881
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Glen J. Lasken, Claimant Attorney
Neil W. Jones, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

On April 15, 1998, 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 her compensable injury. We approve the proposed disposition.

The first page of the proposed disposition agreement provides that the total due claimant is $37,000 and the total due claimant's attorney is $6,000, for a total consideration of $43,000. However, the document provides on the third page, number 12, that the consideration is $49,000. Additionally, the agreement provides in number 21 that "claimant has been paid $6,000 by SAFECO as an advance on the above settlement proceeds. Claimant's net proceeds after subtraction of the advance and attorney fee is $37,000." Thus we conclude that the total consideration for the CDA is $49,000, $43,000 of which is payable to claimant (which includes a $6,000 advanced payment, with the remaining $37,000 payable after approval of the CDA) and $6,000 payable to claimant's counsel as an 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 $6,000, 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
SHANNON E. JENKINS, Claimant
WCB Case Nos. 96-06486 & 96-03275
ORDER OF DISMISSAL
Ernest M. Jenks, Claimant Attorney
Scheminske, et al, Defense Attorneys

Claimant, pro se, requested review of Administrative Law Judge (ALJ) Holtan's July 23, 1997 order. The self-insured employer has moved to dismiss claimant's request for review, contending that claimant did not timely file her request or provide timely notice of her request to the other parties. We dismiss.

FINDINGS OF FACT

On July 23, 1997, ALJ Holtan issued his Opinion and Order that upheld denials of compensability for the left knee. The order contained a statement explaining the parties' rights of appeal, including a notice that, within 30 days of the ALJ's order, a request for review must be mailed to the Board with copies of the request mailed to all other parties.

On August 26, 1997, the Board received claimant's August 21, 1997 request for Board review. The request, which was contained in an envelope with an August 23, 1997 postmark date, indicated that copies had been mailed to the employer and the employer's attorney.

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 July 23, 1997 order was Friday, August 22, 1997. Therefore, August 22, 1997 was the final day to perfect a timely request for review of the ALJ's order. Claimant's request was *dated* August 21, 1997. However, the request was not *received* by the Board until August 26, 1997, more than 30 days from the ALJ's July 23, 1997 order.[1] Consequently, claimant's request for review must be dismissed as untimely filed with the Board.

Moreover, there is no indication that the other parties to the proceeding before the ALJ were provided with a copy, or received actual knowledge, of claimant's request for review within the statutory 30-day period. Instead, based on the employer's counsel's affidavit, the copy of claimant's request that the employer received was not mailed to the employer on or before August 22, 1997. Consequently, the record does not establish that the other parties received notice of claimant's request for Board review within 30 days of the ALJ's July 23, 1997 order. *See John E. Bafford*, 48 Van Natta 513 (1996).

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[1] The "postmark" date on the envelope containing claimant's request for review indicates that the envelope was mailed on August 23, 1997. Nonetheless, even if we considered this date as the "filing" date, claimant's request would still be untimely because the request was not mailed by August 22, 1997.

Finally, we are mindful that claimant has apparently requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. However, instructions for requesting review were clearly stated in the ALJ's order. Moreover, we are not free to relax a jurisdictional requirement. *Alfred F. Puglisi*, 39 Van Natta 310 (1987); *Julio P. Lopez*, 38 Van Natta 862 (1986).

Under such circumstances, we conclude that claimant's request was neither filed with the Board nor was notice of the request provided to the other parties within 30 days of the ALJ's July 23, 1997 order. Consequently, we lack jurisdiction to review the ALJ's order, which has become final by operation of law. ORS 656.289(3); 656.295(2).

Accordingly, based on the foregoing reasoning, claimant's request for Board review is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
GINA E. LAMERE, Claimant
WCB Case Nos. 97-06585 & 97-06315
ORDER ON REVIEW
Rasmussen, Tyler, et al, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Hall and Bock

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that set aside its denial of claimant's occupational disease claim for a head, neck, shoulder, arm, and upper back condition. Claimant requests reconsideration of the Board's decision to grant the employer's motion to strike her respondent's brief as untimely. On review, the issues are motion to strike and compensability. We adhere to our decision to grant the motion to strike, and affirm.

FINDINGS OF FACT

Claimant's head, neck, shoulder, arm, and upper back symptoms have been variously diagnosed as fibromyalgia, myofascial pain and lateral epicondylitis.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Claimant requests reconsideration of the Board's decision to grant the employer's motion to strike her respondent's brief as untimely. Pursuant to OAR 438-011-0020(2), a party's respondent's brief must be filed within 21 days after the date of mailing of the appellant's brief. Here, claimant concedes that her respondent's brief was untimely. Nevertheless, she argues that the Board should consider her brief because "a thorough review of the evidence and arguments before it can only lend credence and finality to its decision." We treat claimant's argument as a motion for waiver of our rules. See OAR 438-011-0030. We may grant such a motion only if extraordinary circumstances beyond claimant's control prevented her from filing the respondent's brief in a timely manner. Claimant has not established such extraordinary circumstances in this case. Accordingly, we decline to waive our rule and do not consider claimant's respondent's brief in deciding this case.

Compensability

We adopt and affirm the ALJ's conclusion and analysis regarding the compensability issue.

ORDER

The ALJ's order dated December 8, 1997 is affirmed.

In the Matter of the Compensation of
STEPHEN B. MURPHY, Claimant
WCB Case Nos. 97-06835, 97-00801 & 96-07154
ORDER ON REVIEW
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) dismissed claimant's hearing requests regarding his mental disorder claim against the SAIF Corporation; and (2) found that claimant had not established a compensable mental disorder claim arising from his employment exposure for PIE Nationwide, Inc.(PIE), while it was a self-insured employer. On review, claimant contends that PIE is responsible for his stress condition and that he is entitled to permanent total disability benefits.

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

In support of his contention that PIE is responsible for his mental disorder claim, claimant contends that PIE did not forward to SAIF claim information/medical evidence in support of his claim. We interpret claimant's argument as a motion to remand to the ALJ for introduction of further evidence.

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. Terrell G. Lee, 49 Van Natta 2041, 2042 (1997).

Here, claimant did not object when the ALJ closed the record based on evidence submitted at the hearing. Claimant specifically agreed that the ALJ had all the necessary documentary information. (Tr. 8). Claimant did not object to any of the proposed exhibits. (Tr. 10). Under such circumstances, we do not find that the record was improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Thus, we find no compelling reason to remand.

Finally, claimant seeks an award of permanent total disability. However, such benefits are unavailable in the absence of a compensable claim. In this case, claimant does not have a compensable claim with either SAIF or PIE. Therefore, claimant cannot receive an award of permanent total disability, even assuming he otherwise met the requirements of the permanent total disability statute, ORS 656.206.

ORDER

The ALJ's order dated November 21, 1997 is affirmed.

In the Matter of the Compensation of
MISTY M. PILTZ, Claimant
WCB Case No. 97-01290
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Thaddeus J. Hettle, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Schultz' order that: (1) upheld the self-insured employer's "back-up" denial of claimant's right gluteal hamstring strain injury claim; and (2) affirmed the employer's acceptance of claimant's L4-5 disc condition under claimant's August 15, 1995 injury claim rather than her June 22, 1996 injury claim. On review, the issues are propriety of the "back-up" denial and compensability. We affirm.

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 works as a bus driver for the employer. On August 15, 1995, she injured her low back when the seat of the bus she was driving suddenly "bottomed out." The initial diagnosis was a sacral coccyx strain. On November 10, 1995, the employer issued a written acceptance of a disabling sacral coccyx strain. (Ex. 26).

After receiving medical treatment over a period of about eight months, claimant was found medically stationary by Dr. Lorish, treating physician, on April 11, 1996. (Ex. 43). At that time, Dr. Lorish's impression was that claimant had a "resolved lumbar strain/herniated disc/ischeal bursitis." (Ex. 43). Claimant's August 15, 1995 claim was closed by Notice of Closure issued on May 10, 1996 and amended on May 30, 1996. (Exs. 44, 45).

On June 22, 1996, claimant drove a bus with a seat that was not adjustable. In order for her feet to reach the pedals, claimant had to sit in an awkward, twisted position for approximately 45 minutes until another bus was available. As a result, claimant began experiencing pain going down the back of her right leg to the knee. Claimant filed an 801 form regarding this incident. (Ex. 46). On July 11, 1996, she returned to Dr. Lorish, who diagnosed a gluteal hamstring strain. (Ex. 48).

On August 27, 1996, an MRI revealed a large disc herniation at L5-S1. (Ex. 52). As the result of increased symptoms, including right foot drop, claimant underwent a right L4-5 hemilaminotomy and microdiscectomy on August 30, 1996, performed by Dr. Calhoun. (Ex. 56).

On September 12, 1996, the employer accepted the June 22, 1996 injury claim as a nondisabling right medial hamstring strain. (Ex. 61). After receiving medical reports regarding the cause of claimant's condition after the June 22, 1996 incident, the employer issued a "back-up" denial on December 16, 1996. (Ex. 73). Two days later, on December 18, 1996, the employer issued an amended Notice of Acceptance accepting a disabling L4-5 disc herniation as part of the August 15, 1995 injury claim. (Ex. 76).

Claimant requested a hearing, contending that the December 16, 1996 "back-up" denial was improper and her L4-5 disc herniation condition should be accepted under the June 22, 1996 injury claim. The ALJ rejected both contentions, upholding the "back-up" denial and finding the L4-5 disc herniation condition was properly accepted under the August 15, 1995 injury claim. We agree with the ALJ.

Back-up Denial

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

We disagree with the employer's characterization of its December 16, 1996 "back-up" denial as a "partial denial." That "back-up" denial clearly states that the employer denies "the June 22, 1996 industrial injury of a right gluteal hamstring strain" and claimant's "claim of June 22, 1996 for benefits." (Ex. 73). A "partial denial," by definition, means something in the claim remains accepted. Here, the employer initially accepted a "right gluteal hamstring strain" injury regarding the June 22, 1996 injury claim and denied that same condition in its "back-up" denial. (Exs. 61, 73). Although the "back-up" denial notes that "[a]ll benefits related to the hamstring complaint's, [sic] have been and will continue to be paid under [claimant's] accepted claim of August 15, 1995," the fact is, after that "back-up" denial, nothing remains accepted regarding the June 22, 1996 injury claim.

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 (i.e., a "back-up" 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.

Prior to the employer's September 12, 1996 acceptance, Dr. Lorish diagnosed and treated claimant for a gluteal hamstring strain and released her to continue her regular work. (Exs. 48, 50). Dr. Lorish also filed an 827 form with the employer's claims processing agent for a gluteal/hamstring strain. (Ex. 51). Although claimant had increased pain upon awakening on August 26, 1996, underwent a MRI the next day that revealed a large herniated disc at L4-5, and underwent emergency surgery on August 30, 1996, no medical evidence initially attributed these events to the June 22, 1996 work incident. (Exs. 52, 53, 56).

The first indication that claimant's current complaints were caused by a disc herniation related to the August 15, 1995 injury was presented on October 10, 1996. (Ex. 66). On that date, Dr. Rosenbaum, neurologist, examined claimant on behalf of the employer and opined that the primary cause of claimant's symptoms, which had initially been diagnosed as a gluteal hamstring strain, was the L4-5 disc herniation, which was caused in major part by the earlier August 15, 1995 injury. On November 26, 1996, and December 3, 1996, respectively, both Drs. Lorish and Calhoun concurred with Dr. Rosenbaum's opinion. (Exs. 69, 70, 71).

Thus, after the employer's September 12, 1996 acceptance of a nondisabling gluteal hamstring strain injury, unrebutted medical evidence from all three physicians, including claimant's treating physicians, agreed that the cause of claimant's need for treatment was the L4-5 disc herniation caused by the August 15, 1995 injury, not a gluteal hamstring strain injury allegedly caused by the June 22, 1996 incident.

On this record, we find that the employer has met its burden of proof, through later obtained evidence, that the "gluteal hamstring strain" injury claim is not compensable. Therefore, we agree with the ALJ that the employer's December 16, 1996 "back-up" denial was proper.[1]

Compensability

The parties agree that claimant's L4-5 disc herniation condition is compensable. In fact, on December 18, 1996, the employer accepted that condition as part of the August 15, 1995 claim. However, claimant argues that the herniation condition should be accepted as part of the June 22, 1996 claim. The ALJ resolved the issue using an "aggravation versus new injury" analysis and concluded the herniation condition was an aggravation of the August 15, 1995 low back injury. We agree that claimant's L4-5 disc herniation condition is compensable as part of the August 15, 1995 claim, as accepted by the employer. However, given our decision that the employer's "back-up" denial was a "full" denial, not a "partial" denial, with nothing remaining accepted regarding the June 22, 1996 injury claim, and our decision upholding that denial, we find no need to separately address whether the disc herniation condition is compensable under the June 22, 1996 claim. After all, that condition was

[1] Moreover, Dr. Lorish later further explained that the symptoms for which he treated claimant in July 1996 were due to the L4-5 disc herniation, which was caused in major part by the August 15, 1995 injury, and not a new gluteal hamstring strain due to her work activities in 1996. (Ex. 80).

accepted as part of the August 15, 1995 injury claim, and it has been determined, as addressed above, that no separate injury occurred in the June 22, 1996 claim. In other words, our upholding the "back-up" denial of compensability renders moot the issue of whether the June 22, 1996 work incident bears responsibility for claimant's disc herniation condition.

ORDER

The ALJ's order dated June 16, 1997, as amended on July 24, 1997, is affirmed.

April 24, 1998 Cite as 50 Van Natta 807 (1998)

In the Matter of the Compensation of
JOSE A. REGALADO, Claimant
WCB Case No. 97-07220
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Mongrain's order that: (1) affirmed an Order on Reconsideration that awarded claimant 20 percent (30 degrees) scheduled permanent disability for loss of use or function of the right forearm (wrist); and (2) awarded claimant's attorney an assessed fee of $3,000. On review, the issues are extent of scheduled permanent disability and attorney fees. We affirm.

FINDINGS OF FACT

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

On November 1, 1996, claimant, who is right hand dominant and drove a Hyster and stacked lumber for the employer for seven years, sought treatment for complaints of pain along the volar surface of his right wrist radiating up to the elbow, and occasional paresthesias in the third, fourth and fifth fingers. The insurer accepted disabling "right wrist tendinitis."

In mid-January 1997, Dr. Weinman became claimant's attending physician. Weinman referred claimant to Dr. Grant for an EMG of both upper extremities. Dr. Grant ruled out a neurologic problem, and diagnosed claimant's condition as chronic right volar wrist flexor tendinitis.

Claimant continued to complain of forearm swelling, right wrist pain, and radicular pain to the third, fourth and fifth fingers. Dr. Weiner had no suggestions for treatment and referred claimant to Dr. Murdock for a second opinion. Murdock made findings regarding claimant's impairment and concluded that the diagnosis of right volar wrist flexor tendinitis was appropriate. Dr. Weinman concurred with Murdock's examination.

The insurer issued a Notice of Closure on April 10, 1997 that awarded no permanent disability. Claimant requested reconsideration, and, based on Dr. Neumann's arbiter examination, an August 29, 1997 Order on Reconsideration awarded 20 percent scheduled permanent disability for the right forearm (wrist). The insurer requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Extent of Scheduled Permanent Disability

We adopt and affirm the ALJ's opinion on this issue, with the following supplementation to respond to the insurer's arguments on review.

The Order on Reconsideration, which relied on the medical arbiter's report, indicated that the award was for reduced range of motion in the right wrist (not in dispute here), loss of sensation in the long, ring and little fingers, reduced strength in the ulnar nerve innervated muscles, and significant restriction in the repetitive use of the right wrist. (Ex. 32-2). See OAR 436-035-0110(2)(a), 436-035-0007(18), and 436-035-0010(5).

The ALJ found that the preponderance of medical opinion failed to establish a level of impairment different from that found by the arbiter and, accordingly, affirmed the Order on Reconsideration. On review, the insurer contends that claimant is not entitled to awards for loss of sensation, strength, or a chronic condition. Specifically, the insurer argues that the EMG's performed by Dr. Grant, which indicated that claimant had no ulnar nerve involvement, establish that claimant's loss of sensation was not due to the accepted right wrist tendinitis condition. The insurer also argues that we should rely on the attending physician's opinion, rather than that of the arbiter, regarding claimant's alleged loss of strength and chronic condition.

The standard for determining whether impairment is related to a compensable injury is specifically set out by statute. ORS 656.214(2) provides that "the criteria for the rating of scheduled disability shall be the permanent loss of use or function of the injured member due to the industrial injury." ORS 656.214(2) (emphasis supplied); see OAR 436-035-0007(1).[1] Thus, the question before us is what impairment is "due to" the compensable right wrist tendinitis condition as opposed to some noncompensable condition.

With the exception of the medical arbiter, only the attending physician at the time of claim closure may make findings concerning a worker's impairment. See ORS 656.245(2)(b)(B); Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666 (1994). However, impairment findings from a physician other than the attending physician may be used if those findings are ratified by the attending physician. See OAR 436-035-0007(12); Roseburg Forest Products v. Owen, 127 Or App 442 (1994).

Claimant's attending physician at claim closure was Dr. Weinman, orthopedist. (Ex. 13). On April 11, 1997, Dr. Murdock evaluated claimant's right wrist and Weinman concurred with his report. Murdock agreed that claimant's diagnosis was tendinitis, flexor carpi radialis, right wrist. Murdock measured claimant's range of motion, grip strength, and two-point sensory discrimination in the right hand. Murdock did not indicate that any of his impairment findings were due to a different, noncompensable condition. (Ex. 22).

Dr. Neumann, the medical arbiter, noted that the decrease of sensation in the ulnar nerve distribution of claimant's right upper extremity was of "undetermined etiology." However, he opined that both the diagnosis of tendinitis and the decrease of sensation "are apparently related" to the October 15, 1996 injury, an opinion supported generally by the medical record.[2]

Because there is no medical evidence that claimant's loss of sensation in his fingers is due to a condition other than the accepted tendinitis, we conclude that the loss of sensation findings are due to claimant's accepted condition.

The insurer next argues that the medical arbiter's notation that claimant had a 3/5 loss of strength with giveway and "probably" had a 4/5 weakness present is insufficient to establish a loss of strength. We do not agree. The arbiter's opinion is based on medical probability, not possibility. Moreover, the arbiter explicitly stated that the impairment findings are valid for the purposes of rating. Therefore, we find that claimant has established valid objective findings of loss of strength due to his work injury. OAR 436-035-007(27)[3]; Gormley v. SAIF, 52 Or App 1055 (1981) (medical opinion must be stated in terms of reasonable medical probability, not mere possibility).

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[1] OAR 436-035-0007(1) provides, in part:

"Except for sections (3) and (4) of this rule, a worker is entitled to a value under these rules for those findings of impairment that are permanent and were caused by the compensable injury or disease including the compensable condition, a consequential condition and direct medical sequelea [sic]. Unrelated or noncompensable impairment findings shall be excluded and shall not be valued under these rules."

[2] Claimant complained of numbness in the third, fourth and fifth fingers of his right hand at the time of his first medical examination and continued to make the same complaints at the time of claim closure. (Exs. 3, 5, 7-2, 14, 16, 17, 22). EMG studies were performed to rule out involvement of the nerves of the right arm. The studies confirmed the diagnosis of tendinitis, as found by Dr. Weinman and Dr. Murdock.

[3] OAR 436-035-0007(27) provides:

"Upon examination, findings of impairment which are determined to be ratable pursuant to these rules shall be rated unless the physician determines the findings are invalid and provides a written opinion, based on sound medical principles, explaining why the findings are invalid.

Finally, the insurer argues that Dr. Murdock's opinion establishes that claimant is not entitled to a chronic condition award. We disagree.

A worker is entitled to a 5 percent scheduled chronic condition impairment value for his right forearm (wrist) 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 his right wrist. OAR 436-035-0010(5).

Here, we find that the medical arbiter, Dr. Neumann, performed a more complete examination for the purpose of determining extent of permanent disability than Dr. Murdock. For instance, Dr. Neumann provided range of motion findings for dorsiflexion, palmar flexion, radial deviation, ulnar deviation, pronation and supination, whereas Dr. Murdock tested only flexion, extension, radial deviation and ulnar deviation. Because Dr. Neumann provided a more thorough evaluation of claimant's permanent impairment than Dr. Murdock, we rely on his opinion. Kenneth W. Matlack, 46 Van Natta 1631 (1994) (Board does not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment, but on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment).

Dr. Neumann found that claimant had some significant loss or limitation in his ability to repetitively use the right hand and wrist due to a chronic and permanent medical condition arising out of the accepted injury of right wrist tendinitis. Moreover, the arbiter specifically opined that his range of motion and muscle strength findings were valid. Considering that Dr. Murdock offered no opinion regarding any limitations on claimant's ability to repetitively use his right wrist, we find no basis for not relying on Dr. Neumann's opinion regarding chronic condition impairment. See Snyder v. Barrett Business Services, Inc., 147 Or App 619, 624-25 (1997) (where the treating physician offered no opinion to weigh against the medical arbiter's opinion, it is inappropriate to rely on the treating physician's lack of opinion to prove no permanent disability). Consequently, on this record, we are persuaded by a preponderance of the evidence that claimant is significantly restricted in the repetitive use of his right wrist due to a chronic and permanent medical condition arising out of his compensable injury.

Attorney Fees

The ALJ awarded claimant a $3,000 attorney fee for his attorney's efforts in successfully defending the compensation awarded to claimant by the Order on Reconsideration. The ALJ determined that the fee amount was reasonable after applying the factors set forth in OAR 438-015-0010(4).[4]

On review, the insurer submits specific arguments regarding the rule-based factors of time devoted to the case and the complexity of the issue, contending that the fee awarded by the ALJ is excessive and should be reduced to $2,000. Because the insurer's arguments specifically address the factors, we provide the following supplementation of the ALJ's decision. See Russell L. Martin, 50 Van Natta 313 (1998).

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[4] OAR 438-015-0010(4) provides that "[i]n any case where an [ALJ] or the Board is required to determine a reasonable attorney fee, the following factors shall be considered:

"(a) The time devoted to the case;

"(b) The complexity of the issue(s) involved;

"(c) The value of the interest involved;

"(d) The skill of the attorneys;

"(e) The nature of the proceedings;

"(f) The benefit secured for the represented party;

"(g) The risk in a particular case that an attorney's efforts may go uncompensated; and

"(h) The assertion of frivolous issues or defenses."

Turning to the factors under OAR 438-015-0010(4), our review of the record reveals the following. We note that claimant's counsel did not submit a statement of services. Furthermore, no hearing was held, closing arguments were conducted by telephone, and claimant's attorney submitted no documents for the record.

The issue--extent of scheduled permanent disability--was of average complexity, considering that the record contained 32 exhibits and three medical reports that needed evaluation in order to rate the extent of disability.

The value of the interest involved is $12,600. Both attorneys are skilled litigators with substantial experience in workers' compensation law. No frivolous issues or defenses were raised. Moreover, based on the conflict in the medical opinions, claimant's attorney assumed a moderate risk that he might go uncompensated for his services.

Based on our consideration of the factors in OAR 438-015-0010(4), particularly the aforementioned factors of value, benefit, and risk, we conclude that $3,000 is a reasonable attorney fee for claimant's services at hearing for defending the Order on Reconsideration award. We accordingly affirm the ALJ's award.

Claimant's attorney is also entitled to an assessed fee for services on review concerning the extent of permanent disability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee on review for services devoted to defending the ALJ's attorney fee award. See Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated December 19, 1997 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
REGGIE D. REICHELT, Claimant
WCB Case Nos. 96-11370 & 96-08549
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorneys
Garrett, Hemann, et al, Defense Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation, on behalf of Superior Quality Construction Company (Superior Quality), requests review of Administrative Law Judge (ALJ) Michael Johnson's order that: (1) set aside its compensability and responsibility denial of claimant's claim for a left shoulder rotator cuff tear; and (2) apportioned responsibility for that condition equally between SAIF/Superior Quality and SAIF/Willamette Valley Christian School (Willamette Valley). Claimant moves to strike SAIF/Willamette Valley's respondent's brief as untimely. On review, the issues are motion to strike, compensability and responsibility. We grant the motion to strike and affirm.

FINDINGS OF FACT

We adopt the "Findings of Fact" set forth in the ALJ's order and make the following additional finding. Claimant's basketball coaching activity ended in mid-February 1996.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Claimant moves to strike SAIF/Willamette Valley's respondent's brief on timeliness grounds. We grant claimant's motion.

Pursuant to OAR 438-011-0020(2), a party's respondent's brief must be filed within 21 days after the date of mailing of the appellant's brief. Here, SAIF/Willamette Valley concedes that its respondent's brief was one day late. Nevertheless, SAIF/Willamette Valley reasons that no party will be prejudiced by the Board's consideration of its respondent's brief because the arguments raised are already before the Board pursuant to the briefs filed by SAIF/Superior Quality and claimant. Thus, SAIF/Willamette Valley argues that substantial justice will be served if the Board considers its brief. We treat this argument as a motion for waiver of our rules. See OAR 438-011-0030. We may grant such a motion only if extraordinary circumstances beyond SAIF/Willamette Valley's control prevented it from filing its respondent's brief in a timely manner. SAIF/Willamette Valley has not established such extraordinary circumstances in this case. Elizabeth E. Heller, 47 Van Natta 253 (1995), citing Lester E. Saunders, 46 Van Natta 1153, 1154 (1994) (A calendering error does not constitute "extraordinary circumstances"). Accordingly, we decline to waive our rule and do not consider SAIF/Willamette Valley's respondent's brief in deciding this case.

Compensability and Responsibility

The ALJ analyzed claimant's rotator cuff tear as an injury. We, instead, conclude that the claim is properly analyzed as an occupational disease. The courts treat a condition as an occupational disease when the symptoms are gradual in onset, not attributable to a specific activity or event, and due to an ongoing condition or state of the body. James v. SAIF, 290 Or 343 (1981); Valtinson v. SAIF, 56 Or App 184 (1982); O'Neal v. Sisters of Providence, 22 Or App 9, 16 (1975). These same cases treat a condition as an injury when the symptoms occur over a discrete, identifiable period of time and are due to a specific activity or event. Id.

Here, claimant did not seek treatment for symptoms which occurred during a discrete period of time or were related to a specific injurious event. Rather, claimant's left shoulder symptoms began in October 1995 and gradually worsened over the following months to the point that he sought medical treatment in March 1996. Accordingly, we conclude that claimant's rotator cuff tear is properly analyzed as an occupational disease under ORS 656.802.

Notwithstanding our disagreement regarding the injury analysis, we agree with the ALJ's deference to Dr. Schilperoort and analysis of this matter under the case law addressing "concurrent employment." We further conclude that Dr. Schilperoort's opinion establishes a compensable claim for claimant's left rotator cuff tear as an occupational disease under this "concurrent employment" case law. Finally, we also agree with the ALJ's assignment of joint and equal responsibility to SAIF/Superior Quality and SAIF/Willamette Valley.

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

ORDER

The ALJ's order dated October 14, 1997 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,500, to be paid by the SAIF Corporation on behalf of Superior Quality Construction.

In the Matter of the Compensation of
VICTOR G. SCHUNK, Claimant
WCB Case No. 97-02266
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order that: (1) admitted a medical opinion letter over claimant's objection; and (2) concluded that the Hearings Division did not have jurisdiction over claimant's request for hearing from the insurer's denial of benefits for his L5-S1 disc lesion and related left L5 radiculopathy. On review, the issues are jurisdiction, evidence and compensability. We reverse.

FINDINGS OF FACT

On April 17, 1987, claimant compensably injured his low back when he bent over to pick up an arm load of shop towels while working at the employer's commercial laundry. Claimant's post-injury symptoms were limited to low back pain. He filed a Form 801 for a lower back strain, and the insurer accepted the claim by marking the appropriate box on the claim form. The working diagnosis at this time was low back strain. (Exs. 1-4).

Claimant's low back pain persisted despite conservative treatment from Dr. Kaesche, orthopedic surgeon. In October 1987, claimant also began experiencing radiating pain into the right leg. (Ex. 5). An October 26, 1987 MRI revealed a right-sided L5-S1 disc protrusion that appeared to correlate well with the claimant's current symptoms. (Ex. 7). The insurer did not amend its acceptance to include this new diagnosis. In November 1987, Dr. Kaesche recommended surgical repair of the L5-S1 disc, but claimant opted for further conservative treatment. (Ex. 9). The injury claim was closed in March 1988 with an ultimate award of 15 percent unscheduled permanent disability (PPD).

Following claim closure, claimant continued to experience periodic right leg pain which resolved around 1990, and periodic low back pain which did not resolve. In October 1996, claimant experienced increased low back symptoms and the onset of left leg symptoms after operating a large industrial carpet shampooer for a total of 90 minutes over a period of two days. Claimant's increased low back and left leg pain continued, and Dr. Kaesche eventually provided further conservative care in December 1996. (Exs. 24, 26, 28, 29). A repeat MRI in January 1997 demonstrated a mild disc bulge at L5-S1, with lateral foraminal narrowing at L5-S1 on the left. (Ex. 27). Dr. Kaesche attributed claimant's symptoms to sciatica due to the bulging disc. (Ex. 28).

On March 6, 1997, the insurer issued a denial of "any workers' compensation benefits" for claimant's current low back condition. (Ex. 32).

On May 16, 1997, claimant was evaluated by Dr. Long, M.D., who diagnosed an L5-S1 disc herniation with left L5 radiculopathy. (Ex. 33). Dr. Long is claimant's current treating physician.

ULTIMATE FINDINGS OF FACT

The insurer's March 6, 1997 denial was a formal denial of the compensability of claimant's underlying claim for a new, unaccepted medical condition, diagnosed as an L5-S1 disk herniation and related left L5 radiculopathy.

The 1987 injury is the major contributing cause of claimant's L5-S1 disc lesion and related left L5 radiculopathy.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

On review, claimant argues that the ALJ erred in concluding that the Hearings Division did not have jurisdiction over claimant's hearing request under the decision of the Court of Appeals in SAIF v. Shipley, 147 Or App 26 (1997). In Shipley, the lower court construed the terms of ORS 656.245(6), which provides in pertinent part:

> "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 the self-insured employer shall request administrative review by the Director [.]" (Emphasis added).

The claimant in Shipley sought to reopen an accepted 1989 claim for a right knee injury to obtain compensation for current medical services. The carrier denied the request, asserting that the claimant had not sustained a compensable aggravation, and that the present knee condition was not work-related because an off-work fall was the major contributing cause of the current disability or need for treatment. The claimant then requested a hearing. At hearing, the claimant conceded that his treatment was not for a compensable aggravation or new medical condition and, instead, argued that medical services were materially related to the right knee condition accepted under the 1989 claim. The lower court concluded that the carrier had denied medical services for a reason "other than the formal denial of the compensability of the underlying claim." Accordingly, the court determined that the Director had sole jurisdiction over the carrier's denial. Id.

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 lower court's decision in Shipley, reasoning that, because the dispute concerned the compensability of a new condition, it necessarily involved the denial of an "underlying claim." Compare Randy R. Kacalek, 49 Van Natta 1121 (1997) (Director has sole jurisdiction over medical services denial where sole issue is whether need for treatment is related to an accepted condition).

Our rationale in Rossi is consistent with the Supreme Court's recent decision affirming the lower court's decision in Shipley. 326 Or 557 (1998). In its decision, the Court explained that the claimant's initial hearing request involved a matter within the jurisdiction of the Board because it concerned the insurer's "formal denial of the compensability of the underlying claim" for aggravation and/or a new medical condition. The Court further concluded that the Board's jurisdiction ended when the issue at hearing was limited to whether the need for treatment was related to the accepted 1989 claim. Id.

Here, claimant is asserting a claim for treatment for a new, unaccepted condition diagnosed as an L5-S1 herniation with left L5-S1 radiculopathy. Thus, while the insurer's denial encompasses medical services, it is also a "formal denial of the compensability of the underlying claim" within the meaning of ORS 656.245(6). Accordingly, pursuant to that statute, the Hearings Division retains jurisdiction over the medical services/compensability dispute in this case. Shipley, 326 Or at 565. See also SAIF v. Pendergast-Long, 152 Or App 780 (1998) (Hearings Division retains jurisdiction over dispute regarding medical benefits for aggravation or new "consequential condition").

Compensability/Related Evidentiary Issue

As a preliminary matter, we note claimant's challenge to the ALJ's admission of Exhibit 37, which is an August 2, 1997 opinion letter from Dr. Kaesche supporting the insurer's denial of the present claim. We need not resolve this evidentiary issue because, even if the disputed exhibit is considered, the record establishes compensability of the claim.

The compensability issue in this case 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). 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).

Claimant relies on Dr. Long's opinion that, while claimant's use of a carpet shampooer in October 1996 probably triggered an increase in lumbar disc pain with left L5 radiculopathy, the initial injury on April 17, 1987 is probably the major contributing cause of claimant's current symptoms. The insurer relies on Dr. Kaesche's contrary opinion that the carpet shampooing activity in October 1996 was the major contributing cause of claimant's symptoms and treatment in the latter part of 1996. (Ex. 31, 37).

The insurer further contends that Dr. Long's opinion is not persuasive because he relied on the type of "but-for" analysis that is disfavored by the courts. See Dietz v. Ramuda, 130 Or App 397 (1994). Dr. Long did opine that, absent the prior injury in 1987, claimant's use of a carpet shampooer in October 1996 would not have provoked an L5-S1 disc injury with L5 radiculopathy. However, we do not interpret that statement as an opinion that claimant's 1987 injury was a mere precipitating cause of claimant's current need for treatment, rather than the major cause of that condition. Furthermore, this "but-for" analysis is a relatively insignificant portion of Dr. Long's otherwise well-reasoned opinion.

In particular, Dr. Long relied on the mechanics of the April 1987 injury, claimant's history of essentially continuous discogenic lumbosacral pain since that injury, and the October 1987 MRI demonstrating a broad L5-S1 disc lesion. Dr. Long also persuasively rebutted Dr. Kaesche's rationale that claimant's current symptoms are unrelated to the 1987 injury because they involve left-sided radicular pain which appeared following the resolution of claimant's previous right-sided symptoms. Specifically, Dr. Long explained that claimant's fundamental condition has been an L5-S1 disc lesion which has resulted in continuous low back pain since the 1987 injury. Dr. Long further explained that, given the relatively broad annulus bulge documented in 1987, claimant was equally at risk to further degenerative change to the right or the left of the midline. (Ex. 34, 36).

Moreover, while we recognize Dr. Kaesche's special status as the former treating physician, the record indicates that he rendered his opinion without benefit of reviewing Dr. Long's contrary opinion or claimant's prior medical records, including his prior MRI study. (Ex. 31). In contrast, Dr. Long's opinion is based on a review of claimant's complete record, including the two MRI studies and Dr. Kaesche's opinion.

For these reasons, we conclude that Dr. Long's well-reasoned opinion establishes a persuasive basis for rejecting the contrary opinion of Dr. Kaesche. See Weiland, 64 Or App at 810. Accordingly, we defer to Dr. Long and conclude that claimant has established a compensable claim for his current L5-S1 disc lesion and related left L5 radiculopathy.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's denial. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $4,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time expended in establishing jurisdiction and compensability of claimant's low back condition (as represented by the hearing record and claimant's appellate briefs), the complexity of these issues, the risk that claimant's counsel might go uncompensated, and the value of the interest involved.

ORDER

The ALJ's order dated October 23, 1997 is reversed. Claimant's hearing request is reinstated. The insurer's March 6, 1997 denial is set aside, and the claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant is awarded an assessed fee of $4,500, to be paid by the insurer.

In the Matter of the Compensation of
RONALD GILDEROY, Claimant
Own Motion No. 95-0617M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Coughlin, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's January 20, 1998 Notice of Closure which closed his claim with an award of temporary disability compensation from October 24, 1995 through January 16, 1998. SAIF declared claimant medically stationary as of "July 10, 1980." Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.[1]

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the January 20, 1998 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).

Here, the closure date is January 20, 1998. All documents, with the exception of one, submitted for consideration, from both claimant and SAIF, are dated after January 20, 1998 and will be treated as post-closure medical evidence. We may consider post-closure medical evidence regarding the question of whether a claimant was medically stationary at the time of claim closure, as long as that evidence relates to the claimant's condition at the time of closure, no subsequent changes in the claimant's condition. Scheuning v. J.R. Simplot & Co., 84 Or App 622 (1987).

Before reviewing the post-closure evidence, we review the only document dated prior to the closure. On December 15, 1997, Dr. Zimmerman authored a report finding that claimant had continued complaints of pain in his low back with soreness in his hips. Dr. Zimmerman recommended that claimant undergo some epidural injections and a check of his hips "for any possible arthritic changes with special attention to the sacroiliac joints. He may have some inflammation there as he indeed had tenderness with the examination. [Claimant] will follow-up in the clinic as needed. He is also following up with Dr. Henbest today." We interpret this recommendation for epidural shots and a check of claimant's hips as an indication that claimant was not medically stationary and that his condition could materially improve with the recommended medical treatment.

Post-closure evidence submitted which addresses claimant's medically stationary status at the time of the January 20, 1998 closure include a January 23, 1998 report from Dr. Zimmerman[2] and a February 18, 1998 report from Dr. Henbest. Dr. Zimmerman states that:" It has come to my attention that [claimant] was deemed medically stable concerning his lower back symptoms. He has not had a permanent disability rating which would still place him under the context of being in a rehabilitative mode." Although relying on an incorrect standard regarding determination of a medically stationary status, Dr. Zimmerman's comments support a conclusion that claimant was not medically stationary at the time of closure.

Dr. Henbest, another of claimant's treating physicians, clearly concludes that claimant is not medically stationary. In his report, he states:

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[1] Claimant also requests that we make a determination as to whether he is entitled to permanent total disability benefits. Effective January 1, 1988, the Board no longer has Own Motion authority to award permanent disability benefits. Independent Paper Stock v. Wincer, 100 Or App 625 (1990). Therefore, we are not authorized to grant claimant's request.

[2] SAIF also submitted a "response" letter to its January 29, 1998 letter to Dr. Zimmerman. The document submitted has a slash mark through the question regarding claimant's medically stationary status and a handwritten "No." However, we are unable to ascertain from the document, as submitted, when the response was made and who made the slash-mark and the handwritten "No." It is undated and not signed by any physician. Further, it is unclear what the "No" response was meant to indicate, whether claimant was or was not medically stationary at the time of closure.

"[Claimant] is suffering from significant back pain and leg pain as a result of arachnoiditis. Unfortunately, the arachnoiditis is potentially progressive, and therefore I do not concur that [claimant] is medically stationary. Unfortunately, I think he is showing a slow, steady decline in neurologic function and pain tolerance.

"If I can be of any further assistance, I would be happy to do so, but I do not think [claimant] is going to reach a point of medical stability, I think he is going to continue to show signs of decline over the next ten years."

Dr. Henbest's February 18, 1998 opinion, coupled with Dr. Zimmerman's December 15, 1997 pre-closure recommendations and post-closure statements, establish that claimant was not medically stationary at the time of the January 20, 1998 closure.

Accordingly, we set aside the Notice of Closure as premature. When appropriate, the claim shall be closed by SAIF pursuant to OAR 438-012-0055.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
PHILLIP A. OBRIST, Claimant
Own Motion No. 98-0179M
INTERIM OWN MOTION ORDER CONSENTING
TO DESIGNATION OF PAYING AGENT (ORS 656.307)
Hollander & Lebenbaum, Claimant Attorneys

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 1985 injury claim with the American Mfg. Mutual Ins. expired on March 4, 1991. Thus, the claim is subject to ORS 656.278.

Under OAR 438-012-0032, the Board shall notify the Benefits Section that it consents to the order designating a paying agent if it finds that the claimant would be entitled to own motion relief if the own motion insurer is the party responsible for payment of compensation. The Board may exercise its own motion jurisdiction if there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, the Board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary. Id.

The record establishes that there has been a worsening of claimant's compensable injury requiring surgery. Inasmuch as claimant would be entitled to own motion relief if the own motion insurer is found responsible for claimant's current condition, the Board consents to the order designating a paying agent for temporary disability compensation under claimant's 1985 own motion claim, beginning December 9, 1997, the date claimant was hospitalized for surgery. ORS 656.278(1)(a).

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

When the responsible carrier has been determined, the Board will either: (1) issue an order reopening an own motion claim, if the own motion carrier is found to be the responsible carrier; and/or

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

IT IS SO ORDERED.

April 24, 1998 Cite as 50 Van Natta 817 (1998)

In the Matter of the Compensation of
PHILLIP A. OBRIST, Claimant
Own Motion No. 98-0180M
INTERIM OWN MOTION ORDER CONSENTING
TO DESIGNATION OF PAYING AGENT (ORS 656.307)
Hollander & Lebenbaum, Claimant Attorneys

The Benefits Section of the Workers' Compensation Division has notified the Board that it is prepared to issue an order designating a paying agent under ORS 656.307 and OAR 436-060-0180. Each insurer has provided its written acknowledgment that the only issue is responsibility for claimant's otherwise compensable claim. Claimant's aggravation rights under his 1988 injury claim with the American Motorists expired on May 22, 1995. Thus, the claim is subject to ORS 656.278.

Under OAR 438-012-0032, the Board shall notify the Benefits Section that it consents to the order designating a paying agent if it finds that the claimant would be entitled to own motion relief if the own motion insurer is the party responsible for payment of compensation. The Board may exercise its own motion jurisdiction if there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, the Board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary. Id.

The record establishes that there has been a worsening of claimant's compensable injury requiring surgery. Inasmuch as claimant would be entitled to own motion relief if the own motion insurer is found responsible for claimant's current condition, the Board consents to the order designating a paying agent for temporary disability compensation under claimant's 1988 own motion claim, beginning December 9, 1997, the date claimant was hospitalized for surgery. ORS 656.278(1)(a).

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

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

IT IS SO ORDERED.

In the Matter of the Compensation of
ORESTE A. CHORNEY, Claimant
WCB Case No. 97-05937
ORDER ON RECONSIDERATION
Gary L. Tyler, Claimant Attorney
Scheminske, et al, Defense Attorneys

Claimant requests reconsideration of our March 26, 1998 order that affirmed an Administrative Law Judge's order which upheld the self-insured employer's partial denial of claimant's claim for a current low back condition. Specifically, claimant asserts that we erred in finding the claim at least partially precluded by a prior dismissal order and in evaluating the medical evidence concerning claimant's condition subsequent to the unappealed August 23, 1996 denial.

Claimant contends that nothing prevents him from establishing that his current condition is compensable (despite the final August 23, 1996 denial) and he relies on Dr. Puziss, treating physician, in support of his contention that his current low back condition is compensable on the merits.

We continue to find that claimant's low back condition was not compensable as of the August 23, 1996 denial, as explained in our initial order.

In addition, as we explained in our initial order, even though the *entire claim* is not precluded by the prior denial (because claimant's condition has changed since that denial), that does not aid claimant's cause. We offer the following supplementation regarding the medical evidence relating claimant's current low back problems to his February 1994 work injury.

Dr. Puziss provides the only expert opinion arguably supporting the current claim.

Claimant acknowledges that, in August 1996, Dr. Puziss agreed that claimant had preexisting lumbar degeneration and that his chronic low back strain syndrome had "subjectively" healed. (Exs. 37, 38). Claimant also concedes that degenerative disc disease was his "major disability" at that time. However, he argues that Dr. Puziss' subsequent opinions establish that a later diagnosed worsened L4-5 disc protrusion, "a direct outgrowth" of the 1994 work injury, causes his current problems. (Exs. 45A, 51, 52). In other words, based on Dr. Puziss' opinion, claimant contends that his 1994 work injury, rather than his preexisting degeneration, is the major contributing cause of his current low back condition. We disagree.

Dr. Puziss did not explain why he believes that the 1994 work injury contributes more to claimant's current condition than the undisputed preexisting degeneration. *See Dietz v. Ramuda*, 130 Or App 397, 401-02 (1994). In fact, there is no indication that Dr. Puziss weighed the relative contribution of the work injury as compared to the degeneration. *See Dietz* at 401-402; *Roger A. Longbotham*, 48 Van Natta 1257 (1996) (physician's conclusions insufficiently supported because he failed to compare the contributions of off-work and work-related causes). Under these circumstances, we find Dr. Puziss' opinion unpersuasive and we decline to rely on it. *See Somers v. SAIF*, 77 Or App 259 (1986); *Weiland v. SAIF*, 64 or App 810 (1983). Consequently, to the extent that the current claim is not precluded by the prior denial, it is nonetheless not compensable in the absence of persuasive supporting medical evidence.

Accordingly, our March 26, 1998 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our prior order in its entirety, effective this date. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
WILLIAM A. HIX, Claimant
WCB Case No. 97-05347
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that affirmed an Order on Reconsideration that: (1) awarded 3 percent (4.5 degrees) scheduled permanent disability for loss of use or function of claimant's left hand; and (2) awarded 3 percent (4.5 degrees) scheduled permanent disability for loss of use or function of claimant's right hand. On review, the issue is extent of scheduled disability. We modify.

FINDINGS OF FACT

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

Claimant is significantly limited in the repetitive use of both hands due to his compensable chronic condition.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant is not entitled to a permanent disability award for a chronic condition significantly limiting repetitive use of his hands, based on a finding that claimant has continued to perform his job duties and other activities of daily living despite his compensable skin condition. We disagree.

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 February 25, 1997 Determination Order. Therefore, the applicable standards are found at WCD Admin. Order 96-051.

Claimant has the burden of proving the extent of his 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:
>
> "* * * * *
>
> "(c) Forearm (below elbow/hand/wrist)[.]"

The medical evidence regarding claimant's permanent disability is provided by Drs. Frisch, Siebe, Staver, Laycoe, and Massar.[1]

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[1] Dr. Siebe, treating physician, generally concurred with Dr. Frisch regarding claimant's permanent disability. (Exs. 8, 10, 12, 13, 14). Drs. Staver, Laycoe and Massar were medical arbiters. (Exs. 17, 18).

Near the end of August 1996 (after claimant was medically stationary), Dr. Frisch opined that claimant's psoriasis[2] is "[l]ocalized by trauma to fingertips, plus asteatosis from solvents. My objective findings are the presence of psoriasis on his body and the knowledge that trauma can localize psoriasis." (Ex. 8-5, emphasis added). Dr. Frisch suggested that decreasing fingertip work might improve claimant's response to treatment, but suspected that "[o]nly traumatic avoidance to fingertips may help." (Ex. 8-6).

Dr. Siebe concurred with Dr. Frische's opinion. (Ex. 10).

Claimant apparently stopped performing work activities involving exposure to diesel fuel and other solvents in September 1996. (Exs. 17-1, 18-2; see Ex. 8-2). His skin condition continued to worsen. (Ex. 11).

In January 1997, Dr. Frisch observed that claimant's dermatitis involved only his fingertips, that his rash coincided with trauma to the fingertips, and that his psoriasis, along with trauma, may be the reason he has dermatitis. (Ex. 13).

Dr. Siebe agreed that claimant's "psoriasis with repeated trauma cause[es] his dermatitis." (Ex. 14).

In May 1997, Drs. Staver and Layco, medical arbiters (orthopedists), examined claimant and noted that his main complaint was "difficulty in repetitive activities, such as trying to pick up a pen or pencil." (Ex. 17-2). Nonetheless, the arbiters found "no evidence of any significant limitation in [claimant's] ability to repetitively use" his hands. (Ex. 17-3). We do not find this conclusion persuasive, because it is inconsistent with the arbiters' prior finding acknowledging claimant's difficulty with repetitive activities involving his fingertips.

Dr. Massar also examined claimant in May 1997 and reported claimant's difficulty contending with "any work entailing frictional or shearing forces to the involved areas." (Ex. 18-2).

Based on preponderance of the above-described medical evidence, we conclude that claimant does have a chronic and permanent medical skin condition which significantly limits repetitive use of both hands. Accordingly, claimant is entitled to awards of 5 percent scheduled permanent disability for each hand under OAR 436-035-0010(5).

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 November 20, 1997 is modified. In addition to the Order on Reconsideration award of 3 percent (4.5 degrees) scheduled permanent disability award for the right hand, claimant is awarded an additional 5 percent (7.5 degrees) scheduled permanent disability, for a total award of 8 percent (12 degrees). In addition to the Order on Reconsideration award of 3 percent (4.5 degrees) scheduled permanent disability award for the left hand, claimant is awarded an additional 5 percent (7.5 degrees) scheduled permanent disability, for a total award of 8 percent (12 degrees). Claimant's attorney is awarded an attorney fee equal to 25 percent of the increased compensation made payable by this order, not to exceed $3,800, payable by the insurer directly to claimant's attorney.

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[2] The accepted condition is dermatitis. However, because the medical experts also use the term "psoriasis" to describe claimant's permanent condition, we find that both diagnoses refer to the compensable condition. (See Exs. 8-5, 13, 14).

In the Matter of the Compensation of
WARREN M. JOHNSON, Claimant
WCB Case No. 97-06882
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Myzak's order that affirmed an Order on Reconsideration award of 7 percent (10.5 degrees) scheduled permanent disability for the loss of use or function of the right forearm (wrist). In his respondent's brief, claimant challenges that portion of the ALJ's order that affirmed the Order on Reconsideration award of 22 percent (33 degrees) scheduled permanent disability for loss of use or function of the right leg (knee). On review, the issue is extent of scheduled permanent disability. We modify in part and reverse in part.

FINDINGS OF FACT

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

We find that claimant is not significantly limited in the repetitive use of his right wrist due to a chronic and permanent medical condition.

CONCLUSIONS OF LAW AND OPINION

Right Wrist

The ALJ concluded, based on the examination report of the medical arbiter, Dr. Scheinberg, that claimant was entitled to a 5 percent "chronic condition" value for the right wrist, and therefore affirmed the Order on Reconsideration award of 7 percent scheduled permanent disability for the wrist condition.[1] On review, SAIF contends that the medical arbiter's report is insufficient to support a chronic condition value. Claimant responds that, because SAIF did not request reconsideration of the Notice of Closure award of 9 percent scheduled permanent disability for the right wrist, SAIF is precluded from seeking a reduction of his scheduled permanent disability award for the right wrist below the 7 percent awarded by the reconsideration order. Claimant cites to Duncan v. Liberty Northwest Ins. Corp., 133 Or App 605 (1995).

ORS 656.268(8) provides:

> "No hearing shall be held on any issue that was not raised and preserved before the department at reconsideration. However, issues arising out of the reconsideration order may be addressed and resolved at hearing."

This provision bars a hearing on an issue that was not first raised at the Department's reconsideration proceeding, unless the issue "ar[ose] out of the reconsideration order." In the instant case, we agree with, and adopt, the ALJ's finding that SAIF's challenge to the chronic condition value arose out of the reconsideration order itself. A chronic condition value was not granted by the Notice of Closure, which awarded 9 percent scheduled permanent disability based solely on reduced ROM in the right wrist. Therefore, SAIF could not have been expected to raise a challenge to a value that did not exist at the time of the reconsideration proceeding.

The chronic condition value was first granted by the reconsideration order, based on the medical arbiter report that issued during the reconsideration proceeding. Under such circumstances, we conclude that the chronic condition issue arose out of the reconsideration order and was properly addressed at the hearing.

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[1] In addition to the 5 percent chronic condition award, the Order on Reconsideration awarded 2 percent impairment based on reduced range of motion (ROM) in the right wrist, (Ex. 24-2), for a total scheduled award of 7 percent for the wrist. Neither party challenged the 2 percent ROM impairment at hearing or on review. Therefore, the sole issue with regard to the right wrist award is whether claimant is entitled to the 5 percent chronic condition award.

This case is distinguishable from Duncan, where the carrier requested a hearing from a reconsideration order, seeking a reversal of the claimant's entire permanent disability award based on a contention that the claimant's disability was not compensable, including the portion awarded by the determination order. The court found that the carrier's objection to the portion of the reconsideration order that merely affirmed the determination order, amounted to an objection to the determination order. 133 Or App at 610-11. Because the carrier did not request reconsideration of the determination order, the court held that it was barred from raising its objection for the first time at hearing, under former ORS 656.268(5) (since renumbered ORS 656.268(5)(b)). Id. at 611. The court noted, however, that if the reconsideration order had changed the determination order, the propriety of that change could have been raised at hearing, notwithstanding the lack of a reconsideration request. Id. Because the carrier had not challenged the compensability of the claimant's injury by requesting reconsideration of the determination order, the Duncan court concluded the determination order served as a floor for the claimant's scheduled permanent disability award.

Here, the reconsideration order changed the closure notice award from 9 percent to 7 percent by reducing the impairment value based on reduced ROM (from 9 percent to 2 percent) and including the 5 percent chronic condition value. Insofar as SAIF challenged the chronic condition value that was first included in the reconsideration order, SAIF met the exception in ORS 656.268(8) and did not act contrary to the court's decision in Duncan.[2]

Turning to the merits of the chronic condition value, we agree with SAIF's contention that the medical arbiter's report does not support such an impairment value. The medical arbiter, Dr. Scheinberg, was asked whether claimant was significantly limited in the ability to repetitively use the right wrist. Dr. Scheinberg answered:

> "[Claimant] is mildly limited in his ability to repetitively use his right wrist, due to a diagnosed chronic and permanent medical condition arising out of the accepted injury of right distal wrist fracture. The limitation is based on the small loss of range of motion of the right wrist, compared to the left. There is no significant limitation noted during the examination today." (Ex. 23-6, emphases supplied).

The ALJ held that Dr. Scheinberg's description of a "mild" limitation on repetitive use supported the finding of a "significant" limitation under OAR 436-035-0010(5)(c).[3] She reasoned that a "mild" limitation has "meaning and effect" and, consequently, is a significant impairment.

We conclude, however, that Dr. Scheinberg's description of a "mild" limitation must be read in the context of his entire response. He also stated that the limitation was "based on the small loss of range of motion of the right wrist." Thus, it appears that claimant's mild limitation on repetitive use is not a separate disability, but rather a result of the reduced ROM for which claimant received a 2 percent impairment value. More importantly, Dr. Scheinberg explicitly stated that "[t]here is no significant limitation." Under these circumstances, we interpret Dr. Scheinberg's report as stating that claimant does not have a significant limitation on the repetitive use of his right wrist. Because the record does not contain any other medical opinion addressing the chronic condition issue, we conclude that SAIF carried its burden of proving by a preponderance of the evidence that claimant is not entitled to the 5 percent chronic condition impairment value. Accordingly, claimant's scheduled permanent disability award for the right wrist is reduced from 7 percent to 2 percent. Because claimant's award has been reduced, his attorney is not entitled to an assessed fee under ORS 656.382(2) for services at hearing or on review.

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[2] Inasmuch as the ROM value was included in the NOC, SAIF would be precluded from raising any challenge to claimant's scheduled permanent disability award based on that value below the 2 percent allowed by the Order on Reconsideration.

[3] 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 body parts:

"* * * * *

"(c) Forearm (below elbow/hand/wrist) * * *"

Right Leg

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

ORDER

The ALJ's order dated December 22, 1997 is affirmed in part, modified in part, and reversed in part. In lieu of the 7 percent (10.5 degrees) scheduled permanent disability awarded by the ALJ and the Order on Reconsideration, claimant is awarded 2 percent (3 degrees) scheduled permanent disability for loss of use or function of the right forearm (wrist). The ALJ's assessed attorney fee award is reversed. The remainder of the ALJ's order is affirmed.

April 27, 1998 Cite as 50 Van Natta 823 (1998)

In the Matter of the Compensation of
WILLIE A. EDWARDS, Claimant
Own Motion No. 98-0164M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable contusion left shoulder and left elbow injury. Claimant's aggravation rights expired on January 17, 1995. 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 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 was not in the work force at the time of the current disability. Claimant responded to SAIF's contention by letter dated April 20, 1998 wherein he states: "I do not expect temporary disability compensation, as I am retired." It appears from claimant's statement, that claimant is only seeking medical services at this time.

Accordingly, we conclude that claimant has withdrawn his request for Own Motion relief (in other words, he is not seeking temporary disability benefits). Therefore, we dismiss, without prejudice, the request for own motion relief.

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
MITCHELL D. JOY, Claimant
WCB Case Nos. 97-04493 & 97-04047
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Neal's order that upheld the self-insured employer's denial of his request for acceptance of several low back conditions. On review, the issue is scope of acceptance. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld the employer's denial of claimant's low back degenerative disc disease, stenosis, and multiple disc bulges from L3 to S1, concluding that the employer was not required to accept those conditions as part of a "combined condition." See ORS 656.005(7)(a)(B).[1] On review, claimant contends that the medical evidence establishes that the disputed conditions are compensable as part of a "combined condition" within the meaning of ORS 656.005(7)(a)(B), and he requests an order requiring the employer to accept them. For the following reasons, we conclude that claimant is entitled to acceptance of the disputed conditions.

We begin by briefly recounting the relevant facts. Claimant injured his low back on December 7, 1994, as a result of which the employer accepted a low back strain. A December 16, 1994 MRI scan revealed degenerative disc disease in claimant's lumbar spine at L4-5 and L5-S1. (Ex. 3). The claim was eventually closed by Determination Order on October 30, 1996, with an award of temporary disability but no permanent disability.[2] Claimant requested reconsideration of the Determination Order and a medical arbiter, Dr. Peterson, was appointed to evaluate claimant's low back conditions in February 1997.

Dr. Peterson opined that claimant's current low back condition resulted from a combination of preexisting underlying degenerative disease and the compensable 1994 low back strain. Dr. Peterson concluded that 60 percent of claimant's permanent impairment was due to the accepted injury and 40 percent was due to the preexisting degenerative condition. (Ex. 21-5).

On March 27, 1997, an Order on Reconsideration issued. It noted Dr. Peterson's opinion regarding the etiology of claimant's current low back condition and awarded 11 percent unscheduled permanent disability.

In the meantime, a consulting neurosurgeon, Dr. Berkeley, evaluated claimant's low back condition in December 1996. (Ex. 18). Dr. Berkeley had an MRI performed which showed multiple disc bulges in claimant's lumbar spine, degenerative disc disease and moderate foraminal stenosis. (Ex. 19).

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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."

[2] Claimant sustained another compensable low back injury in May 1996, which was closed by Notice of Closure in August 1996 without an award of permanent disability. That injury is not at issue in this case.

After Dr. Berkeley opined that the December 1994 injury was the major contributing cause of claimant's need for treatment (Ex. 24), claimant's counsel requested that claimant's disc bulges, stenosis, and degenerative disc disease "be formally accepted as directly caused by the subject injury, or as having combined with claimant's otherwise compensable condition, or as having developed as a consequence of claimant's compensable condition, as appropriate, based on the medical record." (Ex. 25, emphasis added). The employer denied the new medical condition claim/objection to notice of acceptance on May 9, 1997, on the ground that the 1994 injury was not the major contributing cause of the disputed condition. (Ex. 26). Claimant requested a hearing.

The employer asserts that claimant requested that the disputed conditions themselves be accepted and that the medical evidence does not establish that the 1994 injury caused or worsened those conditions. Thus, the employer argues the disputed conditions should not be accepted as independently compensable conditions. The employer also contends that claimant never requested that it accept a "combined condition" under ORS 656.005(7)(a)(B).

We disagree with the employer's contention that claimant never requested acceptance of a combined condition. The April 24, 1997 letter requesting acceptance of additional conditions was phrased in terms of alternative forms of acceptance, i.e., either as a direct result of the compensable injury, a consequential condition, or as a "combined condition." (Ex. 25-2). Because there is no dispute that the conditions at issue preexisted the compensable injury and "combined" with the compensable injury, they may be compensable as part of a "combined" condition pursuant to ORS 656.005(7)(a)(B), if the compensable injury is the major contributing cause of the disability or medical treatment of the combined condition. See SAIF v. Nehl, 148 Or App 101, on recon 149 Or App 309 (1997); Terrell G. Lee, 49 Van Natta 2041 (1997).

Based on our review of the medical evidence from Dr. Peterson and Dr. Berkeley, we conclude that the compensable injury is the major contributing cause of disability or medical treatment for the combined condition. The ALJ noted, however, that claimant was not receiving medical treatment. Even assuming that is correct, Dr. Peterson opined that the compensable injury was the major contributing cause of the disability of the combined condition. (Ex. 21). Accordingly, we conclude that the requirements of ORS 656.005(7)(a)(B) were satisfied.

In summary, claimant requested acceptance of the disputed conditions as part of a potential combined condition. The employer should accept those conditions as part of the combined condition, consisting of the compensable injury and the preexisting low back conditions. We emphasize, however, that our holding should not be construed as a finding that the disputed conditions are independently compensable, in and of themselves. To the contrary, Dr. Berkeley compared MRI scans from 1994 and 1996 and stated that there had been no change in claimant's preexisting low back conditions. (Ex. 29-7). Based on this medical evidence, we find that the compensable 1994 injury did not worsen or accelerate those conditions. Thus, the employer is not responsible for the disputed conditions except as a part of the "combined condition." See Karen S. Carman, 49 Van Natta 637 (1997) (carrier's acceptance of a preexisting condition as part of a "combined condition" could coexist with prior denial of the preexisting condition as independently 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 employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record, claimant's counsel's statement of services and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated September 2, 1997, as reconsidered on October 15, 1997 is reversed. The employer's denial is set aside and the claim is remanded to the employer for processing in accordance with law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $5,000, to be paid by the employer.

In the Matter of the Compensation of
JAMES E. SMITH, Claimant
WCB Case No. 97-05999
ORDER ON REVIEW (REMANDING)
Malagon, Moore, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Black's order that upheld the SAIF Corporation's denial insofar as it pertained to claimant's current cervical condition. Claimant has also submitted further medical evidence and requests that the matter be remanded for admission of that evidence. SAIF objects to claimant's request. On review, the issues are remand and compensability. We remand.

The ALJ upheld SAIF's denial of claimant's cervical degenerative disc condition. Claimant has submitted further evidence and requests that the matter be remanded for admission of that evidence. The proffered evidence consists of a November 4, 1997 pre-surgery examination report from Dr. Gallo; a November 4, 1997 operative report from Dr. Gallo; a November 5, 1997 radiological report from Dr. Kienzle; and a January 13, 1998 medical report from Dr. Gallo. The proffered evidence, all of which was generated "post-hearing," concerns claimant's November 1997 cervical surgery.

We may remand to the ALJ for the taking of further evidence if we determine that the record has been improperly, incompletely, or otherwise insufficiently developed. ORS 656.295(5). In order to satisfy this standard, a compelling reason must be shown for remanding. A compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

Inasmuch as the proffered evidence relates to claimant's cervical surgery, the evidence concerns disability. Moreover, since the surgery did not take place until after the October 24, 1997 hearing, the evidence submitted by claimant was not obtainable, with due diligence, at the time of the hearing. See Wonder Windom-Hall, 46 Van Natta 1619, 1620 (1994), rev on other grounds Nordstrom, Inc. v. Windom-Hall, 144 Or App 96 (1996) (Evidence derived from a "post-hearing" surgery not obtainable with due diligence).

One of the issues presented in this case is whether claimant's current neck symptoms were due to a preexisting degenerative condition or to the April 7, 1997 compensable shoulder and neck injury. In upholding that portion of SAIF's denial which denied claimant's current cervical condition, the ALJ relied on Dr. Strum's analysis which questioned the relationship between degenerative cervical disc disease and claimant's impingement and radiculopathy symptoms. In reaching this conclusion, the ALJ declined to rely on the report of Dr. Gallo, claimant's treating physician, at least in part because Dr. Gallo did not refute Dr. Strum's analysis. Because the proffered evidence concerns the surgical findings regarding claimant's impingement and radiculopathy symptoms, we conclude that the evidence is reasonably likely to affect the outcome of the case. Accordingly, we find a compelling reason to remand. See Parmer v. Plaid Pantry # 54, 76 Or App 405 (1985).

Accordingly, that portion of the ALJ's order which upheld SAIF's denial insofar as it denied claimant's current cervical condition is vacated and this matter is remanded to ALJ Black to reopen the record for the admission of additional evidence regarding claimant's cervical surgery and the resulting findings regarding the cause of claimant's current cervical condition.[1] The ALJ may proceed in any manner that will achieve substantial justice. ORS 656.283(7). The ALJ shall then issue a final appealable order concerning the compensability of claimant's current cervical condition.

IT IS SO ORDERED.

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[1] We note that the ALJ set aside SAIF's denial insofar as it denied a cervical strain and right shoulder injury. That portion of the ALJ's order was not contested on review. Therefore, we do not vacate the ALJ's order in its entirety. Rather, we vacate only that portion of the ALJ's order which addressed the compensability of claimant's current cervical condition.

In the Matter of the Compensation of
RICHARD C. LEWIS, Claimant
WCB Case No. 97-08306
ORDER ON REVIEW
Robert J. Guarrasi, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Neal's order that reduced his scheduled permanent disability award from 3 percent (4.5 degrees) for the left forearm (wrist) and 7 percent (10.5 degrees) for the right forearm (wrist), as awarded by an Order on Reconsideration, to zero. On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ rejected the arbiter's impairment findings of loss of range of motion and a Class 1 skin disorder of claimant's hands. Specifically, the ALJ concluded that the arbiter's range of motion rating for claimant's right thumb was not proper because the insurer had accepted "bilateral hand burns." With respect to the finding concerning the skin disorder, the ALJ concluded that the arbiter's findings were insufficient and were not due to the compensable injury. We separately address each impairment finding.

Range of Motion

The arbiter measured claimant's active range of motion in the IP joint of the thumb as +20/60 degrees. Based on the arbiter's findings, the Department, on reconsideration, awarded claimant 11 percent scheduled permanent disability. The ALJ, however, concluded that the Department should not have rated claimant's loss of range of motion in the thumb because the insurer accepted "bilateral hand burns." Moreover, the ALJ found that the loss of range of motion was not "medically tied" to the hand burns. We disagree.

If a treating doctor or medical arbiter makes impairment findings consistent with a claimant's compensable injury and does not attribute the impairment to causes other than the compensable injury, such findings may be construed as showing that the impairment is due to the compensable injury. See SAIF v. Danboise, 147 Or App 550 (1997). However, where the treating doctor or arbiter attributes the claimant's impairment to causes other than the compensable injury, the opinion is not considered persuasive evidence of injury-related impairment. See, e.g., Marcia G. Williams, 49 Van Natta 313 (1997).

Here, the arbiter reported that, following the compensable injury, claimant had experienced "problems with some loss of motion in the phalangeal joint of his right thumb." (Ex. 11-1). The record references burns extending to the "metacarpophalangeal region" and "along the dorsum of the fingers...." (Ex. 1). The record also discusses "a burn at the distal interphalangeal joint of the right thumb." (Ex. 4). Under the circumstances, we conclude that, because the impairment findings are consistent with claimant's compensable injury and the arbiter has not attributed claimant's impairment to other causes, the arbiter's report supports the Department's award for lost range of motion of the right thumb.

Skin Disorder

The arbiter also found that claimant had itching and dryness in his hands which required lotion applied multiple times daily. The arbiter concluded that claimant had a Class I skin disorder.

Pursuant to OAR 436-035-0110(5), claimant is entitled to an award for a Class I skin disorder if he has "signs and symptoms of a skin disorder and treatment results in no more than minimal limitations of the performance of activities of daily living, although exposure to physical or chemical agents may temporarily increase symptoms." Although the insurer argues that no restrictions have been assigned due to claimant's skin disorder, the rule provides only that claimant have "no more than" minimal limitations. Based on the record, we conclude that the arbiter's report is sufficient to support an award for a Class I skin disorder.

Consequently, we reverse the ALJ's order and reinstate the Order on Reconsideration award of 3 percent scheduled permanent disability for the left forearm (wrist) and 7 percent scheduled permanent disability for the right forearm (wrist).

ORDER

The ALJ's order dated February 4, 1998 is reversed. The Order on Reconsideration award of 3 percent (4.5 degrees) scheduled permanent disability for claimant's left forearm (wrist) and 7 percent (10.5 degrees) scheduled permanent disability for claimant's right forearm (wrist) is reinstated and affirmed. 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.

In the Matter of the Compensation of
SCOTTLAND FOWLER, Claimant
WCB Case Nos. 97-05071, 97-04980 & 97-03869
ORDER OF ABATEMENT
Rasmussen, et al, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Twin City Fire Insurance Company (Twin City), on behalf of Olsten Staffing, requests reconsideration of those portions of our April 9, 1998 Order on Review that: (1) set aside Twin City's denial insofar as it denied claimant's current condition; (2) awarded claimant's attorney an assessed attorney fee of $1,750 pursuant to ORS 656.386(1) for services at hearing concerning compensability of claimant's current condition; (3) awarded claimant's attorney an assessed fee of $1,000 pursuant to ORS 656.308(2)(d) for services at hearing and on review regarding the responsibility issue; and (4) awarded claimant's attorney an assessed fee of $1,000 pursuant to ORS 656.382(2) for services on review concerning Twin City's current condition compensability denial.

In its request for reconsideration, Twin City contends that neither its request for review nor its briefs addressed any current condition denial. Twin City also argues that it raised an issue at hearing concerning SAIF's obligation to share in any assessed fee. In our previous order, we declined to address Twin City's argument on review that SAIF may be responsible for paying the assessed attorney fee because we found that Twin City had not contended at hearing that SAIF's denial included a denial of compensability. Twin City further contends that the assessed fees are excessive.

In order to consider this matter, we withdraw our April 9, 1998 order. Claimant and the SAIF Corporation are granted an opportunity to respond. To be considered, the responses from claimant and SAIF 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
JENNIFER SHARP, Claimant
WCB Case No. 97-02562
ORDER ON REVIEW (REMANDING)
Burt, Swanson, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by the Board en banc.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Garaventa's order that upheld the self-insured employer's denial of her claim for a left knee injury. On review, the issue is course and scope of employment. We vacate the ALJ's order and remand.

FINDINGS OF FACT

Claimant worked for the employer who provided temporary workers to other employers. Claimant was assigned by her employer to work at the Department of Mental Health. The Department of Mental Health was located in the State Hospital Complex. While working at the Department of Mental Health, claimant was permitted to park her vehicle in a parking lot located on State Hospital Grounds. The lot was connected to the building where claimant worked by an access road and sidewalk.

On February 24, 1997, prior to her scheduled work shift, claimant parked her vehicle in the parking lot, crossed the access road and was walking on the sidewalk in order to enter the premises of the Department of Mental Health. While walking on the sidewalk, claimant slipped on a leaf and injured her left knee. She sought medical treatment that day and subsequently filed an 801 Form alleging that her injury was related to her employment. By letter dated March 21, 1997, the employer denied claimant's claim on the basis that it did not arise out of or occur in the course of her employment.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant had not established that her injury arose out of or in the course of her employment. Based on the following reasoning, we conclude that claimant has established that her injury arose out of her employment, but find that the record is insufficiently developed with regard to whether the injury occurred in the course of claimant's employment.

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

We first address the question of whether claimant's injury "arose out of" her employment. An injury is deemed to "arise out of" employment when the injury "originates from some risks to which the work environment exposes the worker." Fred Meyer, Inc. v. Hayes, 325 Or 592, 601 (1997). Claimant need not prove that she was exposed to any "peculiar" or "increased" risk by her employment. Id. Applying this principle to the present case, claimant's injury would arise out of her employment if there was a substance on the sidewalk that caused her to slip. See Ruby J. Williams, 49 Van Natta 1550 (1997).

Claimant testified that she believed she slipped on a leaf, but wasn't completely sure that it was a leaf because there wasn't much of it left when she examined it after the incident. (Tr. 11, 20). Claimant's testimony is supported by the contemporaneous medical evidence wherein Dr. Volkmann recorded a history of claimant slipping on a leaf. (Ex. A). In addition, the 801 Form filed by claimant also indicates that she slipped on a leaf. (Ex. 1). Based on claimant's testimony and the

contemporaneous documentary evidence, we conclude that it is more likely than not that claimant slipped on a leaf which caused her to twist her knee.[1] Accordingly, we find that claimant's injury arose out of her employment. We now turn to the question of whether claimant's injury occurred "in the course" of her employment.

As a general rule, injuries sustained by employees when going to or coming from their regular work place are not deemed to be in the course of employment. See Gwin v. Liberty Northwest Ins. Corp., 105 Or App 171, 173 (1991). There are, however, exceptions to the general rule. One such exception is the so-called "parking lot rule." The "parking lot rule" holds that if an injury occurs in a parking lot or other off-premises area over which the employer has some control, the injury may be compensable. Boyd v. SAIF, 115 Or App 241, 243 (1992). In order to establish that an injury occurring in a parking lot or other off-premises areas is compensable, there must be a sufficient causal relationship between the employment and the injury. Gilmore, 318 Or at 368, 369. In a "parking lot" case, that causal connection exists when the claimant's injury is brought about by a condition or hazard associated with premises over which the employer exercises some control. See Mongtomery Ward v. Malinen, 71 Or App 457, 461 (1984).

We have herein concluded that claimant's injury occurred as the result of slipping on a leaf on the sidewalk. Therefore, the injury was brought about by a hazard. We further conclude that the sidewalk, on which claimant slipped, was a place over which the Department of Mental Health exercised some control. In this regard, Mr. Watts testified that while general maintenance was performed by workers employed by the State Hospital, its janitor occasionally removes ice and other objects from the sidewalks adjacent to the Mental Health Division. (Tr. 31, 36). Mr. Watts further testified that if there was a maintenance problem, a person from the Mental Health Division could contact the State Hospital and request that the maintenance be performed. (Tr. 36).

Mr. Watts' unrebutted testimony establishes that the Mental Health Division performed some maintenance on the sidewalk where claimant slipped and could also request such maintenance be performed by State Hospital personnel. Therefore, we conclude that the Mental Health Division exercised some control over the premises on which claimant was injured. See Henderson v. S.D. Deacon Corporation, 127 Or App 333, 338-39 (1994) (employer control established where lease gave the employer a nonexclusive right to use an elevator where the claimant was injured, providing the employer the right to require repairs of the elevator and requiring employer to pay share of operating expenses.).

Under these circumstances, we conclude that claimant's injury arose out of and in the course of her employment. However, this conclusion does not end our inquiry.

Although we have concluded that claimant's injury arose out of and in the course of her employment, that conclusion is based on claimant's "employment" with the Mental Health Division. The employer in this case is not the Mental Health Division, but rather, is St. Vincent De Paul Rehabilitation Services, which assigned claimant to work at the Mental Health Division as a temporary employee. The question becomes whether an employer that assigns temporary employees to work for another company is responsible for injuries that occur in the course and scope of claimant's work activities for that other company.

In Multnomah County v. Hunter, 54 Or App 718 (1981), the court approved Professor Larson's formulation of the "loaned servant" doctrine. This doctrine applies where an employee in an existing employment relationship is loaned by the original employer to a special employer. In that situation, the original employer remains liable for workers' compensation unless: (1) the special employer contracts with the employee; (2) the work being done is that of the special employer; and (3) the special employer has the right to control the details of the work. Id. at 721; see also Newport Seafood v. Shine, 71 Or App 119 (1984).

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[1] In reaching this conclusion, we acknowledge that Mr. Watts, the officer manager, testified that the trees around the sidewalk did not have leaves in February and that claimant told him she "zigged when she should have zagged." (Tr. 31). However, neither of these assertions directly contradicts claimant's testimony. Consequently, we do not find that Mr. Watts' testimony is sufficient to support a conclusion that claimant is not credible.

The courts have also held that a special employer is immune from tort liability if workers' compensation coverage was provided by a temporary employment agency as part of the cost of using temporary labor. See Robinson v. Omark Industries, 46 Or App 263 (1980); Blacknall v. Westwood Corporation, 89 Or App 145 (1987).

In addition to the case law, the legislature has specially addressed worker leasing companies in Chapter 656. In 1993, the legislature added ORS 656.850. That section requires worker leasing companies to be licensed by the Director of the Department of Consumer and Business Services and requires the worker leasing company to provide adequate supervision, training and instruction for its employees. ORS 656.850(1) and (4). In addition, ORS 656.850(3) specifically provides that:

> "When a worker leasing company provides workers to a client, the worker leasing company shall satisfy the requirements of ORS 656.017 and 656.407 and provide workers' compensation coverage for those workers and any subject workers employed by the client unless during the term of the lease arrangement the client has an active guaranty contract on file with the director that extends coverage to subject workers employed by the client and any workers leased by the client. If the client allows the guaranty contract to terminate and continues to employ subject workers or has leased workers, the client shall be considered a noncomplying employer unless the worker leasing company has complied with subsection (5) of this section."

Subsection (5) provides, in relevant part, that:

> "When a worker leasing company provides subject workers to work for client and also provides workers' compensation coverage for those workers, the worker leasing company shall notify the director in writing. The notification shall be given in such manner as the director may prescribe. A worker leasing company may terminate its obligation to provide workers' compensation coverage for workers provided to a client by giving the client and director written notification of the termination. . . . "

Both the case law and the subsequent statutory provision support a conclusion that an original employer, and more specifically, a worker leasing company, is responsible for injuries to its employees that occur in the course and scope of employment with a special employer or client. The only exception to this responsibility appears to be where the worker enters into a contractual relationship with the special employer, in the case of a "loaned servant," or where the client of a worker leasing company has a guaranty contract that provides workers' compensation coverage for leased workers. Therefore, we hold that an original employer, or a worker leasing company, is responsible for injuries that arise out of and in the course of a claimant's employment with a special employer, or client, unless one of the exceptions mentioned above is applicable.

Here the record is devoid of any evidence concerning the contractual relationship between the original employer/client (Mental Health Division) and the general employer/worker leasing company (St. Vincent De Paul). There is also no evidence concerning a contractual relationship, if any, between claimant and either the special or original employer. Because such evidence is determinative in this case, we conclude that the record has been insufficiently developed. ORS 656.295(5). We further conclude that under these specific circumstances, *i.e.*, no evidence on the determinative legal question and the first time the Board has addressed the application of ORS 656.850, it is appropriate to remand this matter to the ALJ for further proceedings regarding this issue.

Accordingly, we remand this matter to the ALJ to allow the submission of further evidence concerning the contractual relationships between claimant, the Mental Health Division, and the employer as well as evidence concerning the contractual relationships between the Mental Health Division and the employer. The ALJ is instructed to proceed in any manner that will achieve substantial justice. ORS 656.283(7). The ALJ shall then issue a final appealable order.

ORDER

The ALJ's order dated July 10, 1997 is vacated. This matter is remanded to ALJ Garaventa for further proceedings consistent with this order.

In the Matter of the Compensation of
ED GIBSON, Claimant
Own Motion No. 96-0585M
OWN MOTION ORDER (REFERRING FOR FACT FINDING HEARING)
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's December 2, 1997 Notice of Closure which closed his claim with an award of temporary disability compensation from November 27, 1996 through November 16, 1997, less time worked. SAIF declared claimant medically stationary as of November 17, 1997. Claimant does not contend that SAIF's closure was premature. Rather, claimant contends that he is entitled to additional temporary disability benefits. Furthermore, claimant contends that the rate of TTD paid by SAIF was incorrect.

Temporary Disability Rate

Claimant contends that he is entitled to be compensated for wages lost at work during the last period of disability at the "wage rate" that he is receiving presently. Claimant contends that the amount of temporary disability compensation paid "would have been sufficient in 1983, it is not adequate for the wages I have lost in 1996-1997. As stated early I earn nearly three times that amount today and feel I'm entitled to more compensation."

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." SAIF submitted documentation regarding the rate of TTD it used to provide temporary disability benefits. SAIF calculated claimant's average weekly wage to be $261.20.[1] Those calculations were based on claimant's wages at the time of injury in 1983. We therefore conclude that SAIF utilized the correct rate of TTD when providing benefits to claimant during this most recent reopening.

Entitlement to Additional Temporary Disability Benefits

Having found that the rate at which claimant was paid temporary disability benefits was correct, we now turn to the amount of temporary disability benefits provided. In its Notice of Closure, SAIF contends it provided temporary disability benefits from November 27, 1996 through November 16, 1997, less time worked. We requested additional information from SAIF regarding how it arrived at the total amount of $3,883.89 for the period in question.[2]

Claimant has the burden of proving by a preponderance of the evidence that he was entitled to temporary disability benefits for the time in question. See ORS 656.266. A claimant's substantive entitlement to temporary disability benefits is determined at claim closure and is proven by a preponderance of the evidence in the entire record showing that the claimant was disabled due to the compensable injury before being declared medically stationary. ORS 656.210; Lebanon Plywood v. Seiber, 113 Or App 651 (1992).

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

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[1] SAIF submitted a copy of the 1502 Form filed with the Department on November 9, 1983, which demonstrates that the correct average weekly wage is $261.20 which equals a TTD rate of $174.14 per week.

[2] By letters to both parties, dated February 12 and March 17, 1998, we requested documentation regarding the dates and amounts of temporary disability compensation paid. SAIF responded with letters dated March 12 and March 30, 1998, wherein it outlined how it arrived at the correct TTD rate. Claimant did not respond to either request. The record does not contain documentation regarding how SAIF arrived at the total amount of temporary disability compensation it paid for the period in question.

The record does not contain medical evidence regarding when claimant was returned to full, modified and/or part-time work. Additionally, there is no evidence in the record indicating the number of hours claimant worked on a daily basis during the period in question. This information is necessary to determine when claimant returned to full-time work and how long he may have worked on a modified or part-time basis, in order to determine the temporary partial compensation due to claimant.

We are unable, on the current record, to determine whether claimant was paid the correct amount of temporary disability compensation. Despite repeated requests for the information necessary to determine the dollar amount, if any, due for the period of temporary total and/or partial disability to which claimant is entitled, this information has not been received from either party. Under these circumstances, we conclude that the most expedient manner in which to resolve these matters is to refer them to the Hearings Division for an evidentiary hearing. OAR 438-012-0040; 438-012-0060.

At the hearing, the assigned Administrative Law Judge (ALJ) shall take evidence regarding the dollar amount due, if any, for the temporary total/partial disability due for the period from November 27, 1996 to November 16, 1997. This hearing will be conducted in any manner that the ALJ determines will achieve substantial justice. Following the hearing, the ALJ shall issue a recommendation to the Board within 30 days. In that recommendation, the ALJ shall make findings of fact on the questions of the dollar amount due for the above period of temporary total and partial disability. Based on those findings of fact, the ALJ shall recommend to the Board whether it should modify SAIF's December 2, 1997 Notice of Closure. Following the hearing and our receipt of the ALJ's recommendation, we shall implement a briefing schedule, and, upon its completion, proceed with our review, and eventually, issue a final, appealable order.

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

IT IS SO ORDERED.

April 28, 1998 Cite as 50 Van Natta 833 (1998)

In the Matter of the Compensation of
SUSAN M. ABLES, Claimant
WCB Case No. 97-05687
ORDER ON REVIEW
Bennett, Hartman, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

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

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

Because claimant is seeking compensation for a mental condition, the claim must be analyzed under ORS 656.802. See ORS 656.802(3); Fuls v. SAIF, 321 Or 151 (1995); Albert D. Avery, 49 Van Natta 1771, 1773 (1997). Thus, in addition to being subject to the "major contributing cause" standard, claimant must prove the existence of her 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 condition other than those generally inherent in every working situation or reasonable, 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.

For the reasons set forth in the ALJ's order, we agree that claimant has not established that her accepted cervical injury is the major cause of her mental condition. Moreover, there is no persuasive evidence which would satisfy claimant's burden of establishing, by clear and convincing evidence, that her mental disorder arose of out and in the course of her employment. Accordingly, we agree with the ALJ that the insurer's denial should be upheld.

ORDER

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

In the Matter of the Compensation of
MARCUS W. PRUSS, Claimant
Own Motion No. 98-0152M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable small central tear of the lateral meniscus left knee and puncture wound of the right foreman. Claimant's aggravation rights expired on February 26, 1992. SAIF opposes authorization of temporary disability compensation, contending that: (1) surgery or hospitalization is not reasonable and necessary for the compensable injury; (2) the current condition is not causally related to the accepted condition; (3) SAIF is not responsible for claimant's current condition; and (4) surgery or hospitalization 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.

SAIF contends that it has, on two previous occasions, denied compensability and responsibility for claimant's current left knee condition and that those denials have become final by operation of law.[1] In addition, SAIF contends that it is not "appropriate to issue yet another compensability denial on this claim. The claim is in a closed-denied status." Claimant has not responded to SAIF's contentions.

Thus, the issue of whether claimant's current condition is related to his accepted small central tear of the lateral meniscus left knee and puncture wound of the right foreman remains a compensability and a responsibility question which are undetermined at this time.

Inasmuch as the dispute between the parties remains unresolved, we are not authorized to reopen claimant's 1979 injury claim for the payment of temporary disability benefits. See ORS 656.278(1)(a). Should claimant's circumstances change, and SAIF accepts responsibility for claimant's current condition, claimant may again seek own motion relief.

Accordingly, claimant's request for temporary disability compensation is denied.

IT IS SO ORDERED.

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[1] SAIF further relies on our Own Motion Order dated September 29, 1993, wherein we denied reopening claimant's claim at that time finding that claimant's current condition remained in denied status. While a prior finding does not irrevocably commit claimant's current condition to a denied status, he must show that his current condition is causally related to the accepted condition and that SAIF is responsible for his current condition. Compensability and responsibility disputes fall within the Hearings Division's jurisdiction and must be resolved before the Board can proceed with its review.

In the Matter of the Compensation of
LANCE T. HERRING, Claimant
WCB Case No. 97-00738
ORDER ON REVIEW
Black, Chapman, 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 denial of claimant's low back injury claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings."

CONCLUSIONS OF LAW AND OPINION

On September 27, 1996, claimant had the onset of low back pain while working. Claimant's medical history includes low back strains in 1993 and 1994. The ALJ, applying ORS 656.005(7)(a)(B), found that claimant failed to prove the compensability of his low back injury. Claimant challenges the ALJ's order, asserting that a preexisting condition did not combine with claimant's low back injury and the opinion from his treating physician carried his burden of proof.

Claimant's treating neurosurgeon, Dr. Louie, stated on two occasions that claimant's low back sprain was "secondary" to the September 1996 work injury. (Exs. 22, 32).

Examining physicians Dr. Donahoo, orthopedic surgeon, and Dr. Melson, neurologist, found that some of the physical findings had a "functional quality." (Ex. 25-8). The panel also noted that a MRI showed a disc protrusion at L2-L3 and such condition "could be a pain generator." (Id.) The panel's report concluded that, "[t]aken as a whole, we feel that the major contributing cause is his previous ongoing back pain of three years' duration superimposed on the changes dating back to the adolescent years and can be considered waxing and waning." (Id.)

Dr. Naugle, another treating physician, concurred with the panel's report. (Ex. 31). Dr. Naugle also agreed with a report written by claimant's attorney stating that "it was reasonable to conclude that the activity at work, i.e. bending over to pick up wood, was the major cause of the diagnosis and treatment after September 27, 1996." (Ex. 34-1).

Finally, Dr. Melson was deposed and explained that claimant sustained a low back strain which became superimposed on a "worn out back." (Ex. 35-15). Dr. Melson also stated that the major contributing cause of claimant's need for treatment of this condition was his preexisting degenerative condition. (Id. at 15, 16).

We first agree with the ALJ that Dr. Naugle's opinion is not entitled to any weight because he changed his opinion without any explanation for doing so. See Kelso v. City of Salem, 87 Or App 630 (1987). We also find persuasive reasons for not deferring to Dr. Louie's opinion. See Weiland v. SAIF, 64 Or App 810 (1983).

As noted above, Dr. Louie's opinion is conclusory in that it provides no explanation for why he attributes claimant's low back condition to the work incident. We find such absence significant because it does not respond to the panel's report and Dr. Melson's deposition testimony that claimant's injury combined with a preexisting condition, and the preexisting condition was the major contributing cause of claimant's need for treatment. The record also shows that Dr. Louie apparently saw claimant on one occasion; thus, Dr. Louie had no more contact with claimant than the examining panel.

In sum, we find the unpersuasive medical opinions in support of claimant's claim (when considered in light of the more persuasive contrary opinions) to be insufficient to carry his burden of proving compensability (whether under ORS 656.005(7)(a) or 656.005(7)(a)(B)).

ORDER

The ALJ's order dated November 24, 1997 is affirmed.

In the Matter of the Compensation of
TERRY R. TYLER, Claimant
WCB Case No. 96-07138
ORDER ON RECONSIDERATION
Schneider, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Claimant requested reconsideration of our January 30, 1998 Order on Review that reversed an Administrative Law Judge's (ALJ's) order setting aside the SAIF Corporation's denial of claimant's low back injury claim. In moving for reconsideration, claimant contends that we erroneously rejected the ALJ's demeanor-based finding that claimant was a credible witness and ignored the ALJ's implicit finding that the employer's witnesses were not credible. Claimant seeks reconsideration of our decision and affirmance of the ALJ's order.

In order to consider claimant's motion, we withdrew our prior order on February 27, 1998. SAIF has submitted a response. We now address claimant's motion.

Claimant contends that we erroneously replaced the ALJ's demeanor-based credibility findings with our own findings as to both claimant and, implicitly, the other witnesses. As we stated in our prior order, our credibility determination was based on our review of the record and issues raised therein. In this regard, the ALJ expressly noted the existence of discrepancies in the record, but without discussion he dismissed those discrepancies as collateral and minor in nature. We, on the other hand, concluded that those discrepancies were sufficient to call into question the accuracy of the history upon which Dr. Harris's opinion is based. The accuracy of claimant's history was particularly significant in this case because of the potential contribution of at least two prior low back injuries to claimant's current condition.

On reconsideration, we conclude that the reasons supporting our credibility determination were adequately addressed in our prior order. Accordingly, we adhere to and republish our January 30, 1998 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
JOHN R. KENNEDY, Claimant
Own Motion No. 98-0176M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable left knee condition (torn posterior horn medial meniscus). Claimant's aggravation rights expired on May 7, 1996. 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 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 was not in the workforce at the time of the current disability because "[claimant] did not submit proof of earnings." However, with its recommendation form, SAIF submitted chart notes from Dr. Harris, claimant's treating physician, which, not only demonstrate claimant's need for surgery, but also show that claimant was in the workforce at the time of the current disability. In the February 17, 1998 chart note, Dr. Harris stated: "I recommended removal of the screw in hopes that it will alleviate some of his symptoms. He will only be off work a few days. ... As indicated above, he shouldn't be off work more than a week." On March 17, 1998, Dr. Harris further noted: "He is back at work already."

Thus, we conclude that claimant was in the workforce at the time of his current worsening. Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning March 9, 1998, 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.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARK A. MIDDLETON, Claimant
WCB Case Nos. 97-05979 & 97-04936
ORDER ON REVIEW
Callahan & Stevens, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney
Randy Rice, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

EBI Companies, on behalf of Spirit Mountain Casinos, requests review of that portion of Administrative Law Judge (ALJ) T. Lavere Johnson's order that: (1) set aside its denial of claimant's right shoulder condition; and (2) upheld the SAIF Corporation's denial of responsibility for the same condition. On review, the issue is responsibility.

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

Claimant has an accepted right torn rotator cuff injury with SAIF as a result of a July 12, 1996 injury. Claimant underwent surgery on October 11, 1996. On October 20, 1996, claimant sustained another right torn rotator cuff injury; by this date, EBI had become the employer's workers' compensation carrier. On June 25, 1997, claimant underwent a second operation on his right shoulder.

The ALJ found that claimant proved compensability of his second right rotator cuff injury. Furthermore, relying on the opinion of claimant's treating surgeon, Dr. Weiner, the ALJ found EBI responsible for the claim. On review, EBI contests only that portion of the ALJ's order finding it responsible. According to EBI, the more persuasive medical evidence shows that SAIF is liable for claimant's right shoulder condition claim.

When a worker sustains a compensable injury, the responsible carrier remains responsible for the compensable condition unless the worker sustains a new compensable injury involving the same condition. ORS 656.308(1). The standards for determining the compensability of a combined condition under ORS 656.005(7) are used to determine the occurrence of a new compensable injury. Id.

Here, based on the ALJ's reasoning, we agree that Dr. Weiner provided the more persuasive opinion. See Weiland v. SAIF, 64 Or App 810 (1983). According to Dr. Weiner, at the time of the second injury, claimant was in a "vulnerable state" because he was recovering from his first right shoulder surgery. (Ex. 23-2). Dr. Weiner also indicated that the second injury in October 1996 was "consistent with the mechanism of injury of the re-tear of the rotator cuff and was sufficient trauma to have caused the injury." (Id.) Dr. Weiner found that the major contributing cause of claimant's second injury was the incident of October 20, 1996. (Id.)

We understand Dr. Weiner as indicating that claimant's first injury combined with his second injury. Hence, to constitute a "new compensable injury," the second injury must be the major contributing cause of the need for treatment and disability of claimant's combined condition. ORS 656.005(7)(a)(B), 656.308(1). Because Dr. Weiner's opinion provided such a showing, and we find it to be the most persuasive opinion, we conclude that claimant sustained a "new compensable injury." Consequently, EBI is responsible for claimant's right shoulder condition.

Finally, claimant's counsel is entitled to an attorney fee for services on Board review. After considering the factors prescribed in OAR 438-015-0010(4) and comparing to this case, we find that a reasonable attorney fee for claimant's counsel's services on review is $1,000, to be paid by EBI Companies. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the case, and the value of the interest involved.

ORDER

The ALJ's order dated October 24, 1997 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by EBI Companies.

In the Matter of the Compensation of
EDMUND D. MOORE, Claimant
WCB Case No. 97-07185
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Hall and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Hazelett's order that affirmed an Order on Reconsideration that awarded 6 percent (19.2 degrees) unscheduled permanent disability for a thoracic and low back injury, whereas a Notice of Closure awarded no permanent disability. On review, the issue is extent of unscheduled permanent disability.

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

The eighth paragraph of the findings of fact should read as follows. By Opinion and Order dated January 16, 1997, a prior ALJ found compensable claimant's June 16, 1995 lumbosacral strain/sprain and thoracic strain/sprain injuries and set aside the employer's denial of those conditions. (Ex. 15). The employer requested review. By order dated September 10, 1997, the Board affirmed the prior ALJ's findings regarding compensability of claimant's June 16, 1995 injury. (Ex. 18C). On October 9, 1997, the Board denied the employer's request to reconsider its September 10, 1997 order. (Ex. 22).

The employer argues that the ALJ erred in relying on the medical arbiter's findings in evaluating claimant's permanent impairment. In support of this argument, the employer asserts that findings made in reports authored by examining physicians render the medical arbiter's report unpersuasive. However, medical evidence from a non-treating physician may not be used to impeach the opinion of a treating physician or medical arbiter regarding a claimant's impairment. Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666 (1994); Tommy V. Drennen, 47 Van Natta 1524 (1995); Jerome D'Arcy, 46 Van Natta 416 (1994).

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 $1,100, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and claimant's attorney's affidavit in support of an attorney fee), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 28, 1997 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,100, payable by the self-insured employer.

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

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Neal's order that: (1) set aside its denial of claimant's aggravation claim for a right shoulder condition; and (2) awarded an assessed fee of $9,000 for services before the Board and Court of Appeals. Claimant cross-requests review, arguing that the ALJ's attorney fee award should be increased. On review, the issues are aggravation and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.[1]

CONCLUSIONS OF LAW AND OPINION

Aggravation

At the time of the April 24, 1995 hearing, claimant had been a bus driver for the employer for 14 years. She filed three claims for injuries to her back, shoulders and arms between July 1993 and February 1994. The employer denied each claim, and claimant requested a hearing on each denial. Prior to the scheduled date of hearing (June 14, 1994), the parties entered into an oral agreement to settle the claims. (Ex. 26A). Under the terms of the agreement, the employer agreed to rescind its denials and accept claimant's conditions under one nondisabling injury claim.

Meanwhile, in June 1994, claimant began working split shifts due to increased customer demand. During the afternoon shift, she drove Route #78, a particularly busy route. There were more turns required on the route, and she was unable to get adequate rest breaks or sleep. After the shift change, claimant developed worsening pain in the neck, right upper back and right shoulder area. On June 29, 1994, prior to the execution of the parties' written settlement agreement, claimant returned to her attending physician, Dr. Parshley. The doctor diagnosed "[r]eexacerbation of her previous musculoskeletal injury secondary to change of her job status and job description," and released her from work for one week. (Ex. 26AA-1). Claimant's condition improved while off work and she continued to follow up with Dr. Parshley in July 1994.

On August 1, 1994, claimant returned to Dr. Parshley with worsening right shoulder pain and she prescribed anti-inflammatories. (Ex. 26AA-4). On August 19, 1994, the employer denied the aggravation claim. (Ex. 29). Claimant requested a hearing.

At the April 24, 1995 hearing, the employer contended that claimant's aggravation claim was barred by the terms of the prior Stipulation and Order. The ALJ agreed, reasoning that, because the "reexacerbation" of claimant's right shoulder condition was diagnosed and claimant was released from work before the July 26, 1994 approval of the stipulation, the aggravation claim could have been raised and negotiated before the stipulation's approval.

We affirmed. Vicki D. Pollock, 48 Van Natta 463 (1996). The Court of Appeals reversed our order. Pollock v. Tri-Met, Inc., 144 Or App 431 (1996). The court found that we had not ascertained the intent of the parties at the time of their settlement and it instructed us on remand to construe the parties' settlement in such a way as to carry into effect their purpose and intent at the time of the agreement. Id. at 435-36. In our Orders on Remand, we concluded that because the June 1994

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[1] The record before the ALJ included the exhibits before ALJ Johnstone at the April 24, 1995 hearing. Although ALJ Johnstone stated that Exhibits A, B, 1-33, 5A, 26AA, 26A and 27A were admitted into evidence, we note that ALJ Johnstone withdrew Exhibit 28 on his own motion. (Tr. 1; 4/24/95 hearing).

aggravation claim was not in existence at the time the parties orally agreed to settle, and the employer received no notice of the aggravation claim before the ALJ's approval of the written agreement, the June 1994 aggravation claim was not among the "raised or raisable issues" that were contemplated by the parties' settlement agreement. Vicki D. Pollock, 49 Van Natta 1419, 1421, on recon 49 Van Natta 1770 (1997).

Regarding the merits of the aggravation claim, we rejected the employer's contention that claimant intentionally caused the alleged worsening of her shoulder condition. 49 Van Natta at 1421. We considered the present record insufficiently developed to resolve the question of whether claimant's compensable right shoulder muscle strain condition has "actually worsened" under amended ORS 656.273(1) and we remanded this matter to the Hearings Division for further evidence taking. Id. at 1422.

On remand, the ALJ relied on Dr. Parshley's opinion and concluded that claimant established a pathological worsening of her right shoulder condition. The employer contends that Dr. Parshley's opinion does not establish an "actual worsening" pursuant to ORS 656.273.

ORS 656.273(1) provides that "[a] worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings." In SAIF v. Walker, 145 Or App 294, 305 (1996), 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 required to prove an aggravation and that it is no longer permissible to infer a worsened condition from evidence of increased symptoms alone. Id.

As we discussed earlier, the parties executed a Stipulation and Order in July 1994 that was approved by an ALJ on July 26, 1994. (Ex. 26A). As a result of that stipulation, the employer accepted a nondisabling acute right shoulder muscle strain. (Ex. 32). In our previous order, we concluded that claimant's aggravation claim was not in existence at the time the parties orally agreed to settle. 49 Van Natta at 1421. We proceed to analyze whether claimant has sustained an actual worsening of the compensable right shoulder strain.

In June 1994, claimant began working split shifts. During the afternoon shift, she drove Route #78, which required more turns. After the shift change, claimant developed worsening pain in the neck, right upper back and right shoulder area. On June 29, 1994, claimant was examined by Dr. Parshley, who reported that claimant had a lot of spasm and tenderness in her rhomboids on the right up into her trapezius muscle and some spasm in her right deltoid area. (Ex. 26AA-1). She was tender above the AC joint. Claimant also had some paraspinous muscle spasm and had some difficulty abducting above about 80 degrees of the right shoulder. (Id.) Dr. Parshley diagnosed "[r]eexacerbation of her previous musculoskeletal injury secondary to change of her job status and job description." She prescribed medication and released claimant from work for one week. (Id.)

On July 6, 1994, Dr. Parshley reported that claimant was "almost 100% back to normal with just a little aching in her right shoulder which is baseline." (Ex. 26AA-2). Claimant could abduct her arm without difficulty and her upper back was fine without any spasm. (Id.) She returned to work. (Id.)

On August 1, 1994, claimant again complained of right shoulder pain. (Ex. 26AA-4). Dr. Parshley reported that claimant was back to work after vacation and her shoulder had been painful since July 19, 1994. Dr. Parshley found that claimant was tender over the AC joint and lateral to it. (Id.) She had full range of motion, but had a great deal of discomfort with rotation against pressure. (Id.) Dr. Parshley diagnosed "[c]ontinued right shoulder problems." (Id.) Because of the multitude of claimant's symptoms, Dr. Parshley was unclear whether she had a rotator cuff and/or bursitis tendinitis. (Id.) Dr. Parshley released claimant to work starting August 3, 1994. (Ex. 27).

Claimant relies on the opinions of Drs. Parshley, Neumann and Bernstein to establish a temporary pathological worsening of her compensable condition. In evaluating the medical evidence concerning causation, we rely on opinions that are well-reasoned and based on accurate and complete information. Somers v. SAIF, 77 Or App 259 (1986).

On September 7, 1994, claimant was examined by Drs. Neumann and Bernstein on behalf of the employer. They diagnosed "[c]hronic bursitis and biceps tendinitis, right shoulder." (Ex. 30-5). They found that claimant's condition was stable and stationary and she had received maximum benefit of medical treatment. (Id.) However, they commented that claimant's symptoms depended on her activity level and were related to her "overuse activities as a bus driver." (Ex. 30-4, -6). When asked if claimant had sustained an aggravation of her condition since August 1993, they answered "Yes. She has had episodes, as noted in the history above." (Id.) Although Drs. Neumann and Bernstein indicated that claimant had sustained an aggravation, their opinion lacks adequate explanation and their opinion does not establish that the underlying shoulder strain had pathologically worsened. Consequently, their opinion is entitled to little probative weight in determining whether claimant sustained an "actual worsening."

We generally rely on the opinion of a claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). For the following reasons, we are not persuaded by the opinion of Dr. Parshley. We acknowledge that no incantation of "magic words" or statutory language is required to establish the compensability of a claim, provided 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. Parshley's opinion does not meet that standard with regard to claimant's aggravation claim.

Dr. Parshley was deposed on March 28, 1995. She said that claimant had bursitis and tendonitis since 1992. (Ex. 33-29). She examined claimant in June 1994 and said claimant had muscular spasms and complaints when she was on a run that required her to turn the bus more frequently. (Ex. 33-23, -24). Dr. Parshley said that claimant gets exacerbations of her shoulder condition when she had to do more turning of the bus. (Id.) She agreed that claimant's bursitis appears to be "activity-driven" and it had "waxing and waning" with activity. (Ex. 33-33).

When the employer's attorney asked Dr. Parshley whether claimant had a pathological worsening of the right shoulder condition, she responded:

> "I'm not sure what you're referring to in 'pathological worsening.' I mean, she still has acute inflammation at those times in her rotator-cuff apparatus. And in the intervening time when I don't see her, she relates a history that the symptoms are less, and one would assume at those times that the inflammation has decreased." (Ex. 33-34).

Although Dr. Parshley indicated that claimant gets inflammation of her shoulder condition with overuse, she agreed that the level of claimant's symptoms in 1994 appeared to be less than in 1993. (Ex. 33-37). The employer's attorney asked whether claimant had experienced a progressive worsening:

> "Q. It's not -- in other words, there hasn't been a progressive worsening, at least in her report of symptoms and her abilities on exam in August of '93 and August of '94, comparing those two periods?
>
> "A. True. When she gets exacerbation, she usually has about the same level of symptoms." (Ex. 33-38).

Dr. Parshley said that claimant had a "waxing and waning of previous conditions." (Id.) Her concern was that continued and persistent inflammation could damage the rotator cuff apparatus and cause a rupture or tear over the long-term, although claimant did not yet have those problems. (Ex. 33-39).

Dr. Parshley's testimony indicated that claimant's level of symptoms was actually less in 1994 than it was in 1993 and she agreed that claimant usually has the same level of symptoms when she has an exacerbation. Under these circumstances, we conclude that Dr. Parshley's testimony does not provide "direct medical evidence" that claimant's compensable right shoulder strain condition has "worsened." See SAIF v. Walker, 145 Or App at 305. Rather, her testimony indicated that claimant's symptoms were at a level less than in 1993. On this record, we find no persuasive medical evidence of an "actual worsening" of claimant's compensable shoulder condition. Consequently, claimant has not proven a compensable aggravation and the employer's denial must stand.

Attorney Fees

In light of our conclusion that claimant has not established a compensable aggravation, it is not necessary to address claimant's argument that the ALJ's attorney fee award should be increased.

ORDER

The ALJ's order dated December 18, 1997 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

April 29, 1998 Cite as 50 Van Natta 843 (1998)

In the Matter of the Compensation of
LUIS E. SANTOS, JR., Claimant
WCB Case No. 97-07840
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that: (1) declined to award temporary disability for the period beginning August 22, 1997; and (2) declined to assess a penalty based on the insurer's allegedly unreasonable failure to pay that temporary disability. On review, the issues are temporary disability and penalties.

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

A worker is only procedurally entitled to temporary disability compensation if time loss is authorized for the period in question. See ORS 656.262(4)(f); Mark V. Moser, 50 Van Natta 221 (1998). In this case, there is no time loss authorization in the record for the period beginning August 22, 1997. Accordingly, even assuming (without deciding) that the insurer's objection to Dr. Halcomb's status as attending physician was ineffective, claimant has not established that the insurer improperly terminated temporary disability benefits as of August 27, 1997.

ORDER

The ALJ's order dated January 21, 1998 is affirmed.

In the Matter of the Compensation of
DANIEL I. VANWECHEL, Claimant
WCB Case No. 97-06406
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Podnar's order that directed the employer to reopen claimant's right knee injury claim for processing of additional right knee conditions that were accepted after claim closure. On review, the issue is claim processing.

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

On review, the employer contends that ORS 656.262(7)(c) does not require "reopening" of claimant's injury claim for processing of new medical conditions that were accepted after claim closure, if the new conditions were already evaluated for permanent disability during the initial closure. Though acknowledging that the Board previously decided this issue contrary to its position, in Ronald D. Smith, Sr., 49 Van Natta 1807 (1997), and Mario R. Castaneda, 49 Van Natta 2135 (1997), the employer requests that those decisions be disavowed as wrongly decided. The employer argues that there is no "rational basis" for claim reopening in cases where the new medical condition was already rated; that the language of ORS 656.262(7)(c) is ambiguous and does not reflect legislative intent; that the legislature did not intend to require claim reopening in every situation; and that the literal application of ORS 656.262(7)(c) would produce an absurd or unreasonable result.

ORS 656.262(7)(c) provides in 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." The provision went into effect in 1997 and retroactively applies to this claim. See Smith, 49 Van Natta at 1808.

Contrary to the employer's assertion, we find no ambiguity in the text of ORS 656.262(7)(c) when applied to the facts of this particular case. It is undisputed that claimant's additional right knee conditions, namely an anterior cruciate ligament (ACL) tear and fragmentation of the medial femoral condyle, were accepted (i.e., found compensable) after the claim was closed in 1994. (Exs. 17, 23). Having satisfied the statutory condition precedent to application of ORS 656.262(7)(c), the employer has a clear and absolute duty: The employer "shall reopen the claim for processing" regarding the new condition. (Emphasis supplied.) There is only one reasonable interpretation of that text. See State v. Cooper, 319 Or 162, 167 (1994) (statutory language is ambiguous when capable of two interpretations and "either interpretation is reasonable"); Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666, 669 (1994) (a statute is ambiguous if "it is capable of more than one reasonable interpretation"). The text of ORS 656.262(7)(c) does not allow an exception for new conditions that were already rated in the initial or previous claim closure, and we decline to insert an exception for such conditions. See 174.010; PGE v. Bureau of Labor and Industries, 317 Or 606, 611 (1993) (the rules of statutory construction include the enjoinder "not to insert what has been omitted, or to omit was has been inserted").

Having concluded that the text of ORS 656.262(7)(c) is unambiguous, we do not need to inquire into legislative history. See PGE, 317 Or at 611. We note, however, that even the legislative history cited by the employer does not support its assertion that the 1997 Legislature intended to permit an exception to ORS 656.262(7)(c) for new conditions (i.e., conditions accepted after claim closure) that were previously rated in the prior claim closure. For these reasons, we decline to disavow our decisions in Smith and Castaneda and conclude that the ALJ properly applied ORS 656.262(7)(c) to the facts of this case and in accordance with the legislative intent expressed by the unambiguous text of the statute.

Finally, we decline the employer's invitation to depart from the literal construction of ORS 656.262(7)(c) as being absurd or unreasonable. The employer cites to Rick A. Webb, 47 Van Natta 1550 (1995), where the Board departed from a literal construction of a statute that, if applied retroactively, would have defeated an aggravation claim on the basis that the claim was not filed in a form that did not exist at the time of the claim filing. We concluded in Webb that a literal application of the statute would produce an absurd and unintended result. Id. at 1551.

The facts of this case are distinguishable from Webb. Whereas a literal application of the statute in Webb would have made it impossible for the claimant to comply with the statute, no such impossibility exists in this case. The employer is able to comply with the statutory requirement to "reopen the claim for processing."[1] The employer must therefore comply with the statute.

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

ORDER

The ALJ's order dated December 12, 1997 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $250, payable by the self-insured employer.

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[1] This conclusion should not be interpreted as a pronouncement that claimant is, or is not, entitled to additional temporary or permanent disability benefits. Such a determination must await the further processing of this claim. Instead, our decision is solely confined to a ruling that the employer is required to reopen the claim for the processing of the "post-closure accepted" new medical conditions.

In the Matter of the Compensation of
ROBERT N. CLARK, Claimant
WCB Case No. 96-10350
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Baker's order that upheld the insurer's denial of claimant's claim for an L4-5 disc herniation. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

We briefly summarize the relevant findings of fact as follows.

Claimant seriously injured his back in 1978. He had low back surgeries in 1981 and 1983. In 1988, claimant again injured his low back in a slipping and twisting incident while working for a prior employer.

Claimant received chiropractic treatment for his low back over the years following the 1988 work injury. Claimant's family physician, Dr. Koester, followed claimant for the 1988 back injury and authorized chiropractic treatment. On April 29, 1996, claimant was seen by Dr. Koester because claimant wanted to keep the option of palliative chiropractic treatment open. On that date, claimant's back range of motion was normal. Dr. Koester advised that claimant's condition was stable with some low back pain and with occasional radiation down the leg. He recommended continued palliative chiropractic treatments twice per month as in the past. Dr. Koester advised the insurer for claimant's 1988 claim that he would recheck claimant in 60 days.

Claimant returned to Dr. Koester on June 26, 1996. Claimant reported a little recent worsening. He thought he was doing more work around home with firewood. He complained of some numbness in the right foot as well as intermittent bilateral sciatica-type pain. He had not missed any work. Claimant's back range of motion on June 26, 1996 was normal. His "straight leg raising" (SLR) was

mildly painful on both sides but normal and leg strength was otherwise good. Dr. Koester recommended continued chiropractic treatment for several months. The doctor recommended to the insurer for the 1988 claim that claimant continue palliative chiropractic treatments twice per month so that claimant could avoid missing work.

On June 28, 1996, claimant experienced back pain at work after lifting a motor weighing 180 pounds. On the same date, claimant also lifted a second motor with assistance. Claimant's symptoms gradually worsened over several days after the lifting incident. After the incident, claimant worked 10 hours the next day and 13 hours the second day. He was then off work three days.

Claimant sought medical treatment on July 8, 1996 from Dr. Koester. Claimant was evaluated by Dr. Kitchel on July 26, 1996. Dr. Kitchel concluded that there was a herniated nucleus pulposus at L4-5 on the right, radiculitis L5 right, multiple level lumbar degenerative disc disease and degenerative central spinal stenosis at L4-5.

Claimant underwent surgery by Dr. Kitchel on August 10, 1996.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant had not met his burden of proof to establish compensability of his L4-5 disc herniation. In reaching this conclusion, the ALJ relied on examining physician, Dr. Kirschner, who could not state that claimant's June 28, 1996 injury was the major contributing cause of the disc herniation. On review, claimant argues that his treating physicians, Drs. Koester and Kitchel are in the best position to address the cause of the L4-5 disc condition. After reviewing the medical evidence, we agree with claimant that he has met his burden to establish compensability of his disc condition.

Dr. Kirschner, a neurologist, initially opined that claimant's L4-5 disc condition was related to claimant's on the job activities on June 28, 1996. Dr. Kirschner was deposed. At his deposition, he received more information regarding the June 28, 1996 work incident, including claimant's contemporaneous written description of the gradual onset of his symptoms over several days after the work incident. In addition, Dr. Kirschner reviewed for the first time Dr. Koester's chart note indicating that claimant had received treatment on June 26, 1996 and reported symptoms including numbness of the right foot and back pain. After receiving this additional information, Dr. Kirschner modified his earlier opinion and indicated that he could not state that the major cause of claimant's condition was the June 28, 1996 injury.

Dr. Koester, claimant's family physician, followed claimant's condition after his 1988 injury and authorized chiropractic treatment. Dr. Koester concurred with Dr. Kirschner's initial opinion that claimant's L4-5 condition was related to the June 1996 motor lifting incident. Dr. Koester opined that claimant's June 28, 1996 lifting incidents coupled with his subsequent work activity over the next several days was the major contributing cause of the L4-5 disc herniation. Dr. Koester further indicated that claimant has experienced mild-moderate back and leg symptoms for years. However, Dr. Koester indicated that claimant's problems following the June 1996 lifting incident were subjectively and objectively different from what Dr. Koester saw claimant for previously.

Dr. Kitchel, an orthopedist, who performed claimant's surgery following the June 1996 incident, opined that the major contributing cause of claimant's surgery and treatment was the June 28, 1996 lifting injury. Although Dr. Kitchel indicated that claimant's previous injury and surgery also played a role in claimant's condition, the 1996 episode was considered the major contributing cause.

We generally defer to the conclusions of a treating physician absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find no persuasive reason not to rely on the opinions of the physicians who treated claimant for his low back condition. Dr. Koester had followed claimant for the 1988 compensable injury and was familiar with claimant's back condition prior to the 1996 injury. As such, Dr. Koester is in a good position to determine the cause of claimant's current low back condition. Dr. Kitchel performed claimant's surgery for the L4-5 condition. As the physician who performed claimant's surgery, Dr. Kitchel is also in a good position to provide an opinion regarding the cause of claimant's current condition. See Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988). Moreover, there is no indication in the record that Dr. Koester or Dr. Kitchel had an inaccurate history

regarding claimant's injury. In contrast, Dr. Kirschner saw claimant on only one occasion and was less familiar with claimant's condition and prior treatment. Under such circumstances, we are more persuaded by the opinions of Drs. Koester and Kitchel. Accordingly, we find that claimant has met his burden of proof under ORS 656.005(7)(a)(B) to establish compensability of his L4-5 disc condition.

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

ORDER

The ALJ's order dated November 28, 1997 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant's attorney is awarded $4,000, payable by the insurer.

In the Matter of the Compensation of
GORDON K. MEDLEY, Claimant
WCB Case Nos. 97-07000 & 97-06465
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Garrett, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Brazeau's order that: (1) awarded a $1,500 assessed attorney fee for services concerning the self-insured employer's pre-hearing rescission of its denial of claimant's claim for a low back injury; (2) declined to assess penalties for the employer's allegedly unreasonable denials; and (3) declined to assess a penalty for the employer's allegedly untimely payment of temporary disability benefits. With his brief, claimant has also submitted additional evidence and requests that it be admitted into the record. We treat claimant' submission as a motion to remand. On review, the issues are remand, attorney fees, and penalties. We deny the motion to remand and affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Remand

With his brief, claimant submits a copy of an August 6, 1997 check stub from the employer. Claimant asserts the proffered submission should be made part of the evidentiary record. We disagree.

Remand is appropriate if the record was improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988).

Here, claimant offers no explanation why the check stub, which is dated some three months prior to the hearing date, could not be obtained with due diligence at the time of the hearing. Consequently, remand is not appropriate. Accordingly, we do not consider the proffered evidence in conducting our review.

Attorney Fee

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

In his brief, claimant asserts that his counsel is entitled to an increased attorney fee on the basis that the employer issued two denials in this matter. While there were two denials, both denials were of the same injury claim. Consequently, the value of the interest to claimant is exactly the same regardless of the existence of a second denial. In addition, although claimant's counsel submitted a statement of services at the hearing level, the statement of services does not differentiate between time spent on the compensability issue, as opposed to time spent on the other five issues (regarding either penalties or attorney fees) on which claimant was not successful.

For these additional reasons, we conclude that the ALJ's award of a $1,500 assessed attorney fee, for services concerning the employer's pre-hearing rescission of its denial of claimant's low back injury claim, is reasonable.

Penalties

We adopt and affirm the relevant portions of the ALJ's order.

ORDER

The ALJ's order dated November 18, 1997 is affirmed.

In the Matter of the Compensation of
ALBERT D. AVERY, Claimant
WCB Case Nos. 95-13779 & 96-01975
ORDER DENYING RECONSIDERATION
Doblie & Associates, Claimant Attorneys
David L. Runner (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests reconsideration of that portion of our October 9, 1997 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order which set aside its denial of claimant's injury claim for memory loss/dementia conditions. SAIF requests remand for admission and consideration of "post-hearing" medical reports.[1]

After reviewing SAIF's motion for reconsideration, claimant's response, and SAIF's reply to claimant's response, we have nothing further to add to our prior order regarding the compensability issue. However, we offer the following supplementation concerning SAIF's request for remand to the ALJ.

In support of its remand request, SAIF submits "post-hearing" evidence, arguing that this evidence would change the result regarding the compensability of claimant's condition. Having received claimant's response and SAIF's reply, we consider SAIF's motion.

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); *Bailey v. SAIF*, 296 Or 41, 45 n. 3 (1985). In order to satisfy this standard, a compelling reason must be shown for remanding. A compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. *See Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986). We examine the proposed evidence only to determine if remand would be appropriate.

Our prior order found claimant's mental condition compensable, based on the medical experts' agreement that the condition was injury-related, largely because it did not progress after the injury (and absent evidence of such progression). We relied on the persuasive opinions of Drs. Hill and Friedman, which also discounted non-injury related causes for claimant's mental problems, based on the mechanism of injury, claimant's age, lack of family history of mental disease, and his apparently normal pre-injury mental functioning. Further considering the temporal relationship between the injury and claimant's cognitive problems, Drs. Hill and Friedman persuasively concluded that the injury caused claimant's memory loss/dementia condition.

The proffered "post-hearing" evidence consists of: February and March 1998 medical reports authored by Drs. Hill, Friedman, Kirschner, and Laurence Binder; and March 1998 communications from the offices of Drs. Carmicioli and Zimmerman. In addition, claimant attached documents to his response to SAIF's motion for reconsideration and SAIF attached additional documents to its reply to claimant's response. Claimant has also submitted an April 9, 1998 letter from Dr. Zimmerman. We treat these documents as additional proffered evidence.

SAIF argues that claimant has had "post-hearing" changes which militate a conclusion that his condition is not injury-related. Claimant responds that his condition has not progressed since its "post-injury" onset.[2]

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[1] SAIF has also moved for withdrawal and abatement of our order pending our response to its motion for reconsideration and remand. In light of today's decision, SAIF's motion for withdrawal and abatement is denied. Finally, SAIF objects to claimant's supplemental "cross-reply" and submission. Inasmuch as we have also considered SAIF's response and claimant's cross-reply and submission, we decline to grant SAIF's motion to strike the brief and submission.

[2] SAIF relies on February and March 1998 reports by Drs. Friedman, Hills, and Kirschner, indicating these doctors' opinions that claimant's condition is progressive. (*See* Proposed Exs. 82-7, 83-3-4, 84; *compare* Exs. 68-1, 69-3-4; *see also* Ex. 75). Claimant relies on February and April 1998 letters from Dr. Zimmerman (who reviewed claimant's January 1998 EEG results and the "post-hearing" evaluations by Drs. Friedman, Kirschner, and Brown) and Dr. Brown, current attending physician. These doctors have opined that claimant's condition is static. (*See* Proposed Ex. 10-2 and Dr. Zimmerman's April 9, 1998 letter).

Having considered the proffered evidence for the purpose of evaluating whether remand is appropriate, we find that the expert opinions regarding the cause of claimant's mental condition continue to be divided. Moreover, although the record developed at hearing establishes that the static or progressive nature of claimant's condition is important to resolving the causation issue, the proposed evidence is conflicting and we are not persuaded that claimant's condition has changed. Accordingly, because we continue to find the evidence supporting the claim persuasive, the proposed evidence would not likely affect the outcome of the case.

Under these circumstances, we cannot say that the record has been improperly, incompletely or otherwise insufficiently developed and there is no compelling basis for remand. *See also William R. Wallace*, 49 Van Natta 1078 (1997), *aff'd mem Wallace v. Owens Illinois, Inc.*, 153 Or App 124 (1998) (*citing Compton at 646*). Consequently, the *Bailey* and *Compton* criteria are not satisfied and SAIF's motion for remand is denied.

Accordingly, we deny the motion for reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID J. BRUNSWICK, SR., Claimant
WCB Case Nos. 97-05010, 96-10942 & 96-06580
ORDER ON RECONSIDERATION
Craine & Love, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys
Judy C. Lucas (Saif), Defense Attorney

Paulus Insurance/Agricomp Insurance (Agricomp) has requested reconsideration of our April 3, 1998 Order on Review. In that order, we affirmed the Administrative Law Judge's (ALJ's) decision that claimant's current L4-5 disc condition is compensable and the responsibility of Agricomp rather than the SAIF Corporation. In response to Agricomp's request for reconsideration, we withdraw our April 3, 1998 order and proceed with our reconsideration.

We begin with a discussion of the pertinent facts. In May 1987, claimant sustained a compensable low back injury with SAIF's insured. A July 1987 CT scan was read by the radiologist as normal, and SAIF issued an acceptance of a lumbar strain. After that acceptance, the treating doctor reported that the CT scan was consistent with a herniated disc at L5 on the right. SAIF did not modify its acceptance to include this additional diagnosis, and the claim was closed following conservative treatment.

Claimant reinjured his low back while working for Agricomp's insured in February 1996. Agricomp accepted the injury as a lumbar strain and issued a May 28, 1996 denial of "pre-existing degenerative joint disease." A subsequent September 1996 MRI demonstrated a posterior and anterior L4-5 disc herniation. Dr. Misko, the current treating neurosurgeon, recommended a discectomy and interbody fusion to treat this condition.

On October 15, 1996, SAIF issued an amended acceptance of the 1987 injury as a lumbar strain and a "herniated lumbar disc L-5 on the right." By letter dated February 18, 1997, SAIF informed claimant that it was withdrawing its acceptance of the L-5 disc. Meanwhile, on December 4, 1996, SAIF issued a denial of the anterior disc protrusion at L4-5, and on February 19, 1997, it issued a compensability and responsibility denial of the anterior and posterior disc protrusions at L4-5.

Claimant requested a hearing from Agricomp's May 28, 1996 denial and SAIF's December 4, 1996 and February 19, 1997 denials. The matter proceeded to hearing, and the ALJ concluded that claimant's current L4-5 disc condition is compensably related to the February 1996 injury with Agricomp and the responsibility of Agricomp rather than SAIF. We affirmed the ALJ's decision in our April 3, 1998 Order on Review. In so doing, we did not address Agricomp's argument that SAIF has the burden of transferring responsibility to Argonaut under ORS 656.308 because SAIF's attempt to withdraw its

acceptance of an L5 disc condition was ineffective. We, instead, concluded that Dr. Misko's opinion persuasively established that the 1996 Agricomp injury was the major contributing cause of claimant's current need for treatment for his L4-5 disk condition. Accordingly, we concluded that responsibility rested with Agricomp under either ORS 656.308 or Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984).

On reconsideration, Agricomp contends that we erred in not addressing its argument regarding SAIF's acceptance of the L5 disc herniation. Agricomp agrees with the ALJ's decision that SAIF's purported withdrawal of this acceptance was invalid. However, Agricomp challenges the ALJ's ruling that the acceptance was limited to the right L5 disc condition as it existed in 1987 and does not encompass claimant's current condition. Based on this acceptance, Agricomp asks us to conclude that SAIF has the burden of transferring responsibility to Agricomp under ORS 656.308. Agricomp further contends that Dr. Misko's opinion does not satisfy this burden of transferring responsibility because it is speculative and, at most, establishes that the SAIF and Agricomp injuries were together the major contributing cause of the current condition or need for treatment.

After considering Agricomp's argument, we adopt and affirm the ALJ's ruling that SAIF's acceptance of the L5 disc herniation was limited to that condition as it existed in 1987 and does not encompass claimant's current condition. We also adhere to our prior ruling that Dr. Misko's opinion establishes that the 1996 Agricomp injury is the major contributing cause of claimant's current need for treatment. We recognize that Dr. Misko was unable to determine whether the 1996 injury was probably the major cause of the posterior L5 protrusion. However, Dr. Misko persuasively opined that it was medically probable that the 1996 injury was the major contributing cause of a new, anterior L4-5 protrusion. Moreover, Dr. Misko explained that the recommended fusion surgery would be necessary to treat the new anterior L4-5 protrusion, even if the posterior protrusion did not exist. When read as a whole, Dr. Misko's opinion establishes that the 1996 Agricomp injury is the major contributing cause of claimant's current need for treatment.

We, therefore, adhere to our prior decision that Dr. Misko's opinion establishes that the current claim is compensable under ORS 656.005(7)(a)(B), and the responsibility of Agricomp under either ORS 656.308 or Kearns. Consequently, we need not address the validity of SAIF's October 15, 1996 acceptance of the right L5 disc. Even assuming that SAIF's acceptance remains in effect, responsibility would pass to Agricomp under either responsibility analysis.

Accordingly, on reconsideration, we adhere to and republish our April 3, 1998 order as supplemented herein. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES R. HOKLAND, Claimant
Own Motion No. 97-0136M
OWN MOTION ORDER
Cole, Cary, et al., Claimant Attorneys
Reinisch, et al., Defense Attorneys

On May 16, 1997, we referred claimant's request for temporary disability compensation for his compensable right arm (impingement syndrome) injury to the Hearings Division. We took this action because litigation concerning the compensability of his right rotator cuff tear was pending before the Hearings Division. (WCB Case No. 97-02550).

On April 22, 1998, Administrative Law Judge (ALJ) Myzak approved a "Disputed Claim Settlement," which resolved the parties' dispute concerning the compensability of claimant's current right rotator cuff tear which was pending before the Hearings Division. Pursuant to that settlement, claimant agreed that the employer's March 14, 1997 denial would remain in full force and effect. In addition, claimant stipulated that his request for hearing "shall be dismissed with prejudice," and that the settlement resolved "all issues of temporary disability, permanent disability , medical care and treatment."

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 light of the parties' settlement, the current condition for which claimant requests own motion relief remains in denied status. Consequently, we are not authorized to reopen claimant's 1988 injury claim with the employer as he is not entitled to temporary disability compensation.

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

IT IS SO ORDERED.

May 1, 1998 Cite as 50 Van Natta 852 (1998)

In the Matter of the Compensation of
DAVID L. DYLAN, (fka DAVID H. HUBBARD), Claimant
WCB Case No. 96-04448
ORDER ON RECONSIDERATION
Cole, Cary, et al, Claimant Attorneys
Ronald W. Atwood & Associates, Defense Attorneys

On March 19, 1998, we withdrew our February 24, 1998 Order on Review that vacated an Administrative Law Judge's (ALJ's) order setting aside the self-insured employer's denial of claimant's aggravation claim for lack of jurisdiction. We took this action to consider claimant's assertion that we retain jurisdiction to resolve the compensability of his current disc condition and the medical services related thereto, which were in issue at hearing. We have also considered the employer's response to claimant's motion. After reviewing the parties' positions, we issue this reconsideration order.

The ALJ found that claimant's aggravation claim was timely filed under ORS 656.273(4)(a) and, on the merits, set aside the employer's denial. The ALJ determined that the employer had accepted claimant's damaged disc at L5-6 as part of claimant's original injury claim in 1990, and that the medical evidence established a worsening of that disc condition in 1995 which required surgery. On review, we held that we lacked jurisdiction to address the merits of claimant's aggravation claim because he failed to timely perfect a valid claim. In so holding, however, we did not address the compensability of claimant's current L5-6 disc condition nor the causal relationship between claimant's accepted low back injury and his current need for treatment.

On reconsideration, for the reasons set forth below, we conclude that claimant has failed to establish the compensability of his 1995 L5-6 disc condition which required surgery.

On May 21, 1990, the employer accepted claimant's low back claim as a disabling injury without specifying the conditions or limiting the scope of acceptance. At that time, the medical evidence indicated that claimant's condition involved a probable herniated nucleus pulposus with nerve root irritation, without specification of the disc level or levels.[1] (Exs. 6, 7, 8 and 9). The claim was closed by a January 16, 1991 Determination Order which awarded temporary disability only.

Claimant did not seek medical treatment for his back symptoms between December 1990 and October 1995. On October 3, 1995, he sought treatment with Dr. Matthews complaining of pain radiating down the posterior of the left leg into the left foot. A subsequent MRI was interpreted as showing a left paramedian disc herniation at L5-6 and a small central disc herniation at L6-S1, probably unchanged since 1990.

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[1] Prior to the employer's acceptance of the injury claim, claimant's condition had been variously diagnosed as a herniated disc, segmentation anomaly of the lumbar spine with degenerative disc disease L5-6 and lumbar strain with nerve root irritation, probable herniated nucleus pulposus and central disc bulge at L5-6, possible disc herniation, right paramedian region at L6-S1.

Claimant was referred to Dr. Lewis, an orthopedic surgeon. Dr. Lewis examined claimant on November 14, 1995 and diagnosed a disc herniation at the next to the last mobile segment with L5 irritative changes. On November 30, 1995, Dr. Lewis performed an excision of claimant's L5, L6 disc on the left. Dr. Lewis removed a large piece of fragment from under the posterior longitudinal ligament as well as nuclear material from the disc space.

On March 13, 1996, the employer issued a denial of claimant's aggravation claim, which further provided as follows: "We do have a claim for medical services but the medical records indicate that neither your work activity at [the employer] nor your prior April 27, 1990 injury is the major contributing cause of your current need for treatment or disability. We must therefore notify you that we cannot accept your claim."

As an initial matter, we agree with claimant that this denial constitutes a denial of his current condition as well as a denial of medical services, as the employer specifically contends that neither claimant's prior work activity nor his prior compensable injury is the major cause of his "current need for treatment or disability." Consequently, we retain jurisdiction over the parties' dispute. *Cf. SAIF v. Shipley*, 326 Or 557 (1998) (Board lacks jurisdiction to address the compensability of a claim for medical services only).

In this case, three physicians, Drs. Matthews, Fuller and Lewis, have offered opinions concerning the relationship between claimant's accepted injury and his L5-6 disc condition and need for treatment in 1995. Dr. Matthews, claimant's treating doctor since at least May 1990, opined in October 1995 that claimant's then-current low back and left leg symptoms were not related to his 1990 injury because his symptoms in 1990 were on the right side. (Ex. 27-6). Dr. Fuller, who examined claimant at the employer's request in March 1996, agreed with Dr. Matthews that claimant's symptoms in 1995 were unrelated to his right-sided symptoms in 1990. (Ex. 41-5). Dr. Fuller also opined that claimant's disability and need for surgery in 1995 were caused by a combination of preexisting degenerative disc disease at L5-6 (which preexisted the 1990 injury) and his activities in August, September and October 1995. (Ex. 41-7).

Contrary to Drs. Matthews and Fuller, claimant's attending surgeon, Dr. Lewis, opined that claimant's herniated disc in 1995 constituted a worsening of his 1990 lumbar condition, which involved trauma to the L5-6 disc. (Ex. 46). In his deposition, however, Dr. Lewis conceded that he could not state with any medical probability whether claimant's condition in 1995 was the same as it had been in 1990 because his symptoms were on a different side and his clinical picture was different. (Ex. 48, pp. 25-28). Dr. Lewis further testified that he could not state within a medical probability whether claimant's 1990 injury actually caused an injury to claimant's L5-6 disc. (Ex. 48, pp. 30, 43). Dr. Lewis concluded, however, that assuming claimant's 1990 injury caused damage to the disc, claimant's condition in 1995 was causally related to that disc injury.[2] (Ex. 48, pp. 50-51).

Because Dr. Lewis admitted that he did not know whether claimant's condition in 1995 was the same that it had been in 1990 or whether the 1990 injury actually caused damage to claimant's L5-6 disc, his observations support only a possibility that claimant's L5-6 disc herniation and need for treatment is related to the accepted injury. This is insufficient to carry claimant's burden. *See Gormley v. SAIF*, 52 Or App 1055 (1981) (probability, not possibility, is the requisite standard of proof). Consequently, we conclude that claimant has failed to prove the compensability of his disability and need for surgery in 1995.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our February 24, 1998 order except for that portion that dismissed claimant's request for hearing. In exercising our jurisdiction over the compensability dispute, we reverse the ALJ's order. The self-insured employer's denial, insofar as it pertains to claimant's 1995 disc condition and need for treatment, is upheld.

IT IS SO ORDERED.

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[2] Dr. Lewis opined, based on claimant's history, that the actual herniation of claimant's L5-6 disc probably occurred sometime in September or October 1995, well after claimant stopped working for the employer. (Ex. 48-45).

In the Matter of the Compensation of
DARLA J. FEICKERT, Claimant
WCB Case Nos. 97-03157 & 96-09261
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
VavRosky, et al, Defense Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Bock, Haynes, and Hall.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's low back injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

In April 1992, claimant began working for the self-insured employer as a micrographic specialist. (Tr. 14). She had previous back problems. In January 1980, she had neck and back pain after a motor vehicle accident. (Exs. 4, 5). In August 1982, she had a sudden onset of low back pain and was admitted to the hospital for bed rest and pelvic traction. (Exs. 8, 9). She was subsequently diagnosed with a herniated disc at L4-5, which was treated conservatively. (Ex. 12). In June 1983, her back pain increased and on July 11, 1983, claimant underwent a laminectomy at L4-5 and L5-S1 and excision of herniated disc material at L4-5 and L5-S1. (Exs. 13, 15). In February 1984, claimant was in a motor vehicle accident and had low back pain without leg pain. (Exs. 20, 21).

On May 30, 1986, while working for Reliance Insurance Company's insured, claimant was pushing a heavy box of records and injured her back. (Exs. 23, 26). She was diagnosed with a herniated disc at L5-S1 and had surgery on June 19, 1986. (Exs. 32, 33). The claim was closed on April 1, 1987 with a 20 percent unscheduled permanent disability award. (Ex. 49). The award was later increased to 32 1/2 percent unscheduled permanent disability by stipulation of the parties. (Ex. 59). Claimant testified that she did not have treatment for her low back between 1991 and August 30, 1996. (Tr. I-20, -27, -55).

On August 30, 1996, claimant's supervisor, Ms. Seufert, and another co-worker, Jane Schmidt, were moving a reader/printer (printer) from the back of a van onto a chair with wheels so that it could be rolled into the building. The printer weighed approximately 30 to 35 pounds. (Tr. 66, 116). Ms. Seufert and Ms. Schmidt moved the printer from the van to the chair. (Tr. I-67, -71, -104). However, the base of the printer was larger than the seat of the chair so it was wobbly and unstable. (Tr. I-67, -113, -114). Ms. Seufert asked claimant to come out and help them stabilize the printer on the chair. (Tr. I- 68).

Claimant came out and helped stabilize the printer. Ms. Denny also arrived to help shortly thereafter. Ms. Seufert, Ms. Schmidt, Ms. Denny and claimant helped move the chair with the printer into the building. All four helped lift the printer onto a table inside the building. Claimant did not tell anyone that she had any back pain and did not exhibit any pain behavior at work on August 30, 1996.

Claimant testified that her back starting hurting "real bad" on the way home on August 30, 1996. (Tr. 18). Her husband had to assist her at home because she could hardly walk. (Id.) She spent the weekend laying on the couch and putting ice and heat on her back. (Id.)

On September 3, 1996, claimant went to the emergency room and gave a history of back pain while lifting a printer. (Ex. 83-2). Dr. Anderson reported that claimant "had to assist in lifting and moving a heavy printer" and felt a tightening in her low back, which was not initially painful. (Ex. 84-1). He stated that she had "what seems to be delayed increase in back pain and spasm, increasing a few hours after a significant heavy lifting." (Id.) Dr. Anderson diagnosed a back strain related to work. (Ex. 84-2).

Claimant was later treated by Dr. Wilcox, who diagnosed an acute lumbar strain. (Ex. 88).

On January 9, 1997, claimant was examined by Dr. Farris on behalf of the employer. (Ex. 103). She was also examined by Dr. Rosenbaum on behalf of Reliance. (Ex. 110).

On September 20, 1996, the self-insured employer denied the claim on that grounds that it did not appear claimant had sustained any injury as a result of her employment and her back condition was not compensably related to the August 30, 1996 incident. (Ex. 90). On January 3, 1997, the employer amended its denial to contend that, if the claim was found compensable, the condition was a result of her May 30, 1986 injury with Reliance's insured. (Ex. 102).

On January 14, 1997, claimant's attorney wrote to Reliance and asserted a low back claim. (Ex. 106). On April 7, 1997, Reliance denied responsibility and reserved its right to contest compensability. (Ex. 109). Claimant requested a hearing on the denials.

CONCLUSIONS OF LAW AND OPINION

The ALJ found claimant credible and concluded that the only significant fact was that claimant had lifted the printer. The ALJ found that whether the printer was still partially in the van at the precise moment claimant lifted was of little significance. The ALJ concluded that the August 30, 1996 injury was the major contributing cause of claimant's disability and need for treatment and set aside the employer's compensability and responsibility denials.

The employer contends that claimant was not credible and she did not lift the printer on August 30, 1996. The employer asserts that, on the second day of her testimony, claimant admitted that she did not lift the printer onto the chair. According to the employer, based on the inconsistency in claimant's version of the incident, the medical providers did not have an accurate history and are not persuasive.

Reliance agrees that claimant did not establish compensability. Alternatively, if the claim is compensable, Reliance contends that the self-insured employer is responsible for claimant's low back injury.

The central issue in this case is whether claimant injured her back at work on August 30, 1996. The ALJ found claimant to be a credible witness based on his observations during the hearing. Although we generally defer to the ALJ's demeanor-based credibility finding, we are in as good a position as the ALJ to evaluate claimant's credibility based on an objective evaluation of the substance of claimant's testimony and other inconsistencies in the record. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). Even minor inconsistencies can be a sufficient basis to disagree with the ALJ's credibility determination, particularly where factual inconsistencies in the record raise such doubt that we are unable to conclude that material testimony is credible. See, e.g., David A. Peper, 46 Van Natta 1656 (1994).

On review, claimant relies on the ALJ's finding that she was credible and she urges the Board to defer to the ALJ's express demeanor-based credibility finding. She asserts that there is no dispute that she helped to "move" the printer.

Claimant agrees that she has a preexisting low back condition and ORS 656.005(7)(a)(B) applies to this case. Because of the multiple possible causes of claimant's disability or need for treatment, this issue presents a complex medical question that must be resolved on the basis of expert medical evidence. Uris v. Compensation Dept., 247 Or 420 (1967); Barnett v. SAIF, 122 Or App 281 (1993).

We agree with claimant that there is no dispute that she helped move the printer on August 30, 1996. The problem, however, is that claimant testified that her back pain occurred when she was bringing the printer down off the back of the van onto the chair. (Tr. I-60, -61). The other witnesses testified that the printer was already on the chair when claimant arrived and she did not help them lift the printer from the van. For the following reasons, we are not persuaded that claimant sustained a low back injury while lifting a printer at work on August 30, 1996.

On the first day of the hearing, claimant testified about the August 30, 1996 incident:

> "I was in the front office and I heard Chris, my manager, calling out to me, 'Come help, come help, Darla.' So I went running outside our building, and she was -- Chris and Jane were lifting a Reader printer from the back of her Blazer, trying to get it off her Blazer and down onto a rolling chair.

"And it had slipped, and apparently, they needed help. And I went running out there, and I grabbed it. And we lowered it down from the back of the Blazer onto the rolling chair." (Tr. I-15).

Claimant said that she felt "kind of a burning, kind of a stabbing feeling," but she did not pay a lot of attention to it "because it's something that I've had in the past." (Tr. I-15, -16). She acknowledged that on occasion her back pain arises without any particular event or trauma. (Tr. I-59, -60). She testified that she was fine the morning of August 30, 1996 "until I bent over to help them get that Reader printer." (Tr. I-60). She said "[t]he minute I got to that point and got the Reader printer and put it on that chair, I felt it." (Id.) Claimant was asked when she felt the back pain:

"Q. I'm trying to figure out if it was the process of you bending over or the process of you bending --

"A. It was at the time I reached for it. It was in my hands lifting it down to the chair.

"Q. The printer was in your hands and you bent over, when you felt the low back pain?

"A. Right. I was bringing it down off the back onto the chair." (Tr. I-61).

On cross-examination, claimant testified that "[a]ll of us lifted it down onto a rolling chair." (Tr. I-35, -36). When she was asked if she hurt herself at any other time that day besides then, she replied "No." (Tr. I-36).

The self-insured employer's attorney asked claimant:

"Q. Ma'am, isn't it true that on that day when they called you out to help with this printer, the printer was already on the chair?

"A. No.

"Q. Your testimony is that that didn't happen?

"A. It was not on the chair.

"Q. Okay. It was being -- your testimony is it was lifted from the truck --

"A. Right.

"Q. -- onto the chair, and you did the lifting, along with the other two people?

"A. Right.

"Q. Are there two people or three people out there?

"A. There was three people at the time we took it from the back of the chair -- I mean the truck and put it on the chair. And about that time is when Myrna came, and then the four of us pushed it through the door and up into the office.

"Q. So it's your testimony that when you got there, the chair was basically not -- excuse me -- the printer was not on the chair yet and you had to do that?

"A. Right." (Tr. I-37, -38).

In contrast to claimant's testimony, Ms. Seufert and Ms. Schmidt testified that the printer was already on the chair when claimant arrived and she did not help them lift the printer from the van. (Tr. I-71, -104). Ms. Seufert testified that they had taken the printer out of the back of her van and put it on the seat of the chair, but the base of the printer was larger than the seat of the chair so it was wobbly and unstable. (Tr. I-67). Ms. Seufert asked claimant to come out and help them stabilize the printer on the chair so they could get it in the building. (Tr. I-68). Ms. Schmidt testified that the chair started rolling before they had the printer centered and it was off balance. (Tr. I-113, -114).

Ms. Denny arrived shortly after claimant to help them. Ms. Denny testified that she followed right behind claimant and the printer was on the chair when she arrived. (Tr. I-125, -126). Ms. Seufert said that claimant helped them "scoot" the printer back onto the chair. (Tr. I-69). Ms. Seufert explained that "scooting" meant a side-to-side motion (Tr. I-89), and Ms. Schmidt described it as "walking [the printer] backwards[.]" (Tr. I-106). The printer always maintained contact with the chair and was not lifted off the chair while it was in front of the van. (Tr. I-90, -106, -127).

Ms. Seufert and Ms. Schmidt testified that claimant did not appear to be in pain after the printer incident and she did not appear to have any problems the rest of the day. (Tr. I-72, -74, -76, -107, -108, -109). Likewise, Ms. Denny did not observe that claimant was having any problems the rest of the day. (Tr. I-128).

On the second day of the hearing, claimant was recalled as a witness. Reliance's attorney questioned claimant:

"Q. Ms. Feickert, you were present when your co-workers and your supervisor, Ms. Seufert, testified yesterday, were you not?

"A. Yes.

"Q. And those witnesses testified that the printer was not falling out of the back of the truck or the van. It was actually on the chair when you came out of the door.

"A. Right.

"Q. Do you remember that?

"A. I do.

"Q. So isn't it true that the printer was actually on the chair by the time you got out the door to the back of the vehicle?

"A. It happened so fast when they were taking it off of there. I just heard them yelling at me, and I just went over to help them. And one corner of it was on the chair. It was falling, and she was trying to keep it from falling on the ground.

"Q. Who is 'she'?

"A. Jane, and then Chris was on the other side, and she was the one yelling at me, because they couldn't hold it.

"Q. So the printer was actually touching the chair when you arrived.

"A. One corner of it must have been. I mean it happened so fast. All I know, it was falling down, and I went running over to help them steady it onto the chair. They had a chair with rollers." (Tr. II-32, -33).

Reliance's attorney also asked claimant:

"Q. If I understand, the printer is already on the chair when you arrive, and you're steadying it on the chair, and you really didn't have to lift the printer at that point. Is that correct?

"[Claimant's attorney]: I think she said a corner of it.

"A. A corner of it was down -- coming down on the chair. It was falling, and they were screaming at me, because it was falling. So I ran over there to help them, and a corner of it -- I was on the chair, and I helped them grab the reader printer, and there was three of us, and then Myrna came out afterwards. And the four of us put it on the chair, and then we followed it in." (Tr. II-38).

Claimant was then cross-examined by the employer's attorney:

"Q. Yesterday when I asked you about the printer --

"A. Yes.

"Q. -- and I said, isn't it true, Ms. Feickert, that that printer was already on the chair when you got out the door, do you remember that question?

"A. No, I don't recall that question.

"Q. Well, I asked that question yesterday, and my recollection of your -- I want to see it this refreshes your recollection here today.

"A. Okay.

"Q. Your answer to that question was not a quarter of the chair was on that -- a quarter of the printer was on the chair. Your response was, I lifted that printer from the back of the truck onto the chair, and that's how you hurt yourself.

"A. No, that's not what I meant.

"Q. That's not what you meant.

"A. No, it was falling from the back of the automobile, and that's why they screamed at me to come out there running, because they couldn't keep it from falling.

"Q. Do you recall testifying yesterday that when I said, isn't it true that that printer was on the chair already when you got out there --

"A. Uh-huh.

"Q. -- and you testified, no, it was not; you lifted it from the van? Do you remember that?

"A. No, I don't. I may have mistaken what I was saying. I imagine it was coming down from the automobile, and I went out there to grab it when it was -- when they were losing it.

"Q. Did you lift the chair, lift the printer then from the van onto the chair?

"A. No.

"Q. You did not lift it all.

"A. No, it was falling down onto the chair.

"Q. So it fell.

"A. Right.

"Q. You didn't bear any weight of that --

"A. Well, yeah, because it was falling, and I went over to grab them. We all grabbed it, because it was losing its balance, so all of us grabbed it to put it on the chair, to steady it on the chair.

"Q. I see.

"A. I mean it was falling.

"Q. And your testimony is now that when you got out the door, there was a corner of it that was on the chair already.

"A. Yes, I believe there was.

"Q. Yes or no?

"A. Yes." (Tr. II-39, -40, -41).

Based on the testimony of Ms. Seufert, Ms. Schmidt and Ms. Denny, as well as claimant's revised testimony, we conclude that claimant did not lift the printer from the van onto the chair. Claimant did help move the printer on August 30, 1996 and helped stabilize the printer on the chair. However, the medical opinions attributing claimant's low back condition to the August 30, 1996 incident were based on an understanding that claimant lifted the printer.

In the emergency room on September 3, 1996, claimant gave a history of back pain while lifting a printer. (Ex. 83-2). Dr. Anderson reported that claimant "had to assist in lifting and moving a heavy printer" and felt a tightening in her low back, which was not initially painful. (Ex. 84-1). He stated that she had "what seems to be delayed increase in back pain and spasm, increasing a few hours after a significant heavy lifting." (Id.)

Claimant's physical therapist reported that she had injured her low back while lifting a printer at work. (Ex. 87B-1).

Dr. Wilcox signed claimant's "827" form on September 13, 1996 and diagnosed an acute lumbar strain. (Ex. 88). On the "827" form, claimant wrote: "I was helping manager and co-worker lift reader printer off back of Blazer car. Printer slipped while lifting down onto a chair to roll into office. I pulled my back out." (Id.) On December 27, 1996, Dr. Wilcox reported that on August 30, 1996, claimant had assisted in "lifting and moving a heavy printer." (Ex. 101). He felt that the August 30, 1996 injury was the major contributing cause of her current problems and need for medical treatment. (Id.)

Claimant was examined by Dr. Rosenbaum on April 28, 1997. He reported that on August 30, 1996, claimant "lifted a printer and had the onset of a tightening in her back which she described as an aching sensation." (Ex. 110-3). Based on claimant's history and the medical records, Dr. Rosenbaum felt she sustained a lumbar strain on August 30, 1996. (Ex. 110-6).

Claimant was examined by Dr. Farris on behalf of the employer. He reported the following history:

"At that time [August 30, 1996] she was performing her regular duties when she heard her manager call out for help. [Claimant] states that she noted the manager and a co-worker attempting to unload a printer from the back of the manager's Blazer, and it looked as though they were about to drop it. [Claimant] states that she ran out to help them with the printer, and as she bent over to help steady the printer and keep it from falling she noted a pulling sensation in her low back. She then helped her co-workers lift this printer onto a rolling chair and they pushed the chair back into the office. She and the two co-workers then lifted the printer onto a table." (Ex. 103-1; emphasis added).

Dr. Farris reported that, based on claimant's history, it was reasonable to assume that she sustained a mild lumbar strain injury during the course of her work duties on August 30, 1996. (Ex. 103-11). He noted, however, that if claimant's history of the injury was not accurate, it would cast serious doubt on the validity of her claim. (Ex. 103-12).

In light of claimant's admission during the hearing that she did not lift the printer from the van onto the chair (Tr. II-39, -40, -41), the history of the injury given to the physicians is inaccurate. There are no medical opinions that establish that claimant's low back condition resulted from moving the printer. Moreover, claimant initially testified that she was injured lifting the printer onto the chair and she said that she had not hurt herself at any other time that day. (Tr. I-35, -36). Because the medical opinions are based on an inaccurate history, we are not persuaded that claimant sustained a low back injury at work on August 30, 1996. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977). Under these circumstances, we conclude that claimant has failed to sustain her burden of establishing compensability of her claim. Accordingly, the self-insured employer's denial is upheld.

ORDER

The ALJ's order dated September 11, 1997, as reconsidered October 2, 1997, is reversed in part and affirmed in part. The self-insured employer's compensability and responsibility denials of claimant's low back condition are reinstated and upheld. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

Board Member Hall dissenting.

The majority rejects the ALJ's finding that claimant was a credible witness and it concludes that the medical opinions are based on an inaccurate history. For the following reasons, I respectfully dissent.

The ALJ found, based on his close and careful observation of claimant during her testimony, that she was a credible witness and her back symptoms came on exactly as she described. The ALJ concluded that claimant injured her back, as she described. He concluded that claimant's physicians had an accurate history and claimant sustained her burden of proving compensability.

Although not statutorily required, the Board generally defers to the ALJ's determination of credibility. See Erck v. Brown Oldsmobile, 311 Or 519, 525-26 (1991). In Ryf v. Hoffman Construction Co., 254 Or 624, 631 (1970), the Supreme Court --on de novo review of a workers' compensation award--stated: "[W]e * * * have to give some weight to the fact that the Hearing Officer, and he alone, has the opportunity to observe the claimant and other witnesses, a factor which we have regarded as highly significant in reviewing other cases on appeal." (Emphasis added).

When the ALJ's credibility finding is based in part upon the observation of claimant's demeanor, we generally defer to that determination. See International Paper Co. v. McElroy, 101 Or App 61, 64 (1990). The instant case illustrates the very reason why deference is accorded. The majority seizes upon differences to conclude claimant is not credible. Yet these are differences the ALJ already weighed and, then, based on the ability to actually observe first hand the witnesses testify, concluded that the claimant was credible and absolved the differences by concluding that claimant's description of events was correct. In this case, I would defer to the ALJ's finding that claimant was a credible witness and her back symptoms came on exactly as she described. After my review of the evidence, I would affirm the ALJ's conclusion that claimant's low back injury is compensable.

In the Matter of the Compensation of
MARLA R. MOEHLING, Claimant
WCB Case No. 97-08157
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Brazeau's order that set aside its denial of her left knee injury claim. On review, the issue is compensability.

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

We agree with the ALJ's findings regarding the mechanism of the June 14, 1997 incident, i.e., that claimant, a 27-year-old CNA, was stepping around a patient's wheelchair in a care-van when she felt a slight twist in her left knee and the knee buckled, dislocating the left patella and causing her to fall to the floor of the van. The ALJ found no persuasive evidence that the June 14, 1997 incident combined with any preexisting condition to cause the knee injury and, therefore, applied the "material contributing cause" test. Finding that the June 14, 1997 incident was a material contributing cause of the knee injury, the ALJ set aside SAIF's denial.

On review, SAIF argues that claimant's prior history of two left patellar dislocations, in 1984 and 1989, resulted in a preexisting condition that predisposed her to the current dislocation of the knee. It relies on the medical opinion of examining orthopedist, Dr. Strum, who attributed claimant's predisposition to the "inherent anatomy of the patellofemoral joint and overall alignment of the lower extremities." (Ex. 13-5). Based on Dr. Strum's opinion, SAIF contends that claimant has a "combined condition" that is subject to the "major contributing cause" test under ORS 656.005(7)(a)(B).

Even if we agreed with SAIF's "combined condition" analysis, we would still conclude that claimant carried the burden of proving her injury claim. Under ORS 656.005(7)(a)(B), claimant must prove that the June 14, 1997 incident was the major contributing cause of her subsequent disability and need for treatment. The expert medical evidence regarding causation is divided between the opinion of the treating orthopedist, Dr. Lawton, who supports the claim, and that of the examining orthopedist, Dr. Strum, who does not. When there is a dispute between medical experts, we give greater weight to those opinions that are well-reasoned and based on complete information. See Somers v. SAIF, 77 Or App 259, 263 (1986).

Dr. Lawton acknowledged claimant's prior history of patellar dislocations, but noted that claimant's previous dislocation was in 1989 and that she subsequently had been "perfectly symptom free" until the June 14, 1997 incident. Compared to that history, Dr. Lawton viewed the June 14 incident as a "significant one and indeed the major contributing of the dislocation and need for ongoing treatment." (Ex. 16). He further stated: "Were [patellar dislocations] a problem that occurred frequently then I think an argument that work had little contribution to this problem would be more legitimate. That, however, is not the case in my estimation in this current situation." (Id.)

Dr. Strum responded by questioning whether claimant truly twisted her left knee prior to her knee buckling. (Ex. 17). However, assuming that she did, Dr. Strum opined that a "slight twist" was not of sufficient torsional or rotational force to produce a patellar dislocation in a knee that is not predisposed to injury. (Id.) He therefore opined that the preexisting condition (including claimant's weight and poor conditioning) was the major cause of the resultant condition. (Exs. 13-5, 17).

After reviewing the medical opinions, we conclude that Dr. Lawton's opinion is better-reasoned and based on complete information. In this regard, we reject SAIF's arguments that Dr. Lawton did not have a correct history of the June 14, 1997 incident or that he never addressed the preexisting condition. Based on claimant's testimony at hearing, (Tr. 13-15), and the chart note of the emergency room physician, Dr. Strand (Ex. 4-1), we conclude that Dr. Lawton's history of a twisting injury to the knee is accurate. Furthermore, based on Dr. Lawton's observation that claimant's had no preexisting left knee symptoms since 1989 (a period of more than seven years), and that the June 14, 1997 incident was enough to trigger a dislocation, we conclude that Dr. Lawton weighed the relative contribution of the preexisting condition and the June 14 incident in reaching his ultimate conclusion that the June 14 incident was the major cause of the dislocation.

Dr. Strum, by contrast, did not mention the fact that claimant's left knee had been asymptomatic for more than seven years prior to the June 14, 1997 incident, nor did he discuss its significance in determining the relative contribution made by the preexisting condition. Rather, Dr. Strum focused on whether the "slight twist" in the June 14, 1997 incident was of sufficient force to cause injury in a "normal" knee. However, in the context of a "combined condition" analysis involving a previously dislocated knee, Dr. Strum's focus on a "normal" knee is not particularly relevant in this case. The relevant inquiry is whether the June 14, 1997 incident was the major cause of the patellar dislocation in a knee with a history of prior dislocations but with no symptoms for more than seven years. Assuming an already compromised knee, we find Dr. Lawton's causation opinion more persuasive because he actually weighed the relative contribution of the preexisting condition and the June 14, 1997 incident in deciding that the June 14 incident was the major cause. See Dietz v. Ramuda, 130 Or App 397, 401 (1994) (Determining the "major contributing cause" involves evaluating the relative contribution of different causes of an injury and deciding which is the primary cause).

Claimant's attorney is entitled to an assessed fee for services on review. See ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,100, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 23, 1998 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,100, payable by SAIF.

May 1, 1998 Cite as 50 Van Natta 862 (1998)

In the Matter of the Compensation of
LOUIE J. PLUMLEE, Claimant
WCB Case No. 93-01923
SECOND ORDER ON REMAND
Cole, Cary, et al, Claimant Attorneys
Employers Defense Counsel, Defense Attorney

On April 2, 1998, we dismissed the alleged employer's (Oldham's) request for Board review of an Administrative Law Judge's (ALJ's) order that had set aside a Director's determination that claimant was not a subject worker. We took this action pursuant to the court's mandate. See Oldham v. Plumlee, 151 Or App 402 (1997). Asserting that we were not authorized to "remand" this case to the Director, claimant challenges that portion of our decision that stated "Jurisdiction over this matter rests with the Director."[1]

After further considering this matter, we acknowledge that the court's precise instructions were "to dismiss request for review." Because our "jurisdictional" reference exceeded the court's instructions, we withdraw that portion of our order that stated "Jurisdiction over this matter rests with the Director."[2]

Accordingly, our April 2, 1998 order is withdrawn. On reconsideration, as supplemented and modified herein, we republish our April 2, 1998 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] Claimant also notes that a copy of our April 2, 1998 order was not mailed to the SAIF Corporation, who he asserts "has been a party to this matter since the very beginning." Although SAIF received an "Info Copy" of our Order on Review and was listed as a respondent in the court's opinion, SAIF neither appeared at the hearing nor was mailed a copy of the ALJ's order. Thus, claimant's assertion of SAIF's status as a "party" to this proceeding is subject to question. In any event, SAIF has been mailed a copy of this order.

[2] Claimant contends that "[t]his claim should be referred to a processing agent." Insofar as claimant's contention could be interpreted as a request for a Board directive, such a request would be denied. Inasmuch as the court's instructions were to dismiss the request for Board review, we would lack authority to issue any further directive regarding the processing of this claim.

In the Matter of the Compensation of
GUILEBALDO G. RAMIREZ, Claimant
WCB Case No. 97-05219
ORDER ON RECONSIDERATION
Cole, Cary, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys
James B. Northrop (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of that portion of our April 2, 1998 Order on Review that reinstated a Determination Order's 5 percent (7.5 degrees) scheduled permanent disability award for loss of use or function of claimant's left hand, whereas the Order on Reconsideration had awarded 4 percent (6 degrees) scheduled permanent disability and the Administrative Law Judge (ALJ) had reduced the award to zero. SAIF argues that, even though it did not request reconsideration of the Determination Order, *claimant's* request for reconsideration of the Determination Order's 5 percent scheduled permanent disability award that resulted in the Order on Reconsideration's 4 percent scheduled permanent disability established a new "floor" for claimant's permanent disability. Having reviewed SAIF's motion and claimant's response, we proceed with our reconsideration.

A January 23, 1997 Determination Order awarded 5 percent scheduled permanent disability for loss of use or function of claimant's left hand. Claimant requested reconsideration, seeking an increased award. SAIF did not raise the issue of permanent disability on reconsideration.

A June 4, 1997 Order on Reconsideration reduced claimant's scheduled award to 4 percent (and awarded 8 percent unscheduled permanent disability for lost thoracic and lumbar range of motion). SAIF requested a hearing, seeking reduction of claimant's awards to zero.

The ALJ reduced claimant's scheduled award to zero. In our April 2, 1998 Order on Review, we reinstated the Determination Order's 5 percent award, reasoning that SAIF's challenge to that award was precluded by its failure to raise permanent disability on reconsideration. We relied on *Duncan v. Liberty Northwest Ins. Corp.*, 133 Or App 605 (1995) and *Roger R. Powers*, 49 Van Natta 1388 (1997).

On reconsideration of our initial order, we conclude that, by virtue of its failure to seek Director reconsideration of the Determination Order, SAIF is precluded from arguing, as it did at hearing, that claimant is entitled to no permanent disability. However, SAIF is *not* precluded from *defending* the reconsideration order's 4 percent scheduled permanent disability award (*i.e.*, by seeking reinstatement of that award), as it does on review.

Thus, the remaining question is whether claimant is entitled to 5 percent scheduled permanent disability (as awarded by the Determination Order) -- or 4 percent (as awarded by the Order on Reconsideration).

We agree with the ALJ that the record does not establish that claimant has injury-related loss of use or function of the left hand.[1] Accordingly, we reinstate the Order on Reconsideration's 4 percent scheduled permanent disability award for the left hand.[2] Claimant's counsel remains entitled to an "out-of-compensation" attorney fee, payable in the manner prescribed in our prior order. However, that fee is now based on claimant's 4 percent award as granted by this order, rather than our prior 5 percent award.

Accordingly, we withdraw our April 2, 1998 order. On reconsideration, as supplemented and modified herein, we adhere to and republish our April 2, 1998 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 reaching this conclusion, we note that claimant's attending physician and the medical arbiter reported serious inconsistencies and indicators of invalidity on examination and the attending physician found no objective findings of impairment.

[2] We reiterate that SAIF is precluded from arguing for reduction of claimant's scheduled award beyond the 4 percent "floor" established by its failure to request reconsideration of the Determination Order. *See Duncan*, 133 Or App at 605.

In the Matter of the Compensation of
MARGARET A. O'CONNOR, Claimant
WCB Case No. 97-07098
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the SAIF Corporation's denial of her claim for a cervical spine condition. On review, the issue is compensability.

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

We modify the "Conclusions of Law and Reasoning" section to delete the sentence referring to Exhibit 13, a document that was withdrawn by SAIF and is not a part of the hearing record. (O&O p. 5).

The ALJ analyzed claimant's cervical spine claim as an occupational disease. On review, claimant contends that her claim is more appropriately analyzed as an accidental injury claim. We disagree.

In James v. SAIF, 290 Or 343 (1981), the Supreme Court adopted the following distinction between injuries and diseases:

> "What set[s] occupational diseases apart from accidental injuries [is] * * * the fact that they [are] gradual rather than sudden in onset. * * *'" Id. at 348.

In Valtinson v. SAIF, 56 Or App 184, 188 (1982), the Court of Appeals construed the phrase "sudden in onset" to mean occurring during a short, discrete period, rather than over a long period of time. In Donald Drake Co. v. Lundmark, 63 Or App 261 (1983), rev den 296 Or 350 (1984), the court held that the claimant's onset of back pain over a six-week period of employment met the "sudden in onset" requirement because the onset "coincided precisely" with the traumatic jolting of his front-end loader. Id. at 266. More recently, the Supreme Court stated that an "injury" is an event and that a "disease" is an ongoing condition or state of the body or mind. Mathel v. Josephine County, 319 Or 235, 240 (1994).

After reviewing the case law regarding the injury-disease distinction, we conclude that claimant's claim is best analyzed as an occupational disease. At hearing, claimant testified that she began her employment as a food service worker in October 1995 and then was promoted to cook the following month. (Tr. 8-9). Her duties were physically demanding, involving frequent and repetitive lifting of food and pans, and daily stirring in large pots. (Tr. 10-11). After April 1996, claimant noticed the onset of muscle soreness in her neck and shoulders. (Tr. 12-13). She also described the onset of neck stiffness and loss of grip strength in the right hand over the course of about a month before seeking medical treatment from Dr. Fillingame in July 1996. (Tr. 12). Claimant did not report any specific injury to the doctor, but attributed symptoms to her duties as a cook. (Ex. 1-4). Her condition was ultimately attributed to her work duties as a cook. (Exs. 8-2, 14).

Based on claimant's testimony at hearing and her history to doctors, we find that the onset of claimant's cervical condition was gradual and that her condition was ongoing. There is no evidence of a specific event or injury that precipitated the onset of symptoms. Moreover, there is no evidence, as there was in Lundmark, that the onset of symptoms coincided precisely with any particular work exposure or activity. Claimant's doctors indicated that the condition was caused by her overall employment activities as a cook. Given its gradual onset, claimant's cervical condition must be analyzed as an occupational disease.

ORDER

The ALJ's order dated December 31, 1997 is affirmed.

In the Matter of the Compensation of
PERRY A. YOUNG, Claimant
WCB Case No. 97-05697
ORDER ON REVIEW
Meyers, Radler, et al, Claimant Attorneys

Reviewed by Board Members Moller and Hall.

Claimant, pro se, requests review of those portions of Administrative Law Judge (ALJ) Nichols' order that: (1) upheld the self-insured employer's denial of claimant's occupational disease claim for a right wrist condition; and (2) upheld the employer's denial of claimant's occupational disease claim for a left wrist condition. On review, the issue is compensability.

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

On review, claimant objects to the ALJ's order finding that claimant failed to prove compensability of his left wrist condition and right wrist condition. In his brief, claimant questions the ALJ's finding that he had a preexisting condition in his left wrist.

Where a claimant's injuries are of a complex nature so as to require skilled and professional persons to establish causation, expert medical evidence is necessary to meet the burden of proof. Uris v. Compensation Department, 247 Or 420 (1967).

Here, claimant had prior left wrist symptoms, and symptoms in both wrists did not appear immediately. The record also contains expert medical opinion that claimant's work activities could not have caused his bilateral wrist conditions. Thus, we consider the case to be complex, requiring expert medical evidence of causation. See id. at 426. For this reason, we rely on the medical opinions, and not only claimant's testimony, in determining the cause of claimant's conditions in his right and left wrists.

Because claimant's treating surgeon, Dr. Ellison, reported that work activities had "aggravated" left wrist symptoms, (Exs. 28-6, 40-2, 44), we understand Dr. Ellison as indicating that claimant has a preexisting left wrist condition that combined with work activities. Thus, claimant must show that work activities are the major contributing cause of the combined condition and a pathological worsening of the preexisting left wrist condition. See ORS 656.802(2)(b). As the ALJ discussed, because Dr. Ellison stated only that work activities "aggravated" claimant's left wrist condition, his opinion is not sufficient to show that work activities are the major contributing cause of the combined condition and that the left wrist condition pathologically worsened. Consequently, claimant did not prove compensability of the left wrist condition.

We also agree with the ALJ that Dr. Ellison's opinion is inadequate to prove compensability of the right wrist condition. The only reference Dr. Ellison makes with regard to claimant's specific work activities is to state that claimant is "doing repetitive tasks which require pinch and grip function." (Ex. 28-1). Dr. Ellison does not explain how the tasks caused claimant's right wrist condition or provide any reasoning supporting his conclusion that work activities were the major contributing cause of the condition. We find that the conclusory nature of Dr. Ellison's opinion, especially when there is a contrary medical opinion, puts the medical opinions in equipoise. Thus, because we do not consider Dr. Ellison's opinion any more persuasive than Dr. Button's opinion, we agree with the ALJ that claimant did not carry his burden of proving compensability of the right wrist condition.

ORDER

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

In the Matter of the Compensation of
DAVID ALBALOS, Claimant
WCB Case No. 97-04691
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Thye's order that: (1) upheld the self-insured employer's denial of his aggravation claim for his current right shoulder condition; and (2) declined to award temporary disability benefits (interim compensation). On review, the issues are aggravation and temporary disability benefits.

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

On review, claimant argues that he has established a compensable worsening of his right shoulder condition. Claimant contends that the medical opinions of Drs. Peterson and Puziss establish that his right shoulder condition has worsened since the last arrangement of compensation. Specifically, claimant relies on Joe Ann Collins, 48 Van Natta 1562 (1996).

For several reasons, we conclude that Collins is not on point. We first note that the Collins case relied on our decision in Carmen C. Neill, 47 Van Natta 2371 (1995). In Neill, we held that an "actual worsening" under ORS 656.273(1) was established by a pathological worsening of the underlying condition or a symptomatic worsening of the condition greater than that anticipated by the prior award of permanent disability. However, subsequent to our decisions in Neill and Collins, the court issued its decision in SAIF v. Walker, 145 Or App 294 (1996). In Walker, the court held that an "actual worsening" of a compensable condition pursuant to ORS 656.273(1) did not include a symptomatic worsening. Rather, the court concluded that the statute requires that there be direct medical evidence that a condition has worsened, and absent such evidence, the Board cannot infer from evidence of increased symptoms that those symptoms constitute a worsened condition for purposes of proving an aggravation claim. Id.

We also conclude that, factually, Collins is not on point. In Collins, the treating doctor opined that the claimant had internal derangement, including swelling and catching of the knee. For that reason, the doctor recommended a diagnostic arthroscopy. Collins, 48 Van Natta at 1563. In the present case, however, claimant's treating doctor stated that he was not able to verify claimant's complaints objectively on examination. Dr. Peterson also agreed that claimant's complaints were the same as they had been in 1995 and 1996, and there were no objective findings to support a worsening. (Ex. 36-1). Finally, Dr. Peterson stated that the "etiology for [claimant's] shoulder pain has never been clearly determined." (Ex. 39-12). Dr. Peterson acknowledged that, although he was concerned that claimant might have a labral tear, the MRI did not show such a tear. (Ex. 39-12).

Under the circumstances, we conclude that, although Dr. Peterson wished to obtain a shoulder arthroscopy for further evaluation, the medical evidence in the record does not show a pathological worsening of claimant's right shoulder condition. Therefore, there has not been an "actual worsening" sufficient to satisfy the requirements of ORS 656.273, and claimant has not established a compensable aggravation of the accepted condition.

ORDER

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

In the Matter of the Compensation of
PHYLLIS M. HAYS, Claimant
WCB Case No. 95-13427
ORDER ON RECONSIDERATION
Craine & Love, Claimant Attorneys
Nancy J. Meserow, Defense Attorney

Claimant requests reconsideration of that portion of our April 7, 1998 Order on Review that modified the Administrative Law Judge's (ALJ's) order to reduce claimant's assessed attorney fee award for prevailing over the insurer's denial of her consequential condition claim for a psychological condition, from $28,500 to $19,775. Claimant contends that: (1) the insurer did not object to her counsel's statement of services at hearing and therefore failed to preserve its defense that the requested attorney fee was excessive; and (2) our consideration of the factors in the attorney fee rule, OAR 438-015-0010(4), is not supported by the facts and the record.

We address each of claimant's arguments in turn. Under ORS 656.295(6), we have *de novo* review authority and may reverse or modify the ALJ's order or make any disposition of the case that we deem appropriate. *See Destael v. Nicolai Co.*, 80 Or App 596, 600 (1986); *Miller v. SAIF*, 78 Or App 158, 161 (1986); *Neely v. SAIF*, 43 Or 319, 323 (1979), *rev den* 288 Or 493 (1980); *Barbara Barber*, 49 Van Natta 1923 (1997). Therefore, notwithstanding the lack of an objection to claimant's counsel's statement of services at hearing, we are statutorily authorized to modify the ALJ's attorney fee award.

Citing *Fister v. South Hills Health Care*, 149 Or App 214, 218-19 (1997), *rev den* 326 Or 389 (1998), claimant argues that, by reducing the ALJ's attorney fee award in this case, we deviated from our long-standing practice of considering only issues raised by the parties at hearing. Claimant is correct that we have consistently refused to consider issues raised for the first time on Board review. *E.g., Alex S. Warden*, 49 Van Natta 1998 (1997); *Jon S. O'Shane*, 49 Van Natta 1964 (1997); *Kim P. Kennedy*, 49 Van Natta 1859 (1997); *Wray A. Renfro*, 49 Van Natta 1751 (1997). *See also Stevenson v. Blue Cross of Oregon*, 108 Or App 247, 252 (1991). In *Fister*, however, we agreed with the carrier's contention on Board review that the claimant's testimony was inadmissible, even though the carrier did not raise any objection to the testimony at hearing and the testimony was admitted into evidence by the ALJ. The court reversed, ruling that we had not provided an adequate reason for deviating from our well-established practice of considering only issues raised by the parties at hearing. Because the carrier did not object to the claimant's testimony, the court concluded in *Fister* that we should not have entertained the carrier's argument, first made on Board review, that the evidence was inadmissible.

This case is distinguishable from *Fister*. While the issue in *Fister* was the admissibility of evidence, the issue in the instant case is entitlement to an attorney fee under ORS 656.386(1). We have previously held that a represented claimant's entitlement to assessed attorney fees under ORS 656.386(1) is the "natural derivative" of a determination that the claimant prevailed over a denied claim. *E.g., Terry R. Myers*, 48 Van Natta 1039 (1996); *Frank P. Heaton*, 44 Van Natta 2104, 2106 (1992). For this reason, we have not required that a represented claimant "preserve" entitlement to attorney fees as a separate issue at a hearing concerning the compensability of a denied claim. *Id.* If a represented claimant prevails over a denial at hearing, we have held that his entitlement to an assessed attorney fee for his counsel's efforts at hearing is an automatic result of the compensability determination. *Id. See also* OAR 438-015-0035.

Because a represented claimant is not required to "preserve" the issue of attorney fees at a hearing concerning a compensability determination, we have treated the issue of attorney fees (for prevailing over a denied claim) as an exception to our general practice of considering only issues raised by the parties at hearing. *See Wray R. Renfro*, 49 Van Natta at 1752 n 2. For this reason, we likewise treat the "excessive fee" defense as an exception to our general practice as well. That is, if a represented claimant prevails over a denied claim at hearing, and submits a statement of services and/or attorney fee petition for services at hearing, the carrier need not "preserve" at the hearing its defense that the fee amount requested was excessive. Rather, we conclude that the carrier may raise its "excessive fee" defense for the first time on Board review of the ALJ's fee award. Accordingly, the insurer in this case was not required to raise an objection to claimant's counsel's statement of services and fee petition at hearing in order to preserve its defense that the fee amount requested was excessive.

Turning to the merits of the fee dispute in this case, we remain persuaded that the reduced fee of $19,775 was reasonable, based on consideration of the factors set forth in OAR 438-015-0010(4). Moreover, contrary to claimant's assertion, we conclude that our discussion of the rule-based factors in our prior order provided a sufficient explanation of how consideration of the factors led to the fee awarded. *See Schoch v. Leupold & Stevens*, 325 Or 112, 118, *on remand* 49 Van Natta 788 (1997); *Russell L. Martin*, 50 Van Natta 313 (1998) (applying *Schoch*). We acknowledge that there were factors supporting an extraordinary fee in this case. We found as fact that claimant's counsel devoted about 113 hours to this case; that claimant's consequential condition claim for her current psychological condition was of above-average complexity, both factually and legally; and that the value of claimant's interest at stake in this proceeding (*i.e.*, medical and disability benefits for the psychological condition) was significant.

On the other hand, there were also factors that weighed against the requested hourly rate of $250. We did not find that claimant's consequential condition claim was so complex as to justify that extraordinary rate. Contrary to claimant's assertion, the consequential condition claim was relatively less difficult to prove than a mental disorder claim, which would have required several elements of proof and been subject to the "clear and convincing evidence" burden of proof. For this reason, we found that counsel's risk of going uncompensated was somewhat limited. Furthermore, inasmuch as claimant already had an accepted injury claim, the relative value of claimant's interest at stake in this proceeding, while significant, was not as great as the value of establishing an initial claim. After weighing the rule-based factors, particularly the aforementioned factors of time, complexity, value, and risk, we conclude that an attorney fee of $19,775 for 113 hours of legal services was reasonable under the circumstances of this case.

Accordingly, our April 7, 1998 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our April 7, 1998 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

May 4, 1998 Cite as 50 Van Natta 868 (1998)

In the Matter of the Compensation of
GRACIELA KASPRZYK, Claimant
WCB Case No. 97-03018
ORDER ON RECONSIDERATION
Michael B. Dye, Claimant Attorney
Mannix, Nielsen, et al, Defense Attorneys

On March 27, 1998, we withdrew our February 26, 1998 Order on Review that reversed the Administrative Law Judge's order which: (1) set aside the self-insured employer's denial of claimant's current condition (trochanteric bursitis, SI joint dysfunction, right carpal tunnel syndrome and post traumatic synovitis of the right wrist); and (2) assessed a penalty and attorney fee for an allegedly unreasonable denial. We took this action to consider claimant's argument that we should not have rejected the opinions of her treating doctors, Drs. McNabb and Welch.

After considering claimant's motion and the employer's response, we adhere to the reasoning and conclusions expressed in our prior order. Accordingly, on reconsideration, we republish our February 26, 1998 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
PATRICIA A. SAULTZ, Claimant
WCB Case No. 97-03863
ORDER ON REVIEW
Pozzi, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Tenenbaum's order that upheld the insurer's denial of her low back condition at L4-5. The insurer cross-requests review of that portion of the ALJ's order that set aside its denial of claimant's low back condition at L5-S1. On review, the issue is compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the exception of the finding that claimant's 1985 injury and 1988 surgery are the major contributing cause of her need for treatment at L5-S1.

CONCLUSIONS OF LAW AND OPINION

Claimant, then a janitor, compensably injured her low back on April 18, 1985, a claim the insurer accepted as a lumbar strain. Prior to the injury, claimant had asymptomatic degenerative lumbar disc disease that the compensable injury rendered symptomatic. The claim was closed in January 1986 by Determination Order that awarded 20 percent unscheduled permanent disability.

On February 25, 1988, claimant underwent a bilateral hemilaminotomy and fusion of L5-S1. No discectomy or laminectomy was performed. (Ex. 25). After brief improvement, claimant's back symptoms continued.

In August 1993, Dr. Kabin became claimant's treating physician. After identifying a disc disruption at L4-5 and disc protrusions at L4-5 and L5-S1, Dr. Kabin recommended surgery to include "reconstruction" at L4-5 and exploration of the L5-S1 fusion with decompression. When her current need for treatment was denied on March 21, 1997, claimant requested a hearing.

Applying ORS 656.005(7)(a)(B), the ALJ upheld the insurer's denial of treatment directed at the L4-5 level. In doing so, the ALJ found unpersuasive Dr. Kabin's opinion that the 1985 injury and subsequent surgery were the major contributing cause of claimant's need for treatment. The ALJ observed that Dr. Kabin provided little reasoning for his conclusion and that he did not discuss what role, if any, claimant's preexisting degenerative condition might have played in her need for treatment. In addition, the ALJ concluded that expert analysis was more important than expert observation in resolving the causation issue, and thus, that Dr. Kabin's medical opinion was not entitled to deference. Finally, the ALJ noted that Dr. Kabin had only begun treatment of claimant within the last two years and, therefore, did not have the opportunity to observe claimant's original condition or her condition at the time of surgery.

Despite finding Dr. Kabin's opinion insufficient to establish the compensability of claimant's L4-5 back condition, the ALJ nevertheless concluded that Dr. Kabin's opinion established that treatment for claimant's L5-S1 condition was compensable. In reaching this conclusion, the ALJ found Dr. Kabin's opinion more persuasive than that of Dr. Thompson, a physician who reviewed medical records at the insurer's request and concluded that claimant's preexisting degenerative condition was the major contributing cause of the L5-S1 condition.

On review, claimant contends that the ALJ should have found her condition at L4-5 compensable based on Dr. Kabin's opinion. The insurer responds that the ALJ should have found Dr. Kabin's opinion unpersuasive, not only with respect to causation of the L5-S1 condition, but also with respect to the L4-5 disc condition. We agree with the insurer.

At the outset, we express our agreement with the ALJ's reasoning and conclusion with regard to the compensability of the L4-5 low back condition.[1] Moreover, the same reasons that the ALJ cited in support of her decision to discount Dr. Kabin's opinion with respect to the L4-5 condition apply equally to the condition at L5-S1. In addition, we agree with the insurer that Dr. Kabin was not sufficiently familiar with the medical record in that he stated that claimant was suffering from a "failed laminectomy syndrome" when the record indicates that claimant's 1988 surgery did not involve a laminectomy. (Ex. 25; 64:18-21). Also, we agree with the insurer that Dr. Kabin did not sufficiently weigh the various causal factors in accordance with the requirements of Dietz v. Ramuda, 130 Or App 397 (1994), rev den 321 Or 416 (1995) (determining major contributing cause involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause).

In contrast to Dr. Kabin's opinion, we find the medical opinion of Dr. Thompson to be persuasive. Dr. Thompson reviewed the entire medical record and was cross-examined. (Exs. 63, 64). We find persuasive his opinion that claimant had a tendency for disc degeneration and that the preexisting degenerative disc disease was the major contributing cause of claimant's condition at L5-S1. Dr. Thompson's opinion is supported by an examining physician, Dr. Johnson, who concluded that the degenerative condition was the primary cause of claimant's need for treatment. (Ex. 57-3).

In conclusion, we find claimant has failed to sustain her burden of proving by a preponderance of the evidence that her compensable injury is the major contributing cause of her need for treatment at both L4-5 and L5-S1. Because the ALJ concluded that claimant's L5-S1 condition was compensable, we reverse that portion of the ALJ's order.

ORDER

The ALJ's order dated November 14, 1997 is reversed in part and affirmed in part. That portion of the ALJ's order that set aside the insurer's denial of claimant's L5-S1 condition is reversed. The insurer's denial of that condition 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] No party contests the ALJ's finding that the claimant's preexisting degenerative condition "combined" with the compensable 1985 injury to cause a need for treatment. See ORS 656.005(7)(a)(B). Because we agree with this finding, we further agree with the ALJ's conclusion that claimant was required to prove that the original compensable injury (including the subsequent compensable surgery) was the major contributing cause of the need for medical treatment of the "combined condition." SAIF v. Nehl, 148 Or App 101, on recon 149 Or App 309 (1997).

In the Matter of the Compensation of
JANET F. BERHORST, Claimant
Own Motion No. 98-0129M
OWN MOTION ORDER OF ABATEMENT
Malagon, Moore, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our April 15, 1998 Own Motion Order, in which we declined to reopen her claim for the payment of temporary disability compensation because she failed to establish that she was in the work force at the time of disability.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
RICHARD A. YOUNG, Claimant
WCB Case No. 96-04805
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The self-insured employer (Precision Castparts) requests review of Administrative Law Judge (ALJ) Menashe's order that: (1) set aside its denial of claimant's occupational disease claim for bilateral hearing loss; and (2) determined that it was responsible for the claim. On review, the issues are compensability and responsibility.

We adopt the ALJ's "Findings of Fact" and affirm the ALJ's order based on the following reasoning.

On review, the employer contends that the ALJ erred in concluding that ORS 656.308(2)(a) precluded it from asserting that a prior employer (Oregon Steel Mills) was responsible for claimant's hearing loss condition.

Assuming *arguendo* that the employer's contention is correct, it would not change the result in this matter.

The ALJ found, and we agree, that claimant's work exposure with the employer could have caused claimant's hearing loss condition. Therefore, under the "last injurious exposure rule"(rule of proof), claimant has established that his hearing loss condition is compensable as to the employer. *See Bennett v. Liberty_Northwest Ins. Corp.*, 128 Or App 71 (1994) (if a claimant can show that the employment exposure, which may include conditions to which the claimant was exposed at his prior employer, were the major contributing cause of the claimed condition, the claimant can rely on the last injurious exposure rule to prove the compensability of the claim against the last employer by showing that employment conditions there could have caused the condition).

Turning to the responsibility issue, application of the "last injurious exposure rule" (rule of liability) would fix responsibility, in the first instance, with the employer. However, the employer may avoid responsibility if it proves either: (1) that it was impossible for conditions at its workplace to have caused claim's hearing loss; or (2) that the hearing loss was caused solely by conditions at one or more previous employment. *See Roseburg Forest Products v. Long*, 325 Or 305, 313 (1997). We find no persuasive evidence establishing either that it was impossible for claimant's work exposure with the employer to cause the hearing loss condition or that the hearing loss condition was caused solely by a prior employment.

In this regard, Dr. Maurer opined that claimant's work with the employer, while not the major cause, was a contributing factor. (Exs. 36, 40B-42). Similarly, Dr. Epley opined that claimant's hearing loss progressed while claimant was working for the employer. (Ex. 38). Finally, while Dr. Hodgson opined that claimant's work exposure was not the major cause of claimant's hearing loss condition, he does not opine that the condition was solely caused by a prior employment or that it was impossible for the work exposure to have caused claimant's condition. (Exs. 26, 33, 40). On this record, the employer has not established that responsibility for claimant's hearing loss should be shifted to a prior employer.

In sum, assuming that the employer could procedurally implicate a prior employment, the record does not establish that a prior employer would be responsible for claimant's condition. For this reason, we affirm the ALJ's order.

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

ORDER

The ALJ's order dated August 14, 1997 is affirmed. For services on review, claimant's attorney is awarded an assessed attorney fee of $1,500, to be paid by the employer.

In the Matter of the Compensation of
THOMAS J. BARNES, Claimant
WCB Case No. C8-00945
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Blake & Schilling, Claimant Attorneys
Thomas A. Andersen, Defense Attorney

Reviewed by Board Members Haynes and Hall.

On April 24, 1998, 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 CDA.

In the absence of extraordinary circumstances, attorney fees in CDAs are limited to 25 percent of the first $12,500, plus 10 percent of any amount in excess of $12,500. OAR 438-015-0052(1).

Here, the total proceeds of the agreement equal $6,442.22. Thus, in accordance with the aforementioned rule and absent extraordinary circumstances, claimant's attorney fee cannot exceed $1,610.56. The CDA provides for a total fee of $2,000. An additional provision states that "[d]ue to the nature of the claim and the amount of work done by [his] attorney," claimant agrees that his counsel is entitled to "an attorney fee greater than provided by the statute." Accompanying the CDA, claimant's attorney has submitted an "Affidavit in Support of Attorney Fees in Excess of Guidelines." After reviewing that document, we find that the affidavit provides extraordinary circumstances which justify the requested attorney fee. Because the affidavit accompanied the CDA and addresses a particular provision contained in the CDA, we interpret the affidavit as being incorporated into the CDA.[1]

Finally, in addition to the lump sum payment of $6,442.22, the CDA also provides that the insurer agrees to waive its right to an overpayment in the amount of $5,729.14. We have held that an overpayment which has been made pursuant to prior claims processing obligations cannot qualify as CDA "proceeds." *See e.g., Timothy W. Moore*, 44 Van Natta 2060 (1992). However, where a CDA's consideration is the release of a carrier's claim to an overpayment as well as a lump sum payment, we have interpreted the CDA's total consideration as consisting of the lump sum payment excluding the overpayment. *See Georgia A. Cassle*, 49 Van Natta 1387 (1997).

Here, as in *Cassle*, we interpret the consideration underlying the CDA to include only the $6,442.22 lump sum. Based on this interpretation, we find that the agreement is not unreasonable as a matter of law. *See* ORS 656.236(1)(a)(A).

As interpreted herein, the CDA is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' CDA 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] We note that only services pertaining to the CDA are considered in determining whether extraordinary circumstances exist to justify a fee in excess of that allowed by the administrative rule. *See Richard R. Millus*, 45 Van Natta 758 (1993). Thus, although the affidavit also discusses services pertaining to a disputed claim settlement, we have not considered those services in concluding that extraordinary circumstances justify the requested fee.

In the Matter of the Compensation of
CHARLES V. BURKHART, Claimant
WCB Case No. 97-03144
ORDER ON RECONSIDERATION
Philip H. Garrow, Claimant Attorney
Reinisch, et al, Defense Attorneys

On April 10, 1998, we abated our March 12, 1998 order that reversed the Administrative Law Judge's (ALJ's) order setting aside the insurer's denial of claimant's current low back condition. We took this action to consider claimant's motion for reconsideration. Having received the insurer's response, we proceed with our reconsideration.

Claimant has an accepted claim for low back strain, right shoulder strain, and cervical strain. In October 1995, claimant and the insurer entered into a Claim Disposition Agreement (CDA) that released all rights, except medical services, relating to the claim and any compensable consequence. As we noted in our order, the parties agreed at hearing that, based on the CDA, the only benefits at issue were medical services. In March 1997, the insurer denied a claim for "left radiculopathy" on the basis that treatment for the condition was "not related, reasonable or necessary for the accepted condition." (Ex. 120).

The ALJ set aside the denial after finding that claimant proved that the compensable injury was the major contributing cause of the need for treatment and disability of claimant's current low back condition. On review, we reversed, based on the conclusion that there was no persuasive medical opinion showing that the compensable injury was the major contributing cause of the need for treatment and disability of the low back.

Claimant asserts that, pursuant to *SAIF v. Shipley*, 326 Or 557 (1998), the Board and the Hearings Division lacked jurisdiction to resolve this case. In *Shipley*, the claimant first requested a hearing to challenge the carrier's denial of an aggravation claim. At the hearing, the claimant withdrew his aggravation claim and conceded that he had not suffered a new injury. Instead, the claimant argued that he was entitled to medical services for his accepted claim.

The Supreme Court found that the Hearings Division initially had authority to conduct a hearing because the matter to be addressed concerned a claim. The Court further stated, however, that the issue ultimately presented at hearing was a claim for medical services only, which, under ORS 656.245(6), was subject to review solely by the Director. The Court held that because the Board and Hearings Division lacked authority to decide the ultimate issue, it was required to dismiss the case.

Prior to the Court's opinion in *Shipley*, 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), reasoning that such a dispute necessarily involved the denial of an "underlying claim." *Jacqueline J. Rossi*, 49 Van Natta 1844 (1997). We have continued to adhere to this holding subsequent to *Shipley* on the basis that it is consistent with the Court's opinion. *Victor G. Schunk*, 50 Van Natta 812 (1998). That is, when the worker is asserting that medical treatment for a new, unaccepted condition is compensable, we have held that the Hearings Division retains jurisdiction over the medical services/compensability dispute. *Id. Accord SAIF v. Pendergast-Long*, 152 Or App 780 (1998) (Hearings Division retains jurisdiction over dispute regarding medical benefits for aggravation or new "consequential condition").

Here, although medical services are the only benefits at issue, such services are for a new, unaccepted condition. In particular, this proceeding has concerned whether or not claimant's low back condition is "compensable" and causally related to the original injury. Thus, we conclude that, because there is a "formal denial of the compensability of the underlying claim" within the meaning of ORS 656.245(6), we retain jurisdiction over this matter.

Accordingly, we withdraw our March 12, 1998 order. On reconsideration, as supplemented herein, we adhere to and republish our March 12, 1998 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
DONALD L. HOLCOMB, Claimant
WCB Case No. 96-06330
ORDER ON RECONSIDERATION
David C. Force, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

The self-insured employer requests abatement and reconsideration of our April 16, 1998 Order on Review that vacated the Administrative Law Judge's (ALJ's) order that declined to award a penalty and attorney fee for allegedly unreasonable delay in payment of compensation. Both the employer and claimant contend that we have jurisdiction of this matter and request that we amend our order to address the merits.

On December 12, 1992, a Determination Order issued finding claimant no longer permanently totally disabled and awarding scheduled and unscheduled permanent disability. On April 28, 1994, ALJ Stephen Brown reinstated the permanent total disability award and assessed a penalty. On March 6, 1995, the Board affirmed ALJ Brown's order. On April 10, 1996, the Court of Appeals affirmed the Board's order without opinion; the court stated that the "effective date" of the "appellate judgment" was July 19, 1996.

On July 3, 1996, claimant filed a request for hearing for the following reasons: "Other Failure to pay compensation per Ct. of App. Order," "Penalty ORS 656.262(11)(a)," and "Attorney Fee ORS 656.382(1) (2)." On August 15, 1996, the employer paid claimant $26,421.37. The parties continued to hearing on stipulated facts. The ALJ eventually concluded that the employer's payment of $26,421.37 was not untimely and, thus, found that claimant was not entitled to a penalty and attorney fee.

Claimant requested review, continuing to assert that the employer's payment was untimely. On review, we found that we lacked jurisdiction because one act of misconduct was alleged by claimant in support of a penalty and attorney fee. *See Corona v. Pacific Resources Recycling*, 125 Or App 47, 50-51 (1993). Consequently, we vacated the ALJ's order and dismissed claimant's request for review.

Both the employer and claimant assert that we erroneously vacated the ALJ's order. According to the employer, we have jurisdiction because claimant's request for hearing alleged issues in addition to penalty/attorney fee; the additional issues were not "dropped until closing arguments"; and the penalty issue concerns a question of law rather than fact. Claimant argues that this case is like *Leonard Kirklin*, 48 Van Natta 1571 (1996), where the Board found it had jurisdiction because the penalty issue was accompanied by an enforcement action.

We agree with the employer and claimant that we have jurisdiction to consider penalties when such issue is accompanied by an enforcement action. In *Leonard Kirklin*, the claimant sought to enforce a penalty awarded by a prior ALJ, and also sought penalties for nonpayment of the prior ALJ's penalty assessment, as well as the carrier's method of offsetting overpaid temporary disability. We found that, because the claimant was seeking to enforce a prior ALJ's order, we had jurisdiction over the case. 48 Van Natta at 1572. When the sole issue is a penalty and related attorney fee, however, we dismiss the case for lack of jurisdiction. For instance, in *Robert Geddes*, 47 Van Natta 2388, 2390 (1995), the sole issue raised was a penalty and related attorney fee for the insurer's allegedly unreasonable delay in paying the proceeds of a CDA. The insurer, however, paid the CDA proceeds prior to the request for hearing. Thus, we concluded that, because the carrier's obligation was fully satisfied prior to hearing, leaving the penalty and attorney fee issues only, we lacked jurisdiction over the matter.

Here, as noted above, claimant's request for hearing included a request to enforce a decision from the Court of Appeals, as well as allegations of a penalty and attorney fee. Thus, we agree with the employer and claimant that, at the time of filing of the request for hearing, the Hearings Division had jurisdiction of the case. *Leonard Kirklin*, 48 Van Natta at 1572. Following the filing of the request for hearing, however, the employer paid the compensation it had stayed pending its appeals. Although there is no express withdrawal of the "enforcement" matter, claimant's pleadings before the ALJ thereafter argued that the employer's payment of compensation was not timely. In particular, the parties disputed the date when the court's decision became final, which determined whether or not the employer's payment was timely. None of claimant's pleadings argued that claimant continued to be owed additional compensation or that the employer's payment did not fully satisfy claimant's award. In the absence of any argument concerning the "enforcement issue," we understand claimant as effectively withdrawing it, leaving only the penalty and related attorney fee issues.

The subsequent course of the proceeding confirms this conclusion. The ALJ's Opinion and Order stated that the "issue" was "claimant's entitlement to an award of a penalty and attorney fee based on the employer's untimely payment of compensation." The ALJ found claimant entitled to a penalty under ORS 656.262(11)(a); claimant then requested reconsideration, contending that he was also entitled to an attorney fee under ORS 656.382(1). The employer also asked for reconsideration, reiterating its argument that its payment was not untimely. The ALJ then issued an Opinion and Order on Reconsideration agreeing with the employer's position that the obligation to pay benefits began upon the "effective date" of the appellate judgment and, because the employer paid compensation within 30 days of the date, claimant was not entitled to a penalty and attorney fee.

Claimant again asked for reconsideration, arguing that, because the Court of Appeals affirmed the Board's order, the Board's order became final before the appellate judgment was entered because the employer did not appeal the court's decision. The ALJ continued to adhere to his Opinion and Order on Reconsideration.

In his brief on review to the Board, claimant asserted: "The Board should conclude that Employer's deliberate and contemptuous refusal to pay compensation awarded by an Order of this Board that became final on May 16, 1996, until August 15, 1996, was unreasonable; and should therefore award an additional amount of 25 [*sic*] of all PTD compensation then due and owing (together with interest thereon), a penalty." The employer's brief provided: "The issue presented before the [ALJ] is simply whether the employer timely paid stayed compensation when it paid within 30 days of the issuance of the Court of Appeals appellate judgment." The employer continued to argue that payment was within 30 days of July 19, 1996 and, because it paid within this period, payment was timely.

The course of this proceeding is similar to *SAIF v. Shipley*, 325 Or 557 (1998). There, the claimant filed a request for hearing challenging a denial of aggravation. At hearing, the claimant withdrew the claim for aggravation and instead asserted that he was entitled to medical services because such benefits were materially related to his accepted condition. The Court decided that, when claimant initially sought a hearing, the Board had jurisdiction because the matter at that time concerned a claim. The Court further found, however, that the issue ultimately presented at hearing was a claim for medical services only, a matter subject to sole review by the Director. The Court concluded that, when the issue at hearing was "reframed," the Hearings Division and Board had no authority to decide it and, thus, it was required to dismiss.

Based on *Shipley*, we look to the issue ultimately presented at the hearing to determine whether we have jurisdiction. That is, even though the Hearings Division initially properly has jurisdiction, if the issue is reframed to one over which there is no jurisdiction, we are required to dismiss. We find that such reasoning applies here. Because claimant's request for hearing included an "enforcement action," we initially had jurisdiction of the case. When claimant effectively withdrew such issue following the employer's satisfaction of the order sought to be enforced, leaving only the penalty and related attorney fee issue, the Director had exclusive jurisdiction of the matter.

Finally, we note claimant's argument that *Corona v. Pacific Resources Recycling* is not applicable because "the 'act of misconduct' asserted to claim the attorney fee is the refusal to comply with the order, while the act of misconduct asserted to claim the penalty is unreasonable resistance and delay to the payment of compensation as defined in ORS 656.262(11)(a)." (Emphasis in original.) We understand claimant as asserting that different bases underlie the penalty and attorney fee because he seeks a penalty for unreasonable delay in paying compensation while he asserts an attorney fee for refusal to pay compensation due under a Board or court order.

We find claimant's distinction to be inconsistent with the court's holding in Corona. As discussed in our order, the test provided in that case is whether the same "act of misconduct" supports the penalty and attorney fee; if so, then the Director has exclusive jurisdiction. 125 Or App at 50-51. Whether characterized as a refusal to pay compensation or an unreasonable delay to the payment of compensation, claimant relies only on the timing of the employer's payment of compensation in seeking the penalty and attorney fee. *Compare SAIF v. Batey*, 153 Or App 634 (1998) (substantial evidence supported Board's assessment of penalty and attorney fee because carrier failed to satisfy two separate processing requirements, even though carrier would not have made second mistake "but for" the first mistake). Consequently, we continue to find that, because claimant alleges the same act of misconduct, the Director has exclusive jurisdiction.

Accordingly, we withdraw our April 16, 1998 order. On reconsideration, as supplemented herein, we adhere to and republish our April 16, 1998 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
FLOYD A. BLASER, Claimant
Own Motion No. 98-0196M
OWN MOTION ORDER OF DISMISSAL
Liberty Mutual Fire Co., Insurance Carrier

The insurer initially submitted claimant's request for temporary disability compensation for claimant's compensable 1987 industrial injury. Claimant's aggravation rights on that claim expired on March 2, 1995.

On August 10, 1993, the Board approved the parties' Claim Disposition Agreement (CDA), whereby claimant released his rights to the following workers' compensation benefits: temporary disability benefits, permanent disability benefits, vocational assistance, survivor's benefits, and all rights to benefits except those granted to claimant under ORS 656.245.

In other words, claimant has released all rights except his right to medical services for the compensable injury. ORS 656.245. However, because claimant was injured after December 31, 1965, the Board in its own motion authority does not have jurisdiction over any medical services issues that may arise in this claim. Thus, if claimant is contending that his recent medical treatment, including the surgery at L5-S1, constitutes medical services for the compensable injury, that matter is not within the Board's own motion jurisdiction.[1]

Inasmuch as the CDA resolves all pending own motion matters, claimant's request for own motion relief is dismissed.

IT IS SO ORDERED.

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[1] If claimant is making such a contention and to the extent that he may request legal advice regarding his options, we are unable to grant such a 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, because claimant is unrepresented, he may wish to contact the Workers' Compensation Ombudsman, whose job it is to assist injured workers regarding workers' compensation matters, toll-free at 1-800-927-1271, or write to:

Workers' Compensation Ombudsman
Dept. of Consumer & Business Services
350 Winter Street, NE
Salem, OR 97310

In the Matter of the Compensation of
KENNETH C. FELTON, Claimant
Own Motion No. 96-0005M
SECOND OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Zimmerman & Nielsen, Defense Attorneys

The insurer requested reconsideration of our December 9, 1997 Own Motion Order Reviewing Carrier Closure, as reconsidered on March 24, 1998, in which we ultimately set aside its July 3, 1997 Notice of Closure as premature. On April 10, 1998, we abated our order to allow claimant the opportunity to respond to the insurer's motion. Having received claimant's response, we proceed with our reconsideration.

The insurer submits no new evidence[1] regarding the medically stationary status of claimant's compensable right knee condition at claim closure. Instead, the insurer argues that the Board reached the wrong conclusion based on the existing evidence. After further consideration, we continue to find that, on the record before us, claimant has met his burden of proving that his claim was prematurely closed.

As stated in our prior orders, the law regarding premature closure is as follows. 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 July 3, 1997 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harnon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980).

Only Dr. Walker's opinion supports a finding of premature closure. On reconsideration, the insurer makes several arguments that Dr. Walker's opinion is unpersuasive. First, the insurer argues that Dr. Walker's opinion does not reach the level of "further material improvement," as required by ORS 656.005(17). In support of this argument, the insurer cites *Clarke v. SAIF*, 120 Or App 11 (1992), and contends that Dr. Walker's "request for physical therapy is to improve claimant's 'functional ability' and not the underlying condition," which does not support a finding of premature closure. We disagree with the insurer's interpretation of Dr. Walker's opinion.

In *Clarke*, the claimant underwent surgery for a compensable low back disc herniation. Eventually, the treating physician found the claimant's condition medically stationary, although the claimant showed permanent weakness in the right lower extremity. Subsequently, the claimant was prescribed a leg brace to support his weak leg and ankle. The claimant contended that he was not medically stationary until his physician approved the final fit of the leg brace, which occurred several months after his physician had declared him medically stationary. The claimant argued that ORS 656.005(17) applied to medical treatment prescribed solely for the improvement of his functional abilities.

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[1] We note that, in its brief, the insurer refers to a "late December 1996" referral to physical therapy. However, the own motion record contains no such referral. Nor did the insurer submit a copy of any such referral. The insurer also states that "[b]efore claim closure, Dr. Russo [claimant's treating physician at claim closure] encouraged and suggested to claimant that he pursue physical therapy, however, claimant did not do so." (Insurer's brief, page 3). There is no evidence in the record that Dr. Russo either recommended physical therapy or that claimant failed to participate in physical therapy prior to claim closure. Although Dr. Russo stated in a letter to claimant that "I have encouraged you to improve the function of your knee, as the instability you describe is related to persistent lack of strengthening, and there has been no objective evidence of your voluntary participation in carrying out my recommendation[,]" the record contains no evidence of what "recommendation" Dr. Russo provided to improve the strength of claimant's right knee, nor does it indicate that this recommendation was for physical therapy. (Letter from Dr. Russo to claimant dated August 14, 1997). Furthermore, Dr. Walker, the orthopedist who performed claimant's right total knee arthroplasty, stated that claimant "has never been able to participate in a structured physical therapy program." (Letter from Dr. Walker to claimant dated January 30, 1998). Thus, the present record does not support the insurer's contention that Dr. Russo recommended physical therapy prior to closure and claimant failed to participate. In addition, claimant stated in his reply to the insurer's request for this reconsideration that Dr. Russo did not recommend or prescribe physical therapy at any time.

The court disagreed. Reasoning that ORS 656.005(17) dealt with a worker's physical condition, the court held that "medical treatment prescribed solely to improve a claimant's functional abilities is not pertinent to the determination of a claimant's medically stationary status under ORS 656.005(17)." *Clarke*, 120 Or App at 13-14. Because the claimant did not provide any evidence that the leg brace was prescribed to improve his physical condition, the court agreed that the claimant had failed to establish his claim was prematurely closed.

Here, Dr. Walker's opinion establishes that his recommendation of physical therapy was for improvement of claimant's physical condition, not just his functional ability. In this regard, Dr. Walker noted a "significant amount of atrophy of the quadriceps muscle" of the right leg that results in "considerable weakness and a subjective sense of instability." (January 30, 1998 letter). Furthermore, Dr. Walker opined that a strengthening program for claimant's leg would improve claimant's condition, which he opined had not reached medically stationary status since the surgery due to lack of a strengthening program, *i.e.*, a physical therapy program.[2] (January 16, 1998 chart note, January 30, 1998 letter).

The insurer argues that recommendations of physical therapy do not necessarily represent that further improvement could have been reasonably expected at claim closure. *Don M. Boldman*, 44 Van Natta 1809 (1992); *Bobby G. Todd*, 42 Van Natta 1648 (1990). While we agree with that statement of law, we find that Dr. Walker's opinion establishes that further material improvement in claimant's physical condition could have been reasonably expected at claim closure.

Next, the insurer argues that Dr. Walker's opinion is not persuasive because he opines only that physical therapy presents a *possibility* of improvement in claimant's condition. *Gormley v. SAIF*, 52 Or App at 1059-60 (probability, not possibility, is the requisite standard of proof). We disagree.

While, at times, Dr. Walker stated his opinion regarding the physical therapy in terms of possibility, he also stated it in terms of probability. (Compare January 16, 1998 chart note and January 30, 1998 letter from Dr. Walker to claimant). Reading Dr. Walker's opinion as a whole, and given his repeated conviction that physical therapy would improve claimant's condition, we find that Dr. Walker's opinion meets the requisite standard of proving there was a reasonable medical probability of material improvement with physical therapy. In reaching this finding, we contrast Dr. Walker's opinions regarding the recommended physical therapy with his opinions about the possibility of additional surgery. Specifically, Dr. Walker discussed the possibility of replacing claimant's spacer with a thicker component and reported that Dr. Bishop, to whom Dr. Walker referred claimant for a second opinion, suggested the possibility of an arthroscopic synovectomy. In contrast to his discussion of the physical therapy recommendation, Dr. Walker discussed these surgeries only in terms of presenting a possibility of improvement, and even questioned whether the spacer surgery would eliminate claimant's discomfort. Therefore, contrary to the insurer's argument, we do not find that Dr. Walker opined that physical therapy presented only a possibility of improvement in claimant's right knee condition.

Finally, the insurer renews arguments it made in our prior reconsideration. Specifically, it argues that Dr. Russo's opinion establishes that claimant's compensable right knee condition was medically stationary at claim closure. In our prior order on reconsideration, we explained why we found Dr. Walker's opinion more persuasive. The insurer provides no new evidence to dispute our finding. The insurer also renews its argument that, because Dr. Walker re-examined claimant after the date of claim closure, his opinion does not establish claimant's medically stationary status at claim closure. However, in our prior reconsideration, we explained our reasoning supporting our conclusion that Dr. Walker's January 1998 opinion persuasively related claimant's need for physical therapy back to the time of claim closure, thereby establishing that claimant was not medically stationary at claim closure. After further consideration, we have nothing to add to our analysis of the persuasiveness of the existing medical evidence or our determination that, on this record, the persuasive medical evidence establishes that claimant was not medically stationary at claim closure.

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[2] We note that Dr. Walker stated that he was "unsure whether [claimant] will experience complete improvement of the medical side pain and the sensation of looseness." However, the appropriate standard for medical evidence is "medical probability," not medical certainty. Dr. Walker's opinion meets that standard. *Gormley v. SAIF*, 52 Or App 1055, 1059-60 (1981); *Joann Kilmer*, 46 Van Natta 829, 830 (1994).

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our December 9, 1997 and March 24, 1998 orders effective this date. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

May 12, 1998 Cite as 50 Van Natta 879 (1998)

In the Matter of the Compensation of
LELAND S. HAWES, Claimant
WCB Case Nos. 97-04197 & 97-04196
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Herman's order that: (1) upheld the SAIF Corporation's partial denial of his current condition claim for a low back condition; and (2) upheld SAIF's denial of his occupational disease claim for lumbar degenerative disc disease. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the following correction. We correct the ALJ's factual findings to state: "On October 15, 1996, claimant experienced an episode of low back pain as a result of helping to lift a 300 to 400 pound piece of granite."

CONCLUSIONS OF LAW AND OPINION

Occupational Disease

The ALJ concluded that claimant did not carry the burden of proving his occupational disease claim for lumbar degenerative disc disease (DDD). In particular, the ALJ found the record insufficient to prove that claimant's work activities prior to his current employment constituted a "series of repetitive traumas" under ORS 656.802(1)(a)(C). The ALJ also found the medical evidence insufficient to prove that claimant's employment conditions were the major contributing cause of his lumbar DDD. On review, we disagree with the ALJ's conclusions for the following reasons.

Claimant's testimony at hearing provided an adequate summary of his work activities prior to his current employment as a tile setter. He performed a variety of heavy-duty jobs in the construction trade over the 31 years since he was age 15, including framing, rough and finish carpentry, cabinetry, countertops, floors, subfloors, and concrete. (Tr. 11, 21). His work duties have included extensive lifting and carrying of heavy weights, including heavy solid core doors, wooden beams weighing from 25 pounds to 150 pounds, and bags of concrete weighing 90 pounds. (Tr. 12, 22, 31). As a tile setter for the current employer, he lifted and carried boxes of tiles weighing about 60 pounds. (Tr. 31-32).

Dr. Franks, neurosurgeon, stated that the excessive loading, lifting, and bending that claimant performed in the construction trade are among the types of mechanical forces that result in "negative impacts" on discs, causing them to degenerate at a faster pace. (Ex. 24, pp. 16-18). He explained that, as claimant aged and his discs became desiccated (*i.e.*, dried out), resembling a "squashy" grape, his construction work activities caused "more squashing of squashy discs." (Ex. 24, pp. 17, 20). He further explained that the lifting and bending movements also caused "progressive wear and tear changes" in the facet joints as well. (Ex. 24-26). The end result is claimant's "premature older back." (Ex. 24-21).

Dr. Franks' opinion that claimant's construction work activities were injurious to his lumbar discs is well reasoned. Although Drs. Williams and Scheinberg, the examining physicians, opined that claimant's employment activities did not contribute to his DDD, their opinion lacked the specificity of Dr. Franks' opinion and supporting rationale. Based on Dr. Franks' opinion, therefore, we find that claimant's construction work activities constituted a "series of traumatic events or occurrences" under ORS 656.802(1)(a)(C). *See Aetna Casualty Co. v. Aschbacher*, 107 Or App 494, 504, *rev den* 312 Or 150 (1991) (the word "traumatic" in ORS 656.802(1) means injurious).

We turn to the medical causation issue. Claimant relies on the last injurious exposure rule (LIER) to establish compensability. As a rule of proof, LIER allows a claimant to prove the compensability of a disease without having to prove the degree, if any, to which exposure to disease-causing conditions at a particular employment actually caused the disease. *Roseburg Forest Products v. Long*, 325 Or 305, 309 (1997). The claimant need prove only that the disease was caused by employment-related exposure. *Id.*

In concluding that claimant did not carry his burden of proof under LIER, the ALJ reasoned that claimant's treating physicians, Drs. Franks and Bohlman, gave inconsistent opinions as to whether work activities were the major cause of the lumbar DDD. On review, claimant argues that his treating physicians rendered the better-reasoned opinions in the record and that their opinions proved his claim by a preponderance of the evidence. We agree.

The expert medical evidence consists of opinions by Drs. Williams, Scheinberg, Bohlman and Franks. Drs. Williams and Scheinberg, examining physicians, opined that claimant's DDD was "consistent with the normal aging process" and "compatible with the aging process and idiopathic conditions." (Ex. 14-6). They further opined that claimant's work for the employer and his carpenter work did not contribute to the DDD. (*Id.*) To support his opinion that claimant's DDD is primarily due to aging, Dr. Williams noted that patients with sedentary jobs have documented DDD such as claimant's and yet have never performed heavy physical work. (Ex. 16-2).

In response to SAIF's request, Drs. Bohlman and Franks indicated that they concurred with Drs. Williams and Scheinberg's opinions regarding claimant's DDD. (Exs. 17, 22). Subsequently, in response to claimant's attorney's request, Dr. Bohlman wrote: "It is very likely [claimant's] long years of heavy construction-type work has been the cause of his Degenerative [sic] back condition and he most likely will need to seek a less strenuous type of occupation." (Ex. 23).

Dr. Franks was deposed. He agreed that claimant's employment activities in the construction industry during the previous 20 years, including lifting, bending, twisting, and handling heavy weights, were the major contributing cause of his lumbar DDD. (Ex. 24-27). Dr. Franks stated that claimant's employment activities cumulatively were the "overwhelming reason" for his prematurely worn out disc spaces, facet joints and vertebral bodies. (Ex. 24-28). He explained that claimant's employment activities, particularly excessive loading, lifting, and bending, exerted mechanical forces that negatively impacted the discs and facet joints. (Ex. 24, pp. 17-18, 31). Dr. Franks stated that, as claimant's discs desiccated with aging, his employment activities exerted mechanical forces (*i.e.*, like squashing a squashy grape) that caused the discs to degenerate. (Ex. 24, pp. 17-18). He noted that claimant does not have some of the other known factors that cause DDD, such as a history of smoking or being overweight. (Ex. 24-19).

On cross-examination by SAIF's attorney, Dr. Franks addressed the examining physicians' statement that DDD has also been observed in sedentary workers. He noted that, whereas sedentary workers are more likely to have DDD at lower levels of the lumbar spine, such as L4-5 or L5-S1, claimant has DDD at the upper levels, L1-2 and L2-3, indicating accelerated degenerative changes from repetitious lifting or axial loading of the spine. (Ex. 24, pp. 36-37). He also noted that, while he has seen sedentary office workers with DDD and herniated discs, he has also seen severely degenerated backs in workers who performed "back breaking" work, such as farmers. (Ex. 24, pp. 39-40). He acknowledged studies showing that the backs of laboring workers were not much different than those of sedentary workers, but observed that those studies did not consider other factors that may have contributed to the DDD in sedentary workers, such as smoking or poor conditioning. (Ex. 24-40).

After explaining why he believed claimant's laboring activity caused his DDD, Dr. Franks was asked by SAIF's attorney whether he still concurred with Drs. Williams and Scheinberg's reports. (Ex. 24-42). Dr. Franks responded: "I do for most of it. The bottom line is, a lot of his problem is degenerative. The answer is, I agree with it . . . ." (*Id.*) Dr. Franks went on to state that he disagreed with the portion of the examining physicians' report regarding the extent of contribution made by the October 15, 1996 lifting incident to his current back condition. (Ex. 24, pp. 42-43).

Unlike the ALJ, we do not find that Dr. Franks' response to SAIF's attorney's question constituted a change of opinion. Reading his response in the context of his entire testimony, particularly his detailed explanation of why claimant's work activities were the "overwhelming reason" for his

current DDD, we are not inclined to view Dr. Franks' rather conclusory statement of concurrence with Drs. Williams and Scheinberg's reports as a complete and unexplained reversal of opinion. We rely, instead, on Dr. Franks' detailed explanation of why claimant's work activities were the major cause of his DDD.

Dr. Franks' detailed opinion was better-reasoned than the opinions of Drs. Williams and Scheinberg. He also rebutted the rationale supporting their opinion that claimant's work activities did not contribute to his DDD. He identified the mechanical forces that claimant's work activities cumulatively exerted on his lumbar spine structures over the years and explained why studies showing DDD in sedentary and laboring workers were not a reliable basis for concluding that laboring activities do not contribute to DDD. Based on Dr. Franks' thorough and well-reasoned opinion, we find that claimant's employment activities were the major contributing cause of his lumbar DDD. Accordingly, claimant has carried his burden to prove compensability under LIER's rule of proof.

We turn to LIER's rule of assignment of responsibility. Based on Dr. Franks' opinion, we find that claimant's work activities as a tile setter for SAIF's insured contributed to the progression of his DDD. (Ex. 24, pp. 37-38). As the last employer with employment conditions that contributed to the worsening of claimant's disease, SAIF's insured is responsible for the claim. *See Bracke v. Baza'r*, 293 Or 239, 250 (1982); *Timm v. Maley*, 125 Or App 396, 401, *rev den* 319 Or 81 (1994); *Mark A. Davidson*, 49 Van Natta 1918, 1921 (1997). Accordingly, SAIF's insured shall be assigned responsibility for claimant's occupational disease claim for lumbar DDD.

Current Condition

Applying the "combined condition" analysis under ORS 656.005(7)(a)(B) to claimant's current low back condition, the ALJ concluded that claimant did not carry his burden of proving that the October 15, 1996 work incident, in which claimant helped to lift a 300 to 400 pound piece of granite, was the major contributing cause of his current low back condition. Instead, based on her review of the expert medical evidence, the ALJ found that claimant's lumbar DDD was the major contributing cause of his current condition.

Based on our *de novo* review of the expert medical evidence, we agree with the ALJ's finding that claimant's DDD is the major contributing cause of his current low back condition. That finding is supported unanimously by the medical experts. (Exs. 14-5, 16-2, 17, 22, 23, 24 pp. 32-33). However, given our holding (in this order) that claimant's lumbar DDD is compensable and that SAIF is responsible for that disease, the lumbar DDD does not qualify as a "preexisting condition" under ORS 656.005(7)(a)(B) in the compensability context. *See Pepsi Cola Bottling Co. v. Walton*, 147 Or App 698, 703 (1997) (compensable condition does not qualify as "preexisting condition" in compensability dispute). Because claimant's current condition is related in major part to claimant's occupational disease, we conclude that the condition is compensable and SAIF's responsibility.

Attorney Fee

Claimant's attorney is entitled to an assessed fee for prevailing over SAIF's denial of his claims. *See* ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $4,800, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record and appellate briefs), the complexity of the issues, the value of the interest involved, and the risk that claimant's attorney's efforts could have gone uncompensated.

ORDER

The ALJ's order dated December 16, 1997 is reversed. The SAIF Corporation's denial of claimant's occupational disease claim for lumbar degenerative disc disease and his claim for a current low back condition is set aside, and the claims are remanded to SAIF for processing according to law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $4,800, payable by SAIF.

In the Matter of the Compensation of
BARBARA M. JOHNSON, Claimant
Own Motion No. 98-0045M
OWN MOTION ORDER
Malagon, Moore, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable above-knee amputation, right knee, left knee and low back pain secondary to altered gait. Claimant's aggravation rights expired on August 24, 1984. SAIF recommends that we authorize the payment of temporary disability compensation.

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

In a September 8, 1997 chart, Dr. Bishop, claimant's treating physician, recommended claimant undergo a arthrotomy, limited synovectomy and possible revision of her knee prothesis. Thus, we conclude that claimant's compensable injury worsened requiring surgery.

However, in order to be entitled to temporary disability compensation upon a worsening of a work-related injury, 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 submits Dr. Bishop's March 23, 1998 report in support of her contention that she could not work due to the compensable condition and that it would have been futile for her to look for work because of her compensable condition. Dr. Bishop opined: "... I can state with conviction that [claimant] is not employable ... [Claimant] is aged 61 years, and I do believe looking for work would be futile for her with her present and continuing medical condition." Thus, we conclude that claimant has provided a persuasive medical opinion demonstrating that she was unable to work at the time of her current worsening and that it would have been futile for her to seek work due to the compensable condition.

Further, in order to satisfy the third *Dawkins* criterion, claimant must also establish, along with the "futility" standard, that he/she was willing to work. Failing to demonstrate his/her willingness to work, then he/she is not considered a member of the work force, and thus, is not entitled to temporary disability compensation. *See Arthur R. Morris*, 42 Van Natta 2820 (1990); *Stephen v. Oregon Shipyards*, 115 Or App 521 (1992); *Judith R. King*, 48 Van Natta 2303 (1996); *Marlene J. Andre*, 48 Van Natta 404 (1996).

Claimant submitted a March 17, 1998 affidavit wherein she asserts: "I have not sought work, although I am willing to seek employment. I have not sought employment because my doctor has informed me that it would be futile for me to look for work." We are persuaded that claimant is willing to seek employment but unable to do so because of her compensable condition.

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.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
BETHEL A. LAMPING, Claimant
Own Motion No. 97-0482M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable L3-4, L4-5, L5-S1 disc herniations. Claimant's aggravation rights expired on February 15, 1994. SAIF agrees that claimant's current condition, need for multi-level lumbar surgery, is causally related to the compensable condition, that it is responsible for claimant's current condition and that the proposed surgery or hospitalization is reasonable and necessary. However, SAIF contends that claimant was not in the work force at the time of the current disability.

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

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 was not in the work force at the time of the current disability. Claimant responded to SAIF's contention by letters dated November 22, 1997, March 10, 1998 and April 6, 1998. Claimant provided copies of a 1995 W-2 form, a 1996 W-2 form and a March 10, 1998 affidavit wherein she attests that: "No, I was not in the work force at the time of the surgery on 8/20/97, dew [sic] to the injury at work on 11/26/95. I would have been in the work force if it had not been for the great pain I was in prior to surgery and since." The affidavit provided by claimant demonstrates her willingness to work despite her inability to work due to her compensable condition.

Claimant indicates that she was taken off work in February 1996 due to the compensable condition and that she was off work until "the pain got worse till they went in and did the surgery." Claimant provides an April 1, 1998 letter from Dr. Sperley, her attending physician, wherein he opined that claimant has been unable to work since November 26, 1995, due to her compensable condition. Dr. Sperley supplemented his April 1, 1998 letter with a report dated April 22, 1998 wherein he states "[claimant] sustained a back injury 11/26/95 and had been unable to work from 2/16/96 to the present." We interpret Dr. Sperley's letters to indicate that it would have been futile for claimant to seek work due to her compensable condition. Thus, we find that claimant has met the third criteria set forth in *Dawkins, id.*

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning August 20, 1997, the date she was hospitalized for 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
DAVID J. PARDUN, Claimant
Own Motion No. 98-0031M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Malagon, Moore, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's February 9, 1998 Notice of Closure which closed his claim with an award of temporary disability compensation from May 19, 1997 through June 25, 1997. SAIF declared claimant medically stationary as of August 11, 1997. Claimant contends that he is entitled to temporary disability compensation beyond June 25, 1997.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12 (1980).

Claimant does not contend that his medically stationary date is incorrect or that he was not medically stationary when SAIF closed his claim. In any event, the record would not support such a contention. Rather, claimant contends that he is entitled to further substantive temporary disability benefits prior to becoming medically stationary.

Claimant has the burden of proving by a preponderance of the evidence his entitlement to temporary disability. See ORS 656.266. A claimant's substantive entitlement to temporary disability benefits is determined on claim closure and is proven by a preponderance of the evidence in the entire record showing that the claimant was disabled due to the compensable injury before being declared medically stationary. ORS 656.210; Lebanon *Plywood v. Seiber*, 113 Or App 651, 654 (1992); *Daniel J. Bergmann*, 49 Van Natta 519 (1997); *Debra Dale*, 47 Van Natta 2344 (1995); *Donna Anderson*, 46 Van Natta 1160 (1994). Therefore, claimant's substantive entitlement to temporary disability benefits ended on his medically stationary date. SAIF paid claimant time loss benefits through June 25, 1997. To be entitled to further substantive benefits, claimant must establish that he was disabled due to the compensable injury beyond June 25, 1997.

We generally defer to the opinion of claimant's treating physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983). In addition, we give the most weight to opinions that are both well-reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259 (1986).

SAIF offers a June 26, 1997 insurer-arranged medical examination report by Dr. Hodgson in support of its contention that temporary disability compensation was properly terminated on June 25, 1997. In his report, Dr. Hodgson opines "[Claimant] is medically stationary at this time, simply because he has virtually lost all of his hearing." Claimant's attending physician, Dr. Schleuning, concurred with Dr. Hodgson's report on August 11, 1997, the date he was declared medically stationary. However, claimant submitted a March 28, 1998 clarifying report by Dr. Schleuning wherein he stated:

> "[Claimant] received a cochlear implant at Oregon Health Sciences University in May 1997. Because of the need to have programming of his device and processor, he was required to stay until July 30. He had five programming sessions.
>
> "Successful programming is absolutely imperative in allowing the patient to adjust to the device and for us to adjust the implant processor as needed."

We find Dr. Schleuning's opinion more persuasive than Dr. Hodgson's conclusory statement that claimant is medically stationary simply because he has lost all of his hearing. It is apparent that the cochlear implant was performed to help claimant regain some of his hearing loss. Dr. Schleuning, who performed the implant and is familiar with claimant's medical history, explained that in order for the implant to benefit claimant and return some of his hearing, he was required to undergo "programming" sessions. We interpret the "programming" sessions as treatment that was meant to help restore some of claimant's hearing. Dr. Schleuning's opinion expressed in his March 28, 1998 report is unrebutted.

Additionally, claimant is employed in Alaska and because the "programming" sessions were required to complete claimant's recovery from his cochlear implant, claimant was unable to return to his job in Alaska until said "programming" sessions were completed. Thus, we conclude that claimant was disabled due to his compensation condition until the programming sessions were completed on July 30, 1997.

Thus, we find the preponderance of the evidence establishes that claimant is entitled to substantive temporary total disability compensation from May 19, 1997 through July 30, 1997. SAIF's February 9, 1998 Notice of Closure is modified accordingly.

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.

May 12, 1998 Cite as 50 Van Natta 885 (1998)

In the Matter of the Compensation of
DINA M. OLDFIELD, Claimant
WCB Case No. 97-05045
ORDER ON REVIEW
Burt, Swanson, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Tenenbaum's order that set aside its denial of claimant's occupational disease claim for right carpal tunnel syndrome. On review, the issue is compensability.

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

The employer contends that the ALJ "discounted" or "rejected" everything that Dr. Radecki stated in his reports. We do not need to resolve the employer's challenges, because we find no persuasive reasons not to defer to the opinion of claimant's attending physician, Dr. Redmond. *See Weiland v. SAIF*, 64 Or App 810, 814 (1983) (Board generally defers to the treating physician's opinion absent persuasive reasons not to do so).

The employer also objects to claimant's argument that Dr. Radecki's opinion should be discounted because of bias. Claimant's argument is not well-taken. As claimant himself recognizes, the court has held that "the contribution of one expert's opinion to the preponderance of evidence in one case has no bearing on the relative weight of the same expert's opinion in another case with a different mix of medical opinions." *Giesbrecht v. SAIF*, 58 Or App 218 (1982). Therefore, the cases cited by claimant are not relevant to the persuasiveness of Dr. Radecki's opinion in this case, as we consider his opinion only as it pertains to this case.

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 December 11, 1997 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,500, payable by the self-insured employer.

In the Matter of the Compensation of
DELORES J. SWANSON, Claimant
WCB Case No. 95-12394
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Mills' order that set aside its denial of claimant's consequential condition claim for pneumonia. On review, the issue is compensability.

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

Applying ORS 656.005(7)(a)(A), the ALJ set aside the employer's denial of claimant's pneumonia condition that developed during hospitalization for her compensable November 1994 motor vehicle accident (MVA).[1] In doing so, the ALJ relied on the medical opinion of claimant's attending internist, Dr. Tarro, who opined that claimant's hospitalization for her compensable injury (specifically stasis due to immobility and inability to clear her lungs) was the major contributing cause of her pneumonia. (Ex. 65-2).

On review, the employer contends that Dr. Tarro's opinion is flawed because it relies on a "but for" analysis (*i.e.*, that, but for claimant's hospitalization for her compensable injury, she would not have developed pneumonia). The employer urges us instead to rely on the opinion of an examining physician, Dr. Farris, and a consulting physician, Dr. Blair, both of whom identified claimant's preexisting chronic obstructive pulmonary disease (COPD) as the major factor in the development of claimant's pneumonia.[2]

In order to establish compensability, claimant must show that her 1994 injury and its sequelae are the major contributing cause of her need for treatment. ORS 656.005(7)(a)(A). Because claimant's pneumonia condition is an alleged consequential condition and because claimant has preexisting COPD, we find that the causation issue is a complex medical question which requires expert evidence for its resolution. *See Barnett v. SAIF*, 122 Or App 279 (1993). We rely on those medical opinions which are well-reasoned and based on complete histories. *See Somers v. SAIF*, 77 Or App 259 (1986).

We turn first to Dr. Tarro's opinion. Dr. Tarro acknowledged that claimant had COPD for number of years, but noted that it had been treated successfully and that claimant was doing quite well. Dr. Tarro explained that, after the MVA, claimant entered the hospital and was unable to clear her secretions at rest and developed pneumonia. Observing that there was no question that claimant had entered the hospital because of the MVA, and otherwise would not have developed pneumonia, Dr. Tarro concluded that the pneumonia was the direct result of this chain of events. According to Dr. Tarro, the stasis due to claimant's immobility and inability to clear her lungs was the major contributing cause of the pneumonia. (Ex. 65-2).

Although employer contends that Dr. Tarro's opinion reflects merely a "but for" analysis, we disagree. As is apparent from his report, Dr. Tarro considered claimant's preexisting COPD, but noted that it was under control prior to the MVA and that claimant was doing well. This understanding is in accordance with claimant's testimony. (Tr. 18, 19). Given Dr. Tarro's consideration of claimant's preexisting COPD and her medical history, we are persuaded that Dr. Tarro's opinion is well-reasoned and based on an accurate and complete history. We, thus, find that it establishes that claimant's medical treatment (*i.e.*, hospitalization) for the compensable MVA is the major contributing cause of her consequential pneumonia. *See Barrett Business Services v. Hames*, 130 Or App 190, 193, *rev den* 320 Or 492 (1994) (Where reasonable and necessary treatment of a compensable injury is the major contributing cause of a new injury, the compensable injury itself is properly deemed the major contributing cause of the consequential condition for purposes of ORS 656.005(7)(a)(A)).

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[1] ORS 656.005(7)(a)(A) provides: "No injury is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition."

[2] Claimant's COPD was apparently first diagnosed during a non-work related hospitalization in 1992. Claimant was also diagnosed with cor pulmonale, congestive heart failure, hypoxemia and polycythemia. (Ex. A).

Moreover, we do not find the opinions of Dr. Farris and Dr. Blair to be more persuasive. Dr. Blair agreed with a summary prepared by employer's counsel, which stated that he "generally agreed" with the conclusions reached by Dr. Farris, that the MVA did not directly contribute to claimant's respiratory failure, and that, if claimant had not had COPD, she would not have developed respiratory failure. (Ex. 64). However, Dr. Blair's concurrence report provides little reasoning to support his opinion and does not acknowledge, as did Dr. Tarro, that claimant's COPD was under control prior to the MVA.[3]

Dr. Farris believed that claimant's prior hospitalization in 1990, during which COPD was diagnosed, was also for pneumonia. There is no evidence, however, that claimant previously had pneumonia. (Ex. A). Claimant, in fact, testified that she never previously had pneumonia. (Tr. 18). Under the circumstances, we find that Dr. Farris' history is not entirely accurate. The employer, however, argues that, even assuming that Dr. Farris' history is incorrect, his opinion should not be discounted because he did not rely on a previous occurrence of pneumonia in concluding that the preexisting COPD was the major contributing cause of the pneumonia.

The employer's contention notwithstanding , we do not consider this to be an insignificant flaw in Dr. Farris' opinion. Dr. Farris apparently felt a prior hospitalization for pneumonia was sufficiently significant that it was noted in both of his medical reports. (Exs. 61-4, 74-2). While it may be that Dr. Farris' conclusion would have been the same had he been aware that claimant had not previously experienced pneumonia, we are not able to make that assumption. Inasmuch as a complete and accurate history is an important factor in assessing the persuasiveness of medical opinions, *Somers*, 77 Or App at 263, we give less weight to Dr. Farris' opinion.

In conclusion, we acknowledge that claimant had a significant, preexisting COPD condition prior to her compensable MVA. Furthermore, the record is clear that both the COPD and the hospitalization for the MVA were important factors in the development of the pneumonia. On balance, however, we find that the evidence preponderates in favor of the ALJ's conclusion that medical treatment for the MVA was the major contributing cause of the pneumonia condition. Therefore, we affirm.

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 $2,015, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 19, 1997 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $2,015, to be paid by the employer.

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[3] The employer cites claimant's testimony that she had used an inhaler for her lung condition prior to the MVA, as well as refers to x-rays taken prior to the development of the pneumonia, as evidence that the preexisting COPD was severe. However, the medical record does not disclose that claimant was under treatment for her lung condition when injured in the MVA. In addition, claimant was able to work and carry on a relatively active life. (Tr. 18). We are not persuaded that the evidence cited by the employer makes Dr. Blair's opinion more convincing than Dr. Tarro's.

In the Matter of the Compensation of
JERRY D. THATCHER, Claimant
WCB Case No. 96-08971
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

The self-insured employer requests review of Administrative Law Judge (ALJ) Hoguet's order that: (1) set aside its denial of claimant's aggravation claim for a left shoulder condition; and (2) admitted Exhibits 70 and 71 into evidence. On review, the issues are compensability, aggravation and evidence.

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

The employer argues that the ALJ abused his discretion in admitting Exhibits 70 and 71 which are rebuttal reports from claimant's attending physician, Dr. Switlyk. The employer asserts that claimant did not exercise due diligence in obtaining and submitting the reports.

The facts relevant to the evidence issue are as follows. A hearing was scheduled, in response to claimant's request, for December 23, 1996. On December 20, 1997, claimant obtained a postponement of that hearing in order to obtain rebuttal evidence from Dr. Switlyk, to medical opinions submitted by the employer.

On February 24, 1997, claimant's attorney wrote to Dr. Switlyk asking for his response to the medical reports submitted by the employer. Subsequently, on March 18, 1997, a notice of hearing issued which indicated that the continued hearing was set for May 30, 1997. On May 15, 1997, Dr. Switlyk's office contacted claimant's attorney's office and advised that the request for a report had been mislaid and asked if claimant's attorney still needed the report. Claimant's attorney became aware of the problem on May 27, 1997 and, after telephoning the doctor's office, was told that Dr. Switlyk was on vacation for the week. Claimant's attorney then initiated a telephone conference between himself, the employer's attorney and the ALJ. The ALJ granted claimant's attorney the opportunity to submit a rebuttal report from Dr. Switlyk within two weeks of the hearing. The employer objected on the ground that, by the exercise of due diligence, a report could have been obtained prior to the date of the hearing. The employer reserved the right to depose Dr. Switlyk, but ultimately did not request a deposition after the submission of Exhibits 70 and 71.

After the hearing, claimant's attorney submitted a rebuttal report from Dr. Switlyk (Ex. 70) and a second report which was a letter from claimant's attorney to Dr. Switlyk asking two questions in clarification of the first report and providing a space where the doctor could check "yes" or "no" in response to the questions (Ex. 71).

On review, the employer argues that the ALJ abused his discretion in admitting the documents. First, the employer argues that claimant did not exercise due diligence in completing the record and submitting all his evidence prior to the hearing, and second, the employer argues that the record was left open only for a single report from Dr. Switlyk.

An ALJ "may continue a hearing . . . [u]pon a showing of due diligence if necessary to afford reasonable opportunity for the party bearing the burden of proof to obtain and present final rebuttal evidence. . . ." OAR 438-006-0091(3). OAR 438-006-0091(3) is couched in permissive language and contemplates that the exercise of authority to continue a hearing rests within the ALJ's discretion. See Ronald D. Hughes, 43 Van Natta 1911, 1912 (1991). Further, an ALJ is not bound by technical or formal rules of procedure and may conduct the hearing in any manner that will achieve "substantial justice." ORS 656.283(7).

After reviewing this record, we do not find an abuse of discretion in admitting the documents. Although the hearing was initially postponed on December 20, 1997 to obtain rebuttal evidence from Dr. Switlyk, that evidence was not requested until February 24, 1997. Notwithstanding that two-month

delay in submitting the request, the action was still taken well in advance of the May 30, 1997 hearing. Arguably, the attorney could have followed up with the doctor's office when no report was received after the February 24, 1997 request. However, it was ultimately the misplacing of the report by the doctor's office and the doctor's vacation which prevented the evidence from being obtained prior to hearing, rather than the attorney's lack of diligence.

The employer also argues that the second document, Exhibit 71, exceeded the purpose for which the record was left open. The ALJ left the record open for "Dr. Switlyk's report." (Tr. 5). Thus, it appears that the record was left open with the assumption that one report would be submitted, but with no specific agreement between the parties and the ALJ to that effect. Under such circumstances, we are not persuaded that the ALJ exceeded the purpose of his ruling by admitting Exhibit 71.

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

ORDER

The ALJ's order dated August 28, 1997 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $2,500, payable by the employer.

May 11, 1998 Cite as 50 Van Natta 889 (1998)

In the Matter of the Compensation of
DAVID E. STUTZMAN, Claimant
WCB Case No. 96-06436
ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Claimant has requested reconsideration of our April 17, 1998 Order on Review that reversed that portion of an Administrative Law Judge's (ALJ's) order that set aside the SAIF Corporation's denial of his current low back condition. Citing *Norstadt v. Murphy Plywood*, 148 Or App 484, *recon* 150 Or App 245 (1997) and *Garibay v. Barrett Business Services*, 148 Or App 496 (1997), claimant asserts that he has established that his current condition is "work-related." After considering claimant's motion and memorandum in support, we issue the following order.

As noted in our prior order, the issue in this case is not whether claimant's current condition is "work-related," but rather whether claimant's current condition is related to the 1986 compensable injury. Neither *Garibay* and *Norstadt* involved this issue. Rather, the issue in those cases was whether or not the claimant could establish initial compensability of an occupational disease claim by using the last injurious exposure rule. Here, by contrast, claimant was not trying to establish the compensability of his current condition in the first instance. Rather, he was alleging that his current condition is a compensable consequence of the 1986 accepted injury with SAIF. Consequently, ORS 656.005(7)(a)(A) is applicable and not the last injurious exposure rule of proof used in *Garibay* and *Norstadt*.

Accordingly, our April 17, 1998 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our April 17, 1998 Order on Review 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
MICHELLE R. WOOD, Claimant
WCB Case No. 97-06509
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Myzak's order that set aside its "de facto" denial of claimant's partial rotator cuff injury and fraying of the supraspinatus tendon. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

In 1995, claimant developed right arm and shoulder symptoms while working for SAIF's insured. On April 10, 1996, SAIF accepted right lateral epicondylitis, right "bicep" tenosynovitis and right wrist bursitis. (Ex. 3).

On September 16, 1996, Dr. Lundsgaard reported that claimant had continued right shoulder problems. (Ex. 4). X-rays showed that claimant had calcifications in the supraspinatus. (*Id.*) He diagnosed chronic impingement, right shoulder, with some evidence of calcific tendinosis. (*Id.*) In a letter to SAIF, Dr. Lundsgaard explained that the cause of claimant's calcific tendinosis was probably chronic irritation and it was probable that her tendinitis and impingement were secondary to her job. (Ex. 4A). He did not see evidence of a rotator cuff tear, but he noted that she could have a small cuff tear. (*Id.*) Dr. Lundsgaard recommended an arthroscopic exam of the shoulder, decompression and possibly calcium removal.

On October 14, 1996, Dr. Bald examined claimant on behalf of SAIF and diagnosed "[c]alcific tendinitis rotator cuff tendon right shoulder with secondary impingement syndrome" and lateral epicondylitis, right elbow, resolved. (Ex. 5-5). He reported that claimant's current symptoms and need for treatment were the result of preexisting calcific tendinitis and the major contributing factor of the combined condition was the calcific tendinitis. (Ex. 5-5, -6). Dr. Bald agreed that surgical treatment should be considered.

On October 30, 1996, Dr. Lundsgaard concurred with Dr. Bald's opinion, noting that if a rotator cuff tear was identified at surgery, his opinion might change. (Ex. 6). Dr. Lundsgaard commented that claimant's "job did not cause the calcium." (*Id.*)

On November 5, 1996, SAIF issued a partial denial of claimant's combined right shoulder condition. (Ex. 7). SAIF stated that claimant had preexisting calcific tendinitis of the right shoulder that combined with her work activities and the major contributing cause of the combined condition was the preexisting calcific tendinitis. (*Id.*) Claimant requested a hearing.

On February 6, 1997, a "Stipulation and Order" was approved by a prior ALJ. (Ex. 10). The stipulation provided that the parties agreed to settle all issues "raised or raisable" and SAIF's November 5, 1996 partial denial was upheld. (*Id.*) The parties recognized that Dr. Lundsgaard had raised the possibility that claimant may have a right shoulder rotator cuff tear. They agreed that the "November 5, 1996 partial denial is a denial of claimant's combined right shoulder condition insofar as that condition is a combination of claimant's preexisting calcific tendinitis and her work activity." (*Id.*) Claimant was not precluded from filing a claim for a right shoulder rotator cuff tear in the future. (*Id.*)

On March 3, 1997, Dr. Lundsgaard performed an arthroscopic examination of the right shoulder with arthroscopic subacromial decompression and removal of calcium deposits in the right supraspinatus tendon. (Ex. 12).

On May 12, 1997, claimant's attorney wrote to SAIF and requested amendment of the acceptance to include partial rotator cuff injury and fraying of the supraspinatus tendon with subsequent toothpaste calcium deposit. (Ex. 15).

On May 30, 1997, SAIF wrote to claimant, stating the three conditions were part of the right shoulder condition that was denied on November 5, 1996. (Ex. 17). SAIF explained:

> "The denial was affirmed in a stipulation and agreement dated February 6, 1997 that stated that 'The partial denial will not preclude claimant from filing a claim for a right shoulder rotator cuff tear in the future if she should choose to do so.' [Claimant] has not been diagnosed as having a rotator cuff tear, the only condition that was provided for in the February 6, 1997 stipulation." (*Id.*)

SAIF indicated it "will not issue an acceptance or denial of these conditions." (*Id.*)

Claimant requested a hearing on SAIF's "de facto" denial.

CONCLUSIONS OF LAW AND OPINION

Compensability

At hearing, SAIF argued that, absent a showing of a rotator cuff tear, claimant was precluded from relitigating compensability issues concerning the right shoulder. The ALJ found that compensability of the toothpaste calcium deposit (not at issue on review) was resolved by the terms of the February 6, 1997 stipulation. However, the ALJ found that the rotator cuff injury and fraying of the supraspinatus tendon were not diagnosed until after approval of the stipulation. The ALJ set aside the portion of SAIF's letter and/or "de facto" denial pertaining to the partial rotator cuff injury and fraying of the supraspinatus tendon.

On review, SAIF argues that the ALJ erred in concluding that SAIF had either expressly or "de facto" denied claimant's new medical condition claims for partial rotator cuff injury and fraying of the supraspinatus tendon. SAIF's May 30, 1997 letter to claimant stated that those conditions were "part of the **right shoulder condition** that was denied on November 5, 1996." (Ex. 17; emphasis in original). However, SAIF contends on review that the partial rotator cuff injury and fraying of the supraspinatus tendon are "one and the same" as the conditions SAIF accepted in April 1996. SAIF argues that it was not required to formally accept those particular diagnoses under ORS 656.262(7)(a).

After the hearing, SAIF wrote to the ALJ:

> "For the proposition that amended ORS 656.262(7) does not over-ride the doctrine of issue and claim preclusion please see McGrew v. Express Services Inc., 147 Or App 257 (1997); Kelly Eisenberg, 49 Van Natta 538 (1997). SAIF contends that, absent a showing of a rotator cuff tear, claimant is precluded from re-litigating compensability issues concerning the right shoulder." (Underline in original).

Thus, SAIF's position in its May 30, 1997 letter and its letter to the ALJ after the hearing was that the disputed conditions were included in the previous stipulation.

However, SAIF contends on review that the partial rotator cuff injury and fraying of the supraspinatus tendon are "one and the same" as the conditions SAIF accepted in April 1996. SAIF cites *Thomas M. Inglett*, 48 Van Natta 1821 (1996), which held that the claimant's right shoulder condition was the same condition that it had been since the original injury, even though different diagnoses and medical terminology had been employed.

We construe SAIF's argument on review to mean that SAIF agrees that the partial rotator cuff injury and fraying of the supraspinatus tendon are part of claimant's accepted condition. In light of SAIF's position on review, we conclude that claimant's partial rotator cuff injury and fraying of the supraspinatus tendon are therefore compensable.

Attorney Fees

The ALJ awarded claimant's attorney an assessed attorney fee of $3,000 for services at hearing concerning the partial rotator cuff injury and fraying of the supraspinatus tendon. On review, SAIF contends that we should set aside the attorney fee that was awarded for "prevailing over the putative denials."

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

In *Galbraith v. L.A. Pottsratz Construction*, 152 Or App 790 (1998), the court held that the carrier's response to the claimant's hearing request that the "claimant is entitled to no relief" constituted an express denial of the claim. Consequently, the court found that an attorney fee under ORS 656.386(1) was appropriate.

Here, claimant's attorney wrote to SAIF on May 12, 1997, requesting amendment of the acceptance to include partial rotator cuff injury and fraying of the supraspinatus tendon with subsequent toothpaste calcium deposit. (Ex. 15).

On May 30, 1997, SAIF wrote to claimant, stating that the three conditions were part of the right shoulder condition that was denied on November 5, 1996. (Ex. 17). SAIF explained:

> "This denial was affirmed in a stipulation and agreement dated February 6, 1997 that stated that 'The partial denial will not preclude claimant from filing a claim for a right shoulder rotator cuff tear in the future if she should choose to do so.' [Claimant] has not been diagnosed as having a rotator cuff tear, the only condition that was provided for in the February 6, 1997 stipulation." (*Id.*)

SAIF indicated it "will not issue an acceptance or denial of these conditions." (*Id.*)

Claimant requested a hearing on the "de facto" denial of "partial rotator cuff injury, fraying of the supraspinatus tendon with subsequent toothpaste calcium deposit."

At hearing, claimant's attorney asserted that the issue was compensability of the right shoulder conditions identified in the request for hearing, which included partial rotator cuff injury, fraying of the supraspinatus tendon, with subsequent toothpaste calcium deposit. (Tr. 2). Claimant's attorney agreed that claimant was alleging and contesting a "de facto" denial. (*Id.*) SAIF's attorney agreed with that statement of the issues and did not have any cross issues. (*Id.*)

As we discussed earlier, SAIF wrote to the ALJ after the hearing and argued that absent a showing of a rotator cuff tear, claimant was precluded from re-litigating compensability issues concerning the right shoulder. Thus, although SAIF's May 30, 1997 letter said it "will not issue an acceptance or denial of these conditions" (Ex. 17), SAIF argued at hearing that claimant was precluded from relitigating compensability issues concerning the right shoulder.

In *John R. Syron*, 48 Van Natta 2091 (1996), the carrier contended that its notice of acceptance included the claimant's L5-S1 disc herniation. Alternatively, the carrier argued that the claimant was barred by claim preclusion from seeking modification of the notice of acceptance. We concluded that the carrier's claim preclusion argument at hearing constituted an express assertion that the L5-S1 disc condition was not compensable or otherwise does not give rise to an entitlement of compensation. We found that the requirements for an attorney fee under ORS 656.386(1) had been met.

We reach the same conclusion in this case. If successful, SAIF's preclusion argument would have prevented claimant from receiving benefits for the partial rotator cuff injury and fraying of the supraspinatus tendon. SAIF's letter to the ALJ after the hearing meant that claimant's partial rotator cuff injury and fraying of the supraspinatus tendon were "denied" within the meaning of ORS 656.386(1). *See John R. Syron*, 48 Van Natta at 2092; *James C. English*, 48 Van Natta 2077, *on recon* 48 Van

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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).

Natta 2378 (1996). Although SAIF has changed its position on review, that does not negate the fact that it had previously expressly asserted that the partial rotator cuff injury and fraying of the supraspinatus tendon was not compensable or otherwise does not give rise to an entitlement to any compensation pursuant to ORS 656.386(1).

Claimant "prevailed finally" against SAIF's denial at hearing. Therefore, claimant's attorney is entitled to an attorney fee under ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we agree with the ALJ that a reasonable fee for claimant's attorney's services at hearing is $3,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

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 partial rotator cuff injury and fraying of the supraspinatus tendon is $1,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated December 31, 1997 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, payable by SAIF.

May 12, 1998 Cite as 50 Van Natta 893 (1998)

In the Matter of the Compensation of
PRISCILIANO E. LOPEZ, Claimant
WCB Case No. 97-04898
ORDER ON RECONSIDERATION
Willner & Associates, Claimant Attorneys
Lundeen, et al, Defense Attorneys

On April 3, 1998, we abated our March 6, 1998 order that reversed an Administrative Law Judge's (ALJ's) order which set aside the insurer's denial of claimant's injury claim for a "clay shoveler's" fracture. We took this action to consider claimant's motion for reconsideration. Having received the insurer's response, we proceed with our reconsideration.

In our initial order, we concluded that a preponderance of the medical evidence did not establish the presence of a "clay shoveler's fracture" at C7 and T1. Therefore, we upheld the insurer's denial of that condition. On reconsideration, claimant contends that we relied on "secondary medical opinions" rather than the "key piece of evidence"--the actual x-rays interpreted by Dr. Owen. Claimant's contentions notwithstanding, we continue to find insufficient evidence of a "clay shoveler's fracture."

At the outset, we emphasize that we have no radiological expertise to interpret x-rays. The actual x-rays contain markings and drawings, ostensibly supplied by Dr. Owen, which purport to show a "clay shoveler's" fracture. However, the drawings add nothing more to the narrative already supplied by Dr. Owen in his written report interpreting the x-rays. In our prior order, we did not find Dr. Owen's opinion persuasive. After further consideration of that opinion, we reach the same conclusion.

On reconsideration, as supplemented herein, we adhere to and republish our March 6, 1998 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
JOSEPHINE A. AUSTIN, Claimant
WCB Case No. 96-08211
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that upheld the insurer's denial of claimant's right wrist injury claim. In its brief, the insurer moves to strike claimant's appellant's brief as untimely filed. On review, the issues are motion to strike and compensability. We deny the motion to strike and affirm.

FINDINGS OF FACT

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

The last sentence of the third paragraph of the findings of fact should read as follows: Dr. Button noted abnormal calcification in the right wrist and diagnosed: (1) calcific tendinitis of the right wrist; and (2) secondary right ulnar nerve compression syndrome. (Exs. 3-2; 17).

The second sentence of the fourth paragraph of the findings of fact should read as follows: In her history to Dr. Radecki on June 21, 1996, claimant told him that, at the time of the March 14, 1996 work incident, she had "sharp pain that lasted four days, finally going away three to four weeks after its onset." (Ex. 7-1). Claimant reported that she "noticed a sudden onset of very severe pain, some loss of strength, and since then, has also noticed difficulty holding the thread of a needle in her work as a seamstress." (Exs. 7-1; 22-68-69).

The reference in paragraph eight of the findings of fact should be to Exhibit 21, not Exhibit 20.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

The insurer has moved to strike claimant's appellant's brief, which was due on or before March 4, 1998, on the ground that the brief was untimely filed. The insurer argues that, although claimant's "Certificate of Service" is dated March 4, 1998, there is no evidence that the appellant's brief was actually mailed on that date. Furthermore, the insurer argues that the March 5, 1998 postmark on the envelope[1] containing the brief establishes that the brief was untimely filed. We disagree.

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, read as a whole, the certificate of service attached to the brief indicates that it was deposited in the mail on March 4, 1998. Thus, under the applicable administrative rule, claimant's respondent's brief was timely filed. See Steven A. Rossetto, 49 Van Natta 1889 (1997); Thomas P. Harris, 48 Van Natta 985 (1996). Consequently, the motion to strike is denied.

Compensability

Claimant works part time for a County Clerk's office and claims she injured her right wrist, which resulted in immediate pain, while putting a ballot into an envelope on March 14, 1996. This incident was unwitnessed. Claimant did not seek medical treatment until April 12, 1996, and did not report a work injury until June 3, 1996. (Exs. K-3, 1).

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[1] Although the insurer stated that a copy of this envelope was attached to its respondent's brief, no such copy was attached. However, for the reasons that follow, the result would not change even if the Board had received a copy of the envelope.

Given claimant's past medical record of several prior right wrist injuries, her delay in reporting the immediate pain caused by an alleged discrete work incident on March 14, 1996, and her various histories to her medical providers, including "categorically denying" any prior right wrist problems, the ALJ concluded that claimant did not sustain an injury in the work place that caused her to seek medical treatment. ORS 656.005(7)(a). The ALJ also analyzed the claim under ORS 656.005(7)(a)(B), and found that claimant failed to meet her burden of proving a compensable injury under that statute.

We adopt and affirm the ALJ's reasoning and conclusions on this issue with the following supplementation.

Before proceeding with the causation issue, we note that claimant argues that: (1) she is attempting to establish compensability of a specific condition -- a right wrist "strain/injury" sustained on March 14, 1996; and (2) she does not have the conditions that were denied by the insurer: right hand/wrist calcific tendinitis with ulnar nerve compression. We find that the medical record does not support claimant's argument.

We acknowledge that a claimant need not prove a specific diagnosis if she proves that her symptoms are attributable to her work. Boeing Aircraft Company v. Roy, 112 Or App 10 (1992); Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988). However, it does not follow that, where the record establishes that a claimant has a specific diagnosis, she may simply select a more generic condition and argue that the more generic condition is compensable. Based on the following, we find that the preponderance of the medical evidence establishes that claimant has calcific tendinitis in the right wrist, not a right wrist "strain/injury."

Dr. Maskell, claimant's family physician, did not make any diagnosis regarding claimant's right wrist condition; instead, after examining claimant twice for this condition, he referred her to a hand specialist, Dr. Button.[2] (Ex. 30-15). Dr. Button noted abnormal calcification in claimant's right wrist and diagnosed: (1) calcific tendinitis of the right wrist; and (2) secondary right ulnar nerve compression syndrome. (Exs. K-3, 1, 3-2; 17). In addition, Dr. Gritzka, orthopedist, who performed a record review on claimant's behalf, repeatedly agreed that claimant suffered from those two conditions. (19-2-3, 20A-6). Dr. Radecki, who examined claimant and performed electro-diagnostic tests on behalf of the insurer, also concluded that claimant had calcific tendinitis in the right wrist, although he concluded that his electrodiagnostic testing established that claimant did not have right ulnar nerve compression. (Exs. 9, 11, 22-110). Finally, although Dr. Neitling, M.D., apparently examined claimant on March 17, 1997, no chart note or report regarding that exam is in the record. (Ex. 39). Therefore, there is no record of Dr. Neitling's diagnosis.

In fact, no physician diagnosed right wrist "strain/injury." The only mention of a "strain/injury" is in check-the-box letters authored by claimant's attorney and sent to Drs. Gritzka and Neitling for response. (Exs. 28-3, 39-3). We find the diagnoses provided by the physicians more persuasive. Therefore, we conclude that claimant has calcific tendinitis of the right wrist.

Regarding causation, even if we accept claimant's allegations about the March 14, 1996 work incident, the medical evidence does not establish a compensable right wrist injury claim. Given claimant's multiple past right wrist injuries and claimant's delay in seeking medical treatment, we find that the medical causation question is complex, requiring expert medical opinion for its resolution. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986).

The above five physicians provide opinions regarding the cause of claimant's right wrist condition. We rely on those medical opinions which are well-reasoned and based on accurate and complete histories. See Somers v. SAIF, 77 Or app 259 (1986). Dr. Neitling's opinion is simply a check-the-box opinion that offers no reasoning. (Ex. 39). Therefore, we do not find his opinion persuasive.

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[2] Although Dr. Button initially served as a consulting physician, he later examined claimant on behalf of the insurer. (Exs. 3, 17).

Dr. Maskell first concurred with Dr. Gritzka's opinion (which supports claimant's injury claim) and then deferred to Dr. Button's opinion (which does not support claimant's claim) on the basis of Button's expertise as a hand specialist. (Exs. 20B, 26-4, 30-24). On the other hand, when it was pointed out that Dr. Button attributed the major cause of claimant's need for treatment to her off-work sewing activities, Dr. Maskell stated that he did not think that Dr. Button meant to say that. (Ex. 30-25). Given the inconsistencies in Dr. Maskell's opinion, we do not find it persuasive.

Of the remaining physicians, only Dr. Gritzka's opinion might support claimant's injury claim. However, for the following reasons, we find that it does not meet claimant's burden of proof.

Drs. Button, Radecki, and Gritzka all agree that claimant has a preexisting condition of ectopic calcification involving the tendons of the ulnar aspect of the right wrist. (Exs. 11-1, 19-2-3, 20A-9, 21-2, 22-51). Claimant argues that her ectopic calcification is not a "preexisting condition" as defined in ORS 656.005(24),[3] because it is caused by a natural aging process and, as such, is not an "injury, disease, congenital abnormality, personality disorder or similar condition." Therefore, claimant argues, ORS 656.005(7)(a)(B) does not apply to her claim.

We need not consider whether a condition caused by a "natural aging process" is a preexisting condition pursuant to ORS 656.005(24) because the medical record does not support claimant's contention that her ectopic calcification condition is caused by a "natural aging process." Although Dr. Radecki opined that ectopic calcification can be part of the aging process, Drs. Gritzka, Button, and Radecki all opined that claimant's ectopic calcification condition resulted from a prior wrist injury. (Exs. 20A, 21A-1-2, 22-51-54, 22-59-60, 22-90-91, 22-103-106). Therefore, the medical evidence establishes that claimant's ectopic calcification condition is a preexisting condition pursuant to ORS 656.005(24).

The preponderance of the medical evidence also establishes that this preexisting ectopic calcification condition combined with the March 14, 1996 work incident to cause or prolong disability or the need for treatment. While Dr. Radecki first opined only that the ectopic calcification and the work incident possibly combined, after he had reviewed all the medical records and assumed claimant's history regarding the March 14, 1996 work incident was correct, he concluded that the preexisting condition and the work incident did combine. (Exs. 11-2, 22-72-73). Dr. Gritzka offers the only other opinion on this issue and opines that the preexisting ectopic calcification condition and the March 14, 1996 work incident combined to require medical treatment. (Exs. 19, 20A, 23, 28).

Thus, the medical evidence is in agreement that claimant's ectopic calcification condition preexisted the March 14, 1996 work incident and that both the preexisting condition and the work incident contributed to claimant's need for treatment. Therefore, in order to establish compensability, claimant must prove that the work incident on March 14, 1996 was 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). The fact that a work injury is the immediate or precipitating cause of a claimant's condition does not necessarily mean that that injury was the major contributing cause of the condition. Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev dismissed 320 Or 416 (1995). Instead, determination of the major contributing cause involves evaluating the relative contribution of different causes of claimant's need for treatment of the combined condition and deciding which is the primary cause. Id.

Both Drs. Button and Radecki opine that the work was not the major contributing cause of claimant's need for medical treatment. (Exs. 21, 22-82-83). That leaves only Dr. Gritzka, who opined that claimant's preexisting calcific deposit would have probably remained dormant and asymptomatic without some kind of provocation. (Ex. 20A-7). He opined that claimant's work activity was of the type that can be expected to cause an area of ectopic calcification to become symptomatic. Id. He explained that the material making up the calcific deposit is an irritant, and when it begins to break up or

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[3] ORS 656.005(24) provides:

"'Preexisting condition' means any injury, disease, congenital abnormality, personality disorder or similar condition that contributed 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."

dissipate, it causes inflammation. He opined that the March 14, 1996 work activity traumatized this preexisting area of calcific material, causing it to break up, dissipate, and produce an irritating inflammatory reaction. (Ex. 20A-8). Based on this scenario, Dr. Gritzka opined that the March 14, 1996 work activity was the major contributing cause of claimant's need for treatment and/or disability. (Exs. 19, 20A, 23, 28).

While Dr. Gritzka acknowledges that the preexisting ectopic calcific material is an irritant that causes inflammation when broken up and explains the mechanism of the combining of this preexisting condition and the work incident to cause an inflammatory reaction, he simply states that the work is the major contributing cause of the need for treatment of this combined condition. He does not evaluate the relative contribution of the preexisting calcific material and claimant's work incident. Instead, it appears that Dr. Gritzka is simply relying on a precipitating cause, or a "but for" analysis, which, without the required Dietz analysis, is not sufficient to establish the work injury as the major contributing cause of the need for treatment or disability of the combined condition. Georgia Barklow, 49 Van Natta 1261 (1997); Alec E. Snyder, 47 Van Natta 838 (1995) (persuasive medical opinion must weigh the relative contribution of different causes; "but for" analysis not well reasoned).

Accordingly, like the ALJ, we find claimant has failed to meet her burden of proving a compensable right wrist injury.

ORDER

The ALJ's order dated January 23, 1998 is affirmed.

May 13, 1998 Cite as 50 Van Natta 897 (1998)

In the Matter of the Compensation of
PATRICIA A. BROWN, Claimant
WCB Case No. 94-15271
ORDER ON REVIEW
Bischoff, Strooband, et al, Claimant Attorneys
Cummins, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Michael Johnson's order that: (1) awarded temporary total disability (TTD) from May 20, 1994 to May 27, 1994 and from July 6, 1994 to July 15, 1994, and temporary partial disability (TPD) from July 15, 1994 to August 22, 1994; and (2) awarded a penalty for allegedly unreasonable nonpayment of the temporary disability. On review, the issues are substantive temporary disability and penalties.[1] 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 supplementation.

Claimant's work activities were restricted due to her compensable skin irritation condition from July 6, 1994 until August 22, 1994.

CONCLUSIONS OF LAW AND OPINION

We briefly summarize the pertinent facts of the case.

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[1] We note claimant's request for remand for a medical arbiter's examination and the insurer's contention that we should not address this request because it was not raised at hearing. However, because claimant did raise the issue at hearing, (see Tr. 5), and claimant did have a September 25, 1996 medical arbiter's examination, (see Ex. 35), we find no merit to either parties' position on these matters.

In the Spring of 1994, claimant experienced a reaction to a tuberculosis test that had been required by the employer. A chest x-ray was normal, but claimant continued to have a lesion on her right forearm at the site of the original injection. Claimant filed a claim and the insurer accepted a "skin irritation" condition.

Claimant treated with Drs. Shames, Young, and Pons.

Dr. Young released claimant to modified work in July 1994.

On November 17, 1994, a Determination Order issued, which awarded claimant TPD from May 22, 1994 through November 8, 1994. On February 9, 1995, the insurer requested reconsideration.

A March 7, 1995 Order on Reconsideration awarded claimant TPD from May 22, 1994 through October 3, 1994 and no permanent disability.

A March 8, 1995 hearing was convened concerning claimant's request for enforcement of the Determination Order award of temporary disability benefits. Both claimant and the insurer raised issues concerning the March 7, 1995 Order on Reconsideration. The insurer contended that claimant was not entitled to an award of permanent disability, and claimant argued that the matter should be remanded to the Department for an arbiter exam. The hearing was continued for Dr. Pons' deposition.

On March 9, 1995, the Department issued an order that abated and withdrew the March 7, 1995 Order on Reconsideration.

On March 29, 1995, the Department agreed with the insurer that, because a hearing had been requested, the Department lost jurisdiction over the matter and the order of abatement was void. See former OAR 436-30-008.

On May 2, 1995, Dr. Pons' deposition was taken.

The ALJ's order issued November 13, 1995. Finding that claimant had self-inflicted her injury, and therefore, had no disability, the ALJ declined to direct the insurer to pay temporary disability benefits pursuant to the November 1994 Determination Order. Consequently, the award of temporary disability benefits was reversed. The ALJ also declined to remand to the Director for the appointment of a medical arbiter and the issuance of another Order on Reconsideration.

Claimant requested Board review. We vacated the ALJ's order and remanded the case to the ALJ to await the Department's appointment of a medical arbiter and scheduling of a medical arbiter's examination. *Patricia A. Brown*, 48 Van Natta 1164 (1996).

Dr. Naverson, medical arbiter, examined claimant on September 25, 1996 and recommended that she follow up with a pulmonary specialist.

After receipt of the arbiter's report and the parties' closing arguments, the ALJ closed the record. The ALJ issued an Opinion and Order on Remand, which was subsequently abated. The record was reopened and reclosed twice after receipt of additional arguments. The ALJ issued an Amended Opinion and Order on Remand, finding claimant entitled to TTD from May 20, 1994 to May 27, 1994 and from July 6, 1994 to July 15, 1994; as well as TPD from July 15, 1994 to August 22, 1994. Claimant requested review.

ORS 656.156 and 656.325(5)

We adopt and affirm the portion of the ALJ's order entitled "Employer Defense[s] Against *Any* Compensation 'Whatsoever,'" set forth on pages 9-11. We do not find that claimant's injury resulted from her "deliberate intention" to produce such injury or that she committed unsanitary or injurious practices which tended to imperil or retard her recovery at any time relevant to this claim for temporary disability. (*See* note 2, *infra*).

Substantive Temporary Disability

The ALJ found claimant entitled to TTD May 20, 1994 to May 27, 1994 and from July 6, 1994 to July 15, 1994; as well as TPD from July 15, 1994 to August 22, 1994. We agree in part and disagree in part.

We adopt and affirm the ALJ's reasoning[2] and conclusions regarding claimant's substantive entitlement to temporary disability for the period from July 6, 1994 to August 22, 1994, as set forth in the section entitled "Temporary Disability Compensation (Time Loss)" on pages 11-15. (*See* Exs. 5, 8, 9, 10, 13).

The insurer argues that claimant is not entitled to temporary disability benefits for the period from May 20, 1994 through May 27, 1994, because she was off work during that time for reasons unrelated to the work injury. We agree.

Dr. Shames' contemporaneous chart notes indicate that claimant was off work from May 20, 1994 until May 27, 1994 awaiting the results to a chest x-ray to confirm or rule out tuberculosis. (Ex. 1). Thus, she was not disabled *due to* the compensable skin irritation condition at this time.[3] Consequently, in the absence of evidence of injury-related lost wages for this period, claimant is not entitled to substantive temporary disability for this period.

Penalty

The ALJ awarded a penalty based on the insurer's unreasonable failure to pay temporary disability benefits. The ALJ reasoned that the insurer had no legitimate doubt regarding its liability for the Determination Order's temporary disability award, because it could not reasonably doubt that claimant's condition was injury-related before August 22, 1994. Accordingly, the ALJ awarded a penalty of 25 percent of temporary disability awarded by his Opinion and Order. We modify.

The November 17, 1994 Determination Order awarded TPD from May 22, 1994 through November 8, 1994. (Ex. 27). The insurer was required to pay these benefits within 14 days of the date of the Determination Order. *Former* OAR 436-60-150(4); *Sisters of Providence v. East*, 122 Or App 366 (1993) (an insurer may not stay payment of temporary disability benefits pending an order on reconsideration); *Dorothy E. Bruce*, 48 Van Natta 518, 519 (1996).[4] As of the hearing in this matter, the insurer had not paid the aforementioned TPD. The insurer's only explanation for nonpayment is that the Determination Order was "in error."

The insurer's belief that the award was made in error is not a legitimate basis for failure to comply with the order. Rather, the insurer was required to pay the Determination Order award within 30 days. *See id.* Under these circumstances, the insurer's failure to pay temporary disability was unreasonable and a penalty is appropriate, based on the total amount due under the Determination

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[2] However, we do not adopt the first sentence of the last full paragraph on page 14. In addition, we need not determine whether the compensable effects of claimant's injection "combined" with self-induced injury after August 22, 1994, because we agree with the ALJ that claimant was partially disabled due to her compensable condition before that date and she was not disabled due to her compensable condition thereafter. In addition, we modify the same paragraph to rely on Dr. *Young's* causation comments (not Dr. James').

[3] *Compare Keith Faigen*, 50 Van Natta 17 (1998) (diagnostic tests compensable where necessary to determine the cause or extent *of the compensable injury*, whether or not the condition discovered as a result of the tests is compensable) (*citing Counts v. International Paper Co.*, 146 Or App 768 (1997)).

[4] This is not a case where payment of benefits awarded by determination order are stayed pending appeals regarding the compensability of the underlying claim. *See e.g., SAIF v. Vanlamen*, 127 Or App 346 (1994); *Felipe A. Rocha*, 45 Van Natta 47 (1993). We note, however, that from December 1, 1994 until March 1995, the insurer was authorized to stay payment of temporary disability awarded by the Order on Reconsideration (which included most of the temporary disability awarded by the Determination Order) by virtue of its request for hearing contesting the March 7, 1995 Order on Reconsideration. *See* ORS 656.313(1).

Order.[5] *See Roger R. Powers*, 49 Van Natta 1388, 1390 (1996) (penalty based on entire Determination Order permanent disability award because it was an "amount then due" when not timely paid). The ALJ's order is modified accordingly.

ORDER

The ALJ's order dated March 17, 1997, as amended September 25, 1997, is reversed in part, modified in part, and affirmed in part. That portion of the order that directed the insurer to pay temporary disability benefits for the period from May 20, 1994 through May 27, 1994 is reversed. That portion of the order that awarded a penalty of 25 percent of the temporary disability benefits awarded by the Opinion and Order is modified. The penalty shall be 25 percent of the temporary disability awarded by the November 17, 1994 Determination Order. This penalty shall be shared equally by claimant and her counsel. The remainder of the order is affirmed.

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[5] Even though our order reduces claimant's temporary disability award, the *total* Determination Order award was an "amount due" for penalty purposes. *See e.g., Pascual Zaragosa*, 45 Van Natta 1221, 1223 (1993), *aff'd mem* 126 Or App 544, *rev den* 319 Or 81 (1994). Because the insurer did not pay those "amounts due," it is liable for a penalty based on the entire amount due during the "delay period" when that amount was due. *See id.*

In the Matter of the Compensation of
JESUS GOMEZ, Claimant
Own Motion No. 98-0080M
OWN MOTION ORDER
Stanley Fields, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable right shoulder strain with anterior capsulolabral reconstruction claim. Claimant's aggravation rights expired on January 19, 1994. SAIF opposes authorization of temporary disability compensation, contending that: (1) claimant's current condition does not require surgery or inpatient hospitalization; (2) surgery or hospitalization is not reasonable and necessary; and (3) claimant was not in the work force at the time of the current disability.

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

SAIF initially objected to the provision of temporary disability compensation because there was no evidence of a need for surgery and/or inpatient hospitalization. However, SAIF submitted additional medical reports on March 3, 1998 which demonstrated claimant's need for surgery for his worsened compensable condition. On April 30, 1998, SAIF sent in further documentation which demonstrated that the recommended surgery was both medically necessary and reasonable. Under such circumstances, we conclude that claimant's compensable condition required 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 was not in the work force at the time of the current disability. Claimant responded by letter dated April 6, 1998 to SAIF's work force contention and attached several

documents to support his position.[1] However, we have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction,[2] is the date he enters the hospital for the proposed surgery. Fred Vioen, 48 Van Natta 2110 (1996); John R. Johanson, 46 Van Natta 2463 (1994). The relevant time period for which claimant must establish he was in the work force is the time prior to his March 19, 1998 surgery, when his condition worsened requiring that surgery. See generally Wausau Ins. Companies v. Morris, 103 Or App at 273; Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990); Jeffrey A. Kyle, 49 Van Natta 1331 (1997); Michael C. Batori, 49 Van Natta 535 (1997); Kenneth C. Felton, 48 Van Natta 725 (1996).

A review of the medical reports submitted by SAIF reveals that claimant first became disabled in June of 1997. He sought treatment with Dr. Benz, who prescribed a course of physical therapy and medication. By December of 1997, it became evident that conservative measures were not working and Dr. Benz recommended surgery. In his December 19, 1997 chart note, Dr. Benz noted that "[Claimant] continues to have problems with his shoulder. ... [Claimant] is unable to work and really wants to be able to work."

Claimant was referred to Dr. Greenleaf by Dr. Benz for a second opinion. In a January 28, 1998 report, Dr. Greenleaf opines "In view of [claimant's] failed conservative therapy and persistent instability symptoms, I feel that at this point, it would be appropriate to go ahead with an open or arthroscopic capsular shift procedure." Dr. Benz requested authorization to proceed with the surgery on February 17, 1998 and claimant underwent a arthroscopic right shoulder exploration and open capsular shift on March 19, 1998.

We are persuaded that claimant worked until he was unable to continue working due to the worsening of his compensable injury. The record establishes that claimant was unable to work, but willing to work, and that it would have been futile for him to seek work due to the compensable condition.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning March 19, 1998, the date he was hospitalized for surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

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

IT IS SO ORDERED.

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[1] Claimant attached a copy of his 1997 W-2 form, a paystub for the period between 6/16/96 to 6/30/96, an award letter reflecting excellence in service and correspondence between his attorney and his employer.

[2] The Board in its own motion jurisdiction can only authorize temporary disability from the time of surgery or hospitalization. See ORS 656.278(1)(a).

In the Matter of the Compensation of
PATRICIA A. HOLDER, Claimant
Own Motion No. 97-0363M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Greg Noble, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation initially submitted claimant's request for temporary disability compensation for her compensable L5-S1 left disc protrusion. Claimant's aggravation rights on that claim expired on June 3, 1997.

On August 11, 1997, as corrected on August 20, 1997, we issued an Own Motion Order wherein we declined to reopen her claim for the payment of temporary disability compensation because the record submitted to us failed to demonstrate that claimant requires surgery or hospitalization now or in the near future. Claimant requested reconsideration of our August 20, 1997 order.

Claimant filed a request with the Hearings Division to dispute that her claim is an "aggravation" claim rather than an Own Motion claim. (WCB Case No. 97-07344). We issued an Own Motion Order on Reconsideration and Order Postponing Action on October 6, 1997, because the issues to be decided at hearing would affect our jurisdiction over this claim.

On December 15, 1997, Administrative Law Judge (ALJ) Nichols issued an Opinion and Order, finding that claimant had not perfected the "aggravation" claim prior to the expiration of the five year aggravation period pursuant to ORS 656.273. ALJ Nichols further found that the accepted 1992 injury claim, now in own motion status, was responsible for the processing of claimant's current low back condition. Claimant requested Board review of ALJ Nichols' order, and in an order issued on today's date, the Board affirmed ALJ Nichols' order.

Inasmuch as it has been determined that claimant's current low back condition falls under the Board's own motion jurisdiction, we proceed with our review of our August 20, 1997 order.

Under ORS 656.278(1)(a), we may exercise our own motion authority to reopen a claim for additional temporary disability compensation when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization.

Here, claimant submits no evidence that surgery or hospitalization has been recommended. Therefore, the record fails to demonstrate that claimant requires surgery or hospitalization for treatment now or in the near future. As a result, we continue to find that claimant's compensable condition has not worsened requiring surgery or hospitalization, and therefore, no temporary disability compensation is due.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our August 20, 1997 order 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
HAROLD G. JACKSON, Claimant
WCB Case No. 97-00755
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Lipton's order that set aside its denial of claimant's aggravation claim for a low back condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

On August 31, 1995, claimant sustained a compensable injury to his low back. (Ex. 1). He was diagnosed with a low back strain, treated conservatively, and released to regular work on March 26, 1996 by Dr. Ward, his then-attending physician. The claim was closed on April 18, 1996 by a Notice of Closure that awarded temporary disability but no permanent disability. (Ex. 38). Claimant requested reconsideration and a July 11, 1996 Order on Reconsideration affirmed the Notice of Closure in all respects. (Ex. 46). Claimant requested a hearing.

On October 2, 1996, claimant experienced the onset of low back pain after moving wet rolls of fabric weighing over 100 pounds each. On October 8, 1996, he sought emergency room attention for his low back. He was taken off work until October 10, 1996, at which time lifting restrictions were imposed. Claimant was diagnosed with a lumbosacral strain, and filed an aggravation claim. (Exs. 47, 48, 50).

On November 19, 1996, claimant was examined for the employer by Dr. Gardner, neurologist, and Dr. Duff, orthopedic surgeon. (Ex. 52). They opined that claimant's low back condition had not pathologically worsened based on a lack of objective findings. (Id.)

On November 21, 1996, claimant was examined by Dr. Flemming. Flemming opined that claimant had a chronic lumbar strain with a superimposed acute strain due to the lifting incident in October 1996. He released claimant to modified work with lifting restrictions and opined that it was inadvisable for claimant to return to heavy lifting and the risk of increasing his back pain. (Ex. 53).

On December 6, 1996, a prior ALJ issued an Opinion and Order that awarded claimant 7 percent unscheduled permanent disability for his low back. (Ex. 56). This order was affirmed by the Board on April 17, 1997. (Ex. 67).

On December 17, 1996, claimant was evaluated by Dr. Freeman. Claimant complained of nagging posterior pelvic pain, worse on the right. Dr. Freeman made provisional diagnoses of sacroiliac joint strain and sacroiliac joint-piriformis pain generators. (Ex. 60). Claimant failed to return for his scheduled follow up appointment. (Ex. 64).

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant had established a compensable aggravation. On review, the employer argues that, because claimant failed to prove a pathological worsening, he failed to prove his aggravation claim. We agree.

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 required to prove an aggravation and that it is no longer permissible, as it was under the former law, to infer a worsened condition from evidence of increased symptoms alone. Id.

Here, opinions regarding claimant's condition were provided by Dr. Flemming and Dr. Gardner. Dr. Flemming opined that claimant's increased symptomatic condition was due to waxing and waning of claimant's underlying low back strain condition. (Ex. 70). Similarly, Dr. Gardner opined that,

objectively, claimant's low back condition had not changed since his last arrangement of compensation. He, too, attributed claimant's symptoms to waxing and waning of his chronic susceptibility to low back strain. Additionally, Dr. Gardner reviewed Dr. Freeman's chart note and confirmed that claimant's lower extremity pain complaints were similar to those voiced to him by claimant. Dr. Gardner noted that the "posterior pelvic pain" and piriformis condition referred to by Dr. Freeman were areas lower than the claimant's lumbosacral strain, and were part of a general differential diagnosis of possibilities to explain claimant's ongoing subjective symptoms. (Ex. 66).

On this record, claimant has failed to show by direct medical evidence that his lumbosacral strain condition has pathologically worsened.

ORDER

The ALJ's order dated October 29, 1997 is reversed. The self-insured employer's aggravation denial is reinstated and upheld. The ALJ's assessed attorney fee award is also reversed.

May 13, 1998 Cite as 50 Van Natta 904 (1998)

In the Matter of the Compensation of
MILDRED D. MITCHELL, Claimant
WCB Case No. 96-08898
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Stoel, Rives, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock, and Hall.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Tenenbaum's order that set aside its denial of claimant's left elbow and biceps injury claim. Claimant cross-requests review of that portion of the order that upheld the employer's denial of claimant's left shoulder condition. On review, the issue is compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant, age 60, was employed as a CNA for the employer in a long-term care unit. Claimant had disciplinary issues at work such that she was terminated in March 1996. She grieved her termination and was returned to work on May 8, 1996, on a second written "final warning and last chance" agreement. On Friday, June 14, 1996, claimant met with Ms. Maccarone, unit supervisor, and Ms. Goemmel, patient care manager, regarding continuing complaints about claimant's job performance. (Ex. 32, Tr. 57, 58). Rather than terminating claimant's employment with the employer, Maccarone offered to review the employer's job offerings in other areas with claimant to evaluate other, more suitable positions at the employer. (Ex. 32, Tr. 59, 192). At this meeting, claimant did not mention any left arm or shoulder problems. (Tr. 60).

On Sunday morning, June 16, 1996, claimant telephoned the employer and spoke to her direct supervisor, Ms. Phelps. She advised that she would not be able to work as scheduled on Monday, June 17, 1996, as she had urgent family business that day, and would return to work on Tuesday, June 18, 1996. (Ex. 33). Claimant did not mention any arm or shoulder symptoms to Phelps. Claimant did not return to work on June 18 or 19, 1996.

On Thursday, June 20, 1996, claimant sought treatment from Dr. Freistat, osteopath, for pain in the AC joint of the left shoulder, left biceps and left elbow. (Ex. 36-1). Claimant reported to him that she had experienced an incident at work on June 11, 1996, when she was transferring a patient from a wheelchair to a shower chair, and felt weakness in her right and left shoulders. (Id.) Freistat took claimant off work until July 8, 1996, when he released her to modified work. (Ex. 36).

On Friday, June 21, 1996, claimant called the employer and spoke to Ms. Phelps to let her know that she had hurt her arm and shoulder at work. Claimant told Ms. Phelps that Ms. Wimberly, a co-worker, had reminded her that she hurt her shoulder at work during a two-person patient transfer. (Ex. 37). On Monday, June 24, 1996, claimant filed a Form 801 for a left arm injury that occurred while attempting a two-person lift of a patient from a wheelchair to a shower chair on June 11, 1996. (Ex. 38, 39).

On September 12, 1996, the employer denied claimant's left arm, elbow and shoulder injury on the basis that it did not occur "from your work." (Ex. 48).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant was credible and concluded that she had established a compensable injury to her left elbow and biceps. The ALJ also concluded that claimant failed to prove that the compensable injury was the major contributing cause of her shoulder condition.

The pivotal 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 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 that, although claimant's own testimony regarding the work incident on June 11, 1996 is consistent, other inconsistencies in the record raise doubts regarding material testimony. 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); see also Gail A. Albro, 48 Van Natta 41, 42 (1996) (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); Angelo L. Radich, 45 Van Natta 45 (1993) (same). Moreover, 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).

To begin, there is no dispute that claimant's daily duties included transferring patients from beds or wheelchairs to shower chairs for bathing and weighing. Claimant reported that, on June 11, 1996, she was lifting a patient from a wheelchair to a shower chair in his room between 2 and 3 p.m. with Ms. Wimberly when she felt pain in her left arm and elbow, cried out "Ow!," and terminated the lift. (Tr. 46, 47). Claimant also reported that a co-worker, Ms. Kaufman, witnessed the incident and clearly offered to help finish the lift.[1] (Tr. 47-49). Kaufman did not recall such an incident, although she remembered conversing with claimant that day. (Tr. 144).

Ms. Wimberly, in contrast to claimant, testified that the incident took place in the morning, in the shower room, and that there was no one who was present or offered to help. (Tr. 108-110). Wimberly also testified that that when claimant injured her arm, she cried out, "Oh, God! Oh, my arm!" (Tr. 101).

Additional irregularities cast more doubt on claimant's credibility. Although claimant allegedly injured her arm on June 11, 1996, claimant finished her shift without reporting the incident or filing a claim, although she had pain in her left shoulder, arm and neck, and had promptly reported prior work incidents and filed claims when she had experienced prior injuries. (Tr. 33, 44-46). Moreover, claimant testified that she failed to report her injury or file a claim after returning to work on June 13, 1996, because she forgot that she had injured herself, even though she continued to work the next two days favoring her left arm. (Tr. 33, 34). In addition, although she favored her left arm, she did not mention either the work incident or any problems, work-related or not, with her shoulder, arm or elbow to her supervisors at the June 14, 1996 meeting, nor did they notice that claimant had any physical problems. (Tr. 91, 158). Finally, although claimant called her physician on June 17, 1996 to make an appointment regarding her left arm and shoulder complaints, she testified that she did not remember the work incident until Wimberly reminded her of it after June 17, 1996, which enabled claimant to report the incident to her doctor on June 20, 1996.[2] (Tr. 35, 36; Day 2, Tr. 58).

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[1] Although claimant stated that she may have mistakenly identified Kaufman as the witness, the other CNA claimant named as a possible witness was not working on June 11, 1996.

[2] We also note that claimant testified that she called Wimberly, when Wimberly reminded her of the incident. (Tr. 36). Wimberly testified that it was she and Ms. Altman, another co-worker, who contacted claimant. (Tr. 104-105). Altman did not recall contacting claimant at that time. (Day 2, Tr. 28-29).

In light of the above, particularly the discrepancies between claimant's and Wimberly's testimonies regarding the circumstances surrounding the incident (time of day, location, who else was present, claimant's outcry), and claimant's admitted failure to remember that the incident happened until reminded over a week later by Wimberly, we conclude that claimant's testimony is insufficient to prove that the June 11, 1996 incident occurred as alleged.

Finally, we adopt and affirm that portion of the ALJ's order that found that claimant's left shoulder condition was not compensable. Accordingly, we conclude that claimant has failed to establish that her work activities on June 11, 1996 resulted in an injury to her arm, elbow or shoulder. ORS 656.266.

ORDER

The ALJ's order dated June 1, 1997 is reversed in part and affirmed in part. Those portions of the order that set aside the self-insured employer's denial of claimant's left elbow strain and left bicep tendinitis and awarded an assessed attorney fee are reversed. The employer's denial of those conditions is reinstated and upheld. The remainder of the order is affirmed.

Board Member Hall dissenting.

The majority concludes that claimant failed to carry her burden of proving that she sustained a compensable left elbow and biceps injury as a result of a lifting incident. I respectfully dissent.

The ALJ found that claimant and her witnesses were credible based on their demeanor. There is sound reasoning for our deference to the one person (ALJ) that closely observed the witnesses and determined their credibility based upon those observations. Moreover, claimant's injury was witnessed by a credible witness. How does an event, credibly testified to by claimant and her co-worker as having occurred, turn into an event that never happened?[1] I would find that claimant's injury occurred as contended. Consequently, I would affirm the ALJ's opinion.

[1] For example, the majority relies on the "discrepancy" between claimant's outcry of "Ow!" when the injury occurred and her co-worker's description of the outcry as "Oh, God! Oh, my arm!" The other "discrepancies" relied upon by the majority are no more compelling. After all, the majority does not reverse the ALJ's finding that the co-worker witness was credible. Thus, despite differences in describing the time and place, there remains credible evidence that the event actually occurred.

In the Matter of the Compensation of
DAVID L. STARKEY, Claimant
WCB Case No. 97-05842
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Bock, Biehl, and Moller.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Podnar's order that set aside its 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 his employment.

We adopt and affirm the ALJ's order.

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

ORDER

The ALJ's order dated October 21, 1997 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,000, payable by SAIF.

Board Chair Bock specially concurring.

Claimant injured his right ankle in the employer's parking lot as he was walking to his immediate work area in the morning. He had received a ride to work and, as he was exiting the car (which was stopped close to the entrance of the particular building in which he worked), he stepped on the curb and twisted his ankle. Relying on Lisa M. Bean, 48 Van Natta 1216 (1996), the ALJ determined that, because claimant was making a normal ingress to work when he twisted his ankle, his injury was sufficiently work-related.

On review, SAIF argues that claimant has not shown a sufficient connection between his injury and a risk of his employment. Specifically, SAIF asserts that claimant must show that his injury arose from an employer-related hazard (such as a defect in the curb) and that his injury was directly related to his particular work as a computer wafer manufacturer. I believe that, based on the recent Oregon Supreme Court cases interpreting ORS 656.005(7)(a) and addressing whether a worker's injury "arises out of" employment, SAIF's position lacks merit.

Previously, in cases such as James D. Johnson, 48 Van Natta 303 (1996), aff'd Johnson v. Beaver Coaches, Inc., 147 Or App 234 (1997), and James R. Montoya, 48 Van Natta 1841 (1996), we declined to find the claimant's injury compensable where the claimant was injured while walking on the employer's premises but the evidence failed to show anything abnormal about the claimant's activity or that the claimant slipped, twisted or tripped over anything on the floor. More recently, however, the Oregon Supreme Court has advised us that Oregon has "rejected the largely obsolete 'peculiar-risk' and 'increased-risk' considerations in assessing whether a worker's injury was linked to a risk associated with employment." Redman Industries v. Lang, 326 Or 32, 36 (1997).

In addition, the court has reminded us that "worker's compensation is a no-fault system that compensates a worker for injuries that arise out of and occur in the course of the worker's employment" and has held that a claimant, who injures herself while "skip-stepping" around a corner in the workplace, has sustained an injury that arises out of employment, even in the absence of some particular hazard arising from the employer's premises. See Wilson v. State Farm Ins., 326 Or 413 (1998) (reversing Donna M. Wilson, 47 Van Natta 2160 (1996)).

In this case, as in Lisa M. Bean upon which the ALJ relied, claimant's injury occurred as he made his way through the employer's parking lot. The situation presented a neutral risk, but claimant's trip through the parking lot was, in a general sense, a condition of his employment. See SAIF v. Marin, 139 Or App 518 (1996). In the absence of any evidence that claimant's activities were anything but his normal ingress to work, I believe that, under the court's interpretation of ORS 656.005(7)(a), claimant has shown a sufficient causal connection between his injury and his work. See also Cheryl T. Torkko, 49 Van Natta 1910 (1997) (the claimant had established a sufficient work connection where, as she walked from her car into work, she was injured when she inadvertently struck a mirror on a coworker's van parked in an adjacent space).

According to Larson, 1 Workmen's Compensation Law, Section 15.42(b), 4-101 (1995), injuries that occur in employer-controlled parking lots are given the same status as those that occur on the main premises. In other words, they are compensable to the same degree they would be compensable on the main premises. Therefore, assuming claimant injured his foot walking inside the building rather than on the curb just outside the entrance door, I believe this case would present essentially the same circumstances as Donna M. Wilson. Consequently, based on Bean, Torkko and the Court's analysis and opinion in Wilson v. State Farm Ins., 326 Or at 417, I concur in the result in this case.

Board Member Moller dissenting.

The majority concludes that claimant's right ankle injury arose out of and in the course of his employment. Because I believe the relationship in this case between claimant's injury and his employment is insufficient to support compensability, I respectfully dissent.

"An injury is compensable if it 'aris[es] out of and in the course of employment."' ORS 656.005(7)(a). The 'arising out of [employment]' prong concerns the causal connection between the injury and the employment. Norpac Foods, Inc. v. Gilmore, 318 Or 363, 366 (1994). The 'in the course of employment' prong concerns the time, place and circumstances of the injury. Id. The two prongs constitute a unitary work-connection test, that is, 'whether the relationship between the injury and the employment is sufficient that the injury should be compensable.' Id. Both the 'arising out of' and the 'in the course of' prongs must be satisfied to some degree. Krushwitz v. McDonald's Restaurants, 323 Or 520 (1996). However, the ultimate test involves consideration of the temporal, spatial, circumstantial, and causal connections between the injury and the employment. Andrews v. Tektronix, Inc., 323 Or 154 (1996).

In this case, I would find that the connections between the injury and the employment are insufficient to support compensability. First, with regard to the time, place and circumstances of the injury (*i.e.*, the "in the course of" element), I find it significant that claimant had not commenced performance of his work duties when he was injured. Rather, he was injured in the parking lot while making his ingress to work in the morning. Similarly, there is no evidence that claimant was paid for his time when injured.

Second, with regard to the "arising out of" prong, I find no causal connection between the injury and claimant's work activities other than the fact that the injury occurred at work. Claimant has not contended that his injury resulted from any risk associated with either the employer's premises or the performance of his work duties. See Redman Industries, Inc. v. Lang, 326 Or 32, 35-36 (1997) (causal connection requires more than mere showing injury occurred at the workplace during working hours; causal connection must be linked to risk connected with the nature of the work or risk to which work environment exposed the claimant). Given the facts of this case, I would find that there is not a sufficient connection between the injury and claimant's work to render the injury compensable.

Furthermore, I do not believe that we should extend Wilson v. State Farm Ins., 326 Or 413 (1998) to the circumstances of this case. In Wilson, the court focused on whether the claimant's "skip step" undermined compensability because it was not her usual means of moving about the office during work hours and her employer did not contemplate or expect her to act in that manner. Reviewing for errors of law, the court held that an injury resulting from an unusual method of accomplishing a work-related task is generally compensable, and concluded that claimant had satisfied the "arising out of prong" of the work connection test.

In this case, unlike Wilson, claimant was not injured while moving about the office and performing work-related tasks. As noted above, he was injured in the parking lot, before commencing his work, and without any evidence linking his injury to a risk of his employment. Consequently, I would not find his injury compensable.

May 13, 1998 Cite as 50 Van Natta 908 (1998)

In the Matter of the Compensation of
MARK D. SULLIVAN, Claimant
WCB Case No. C8-01017
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Malagon, et al, Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

On May 1, 1998 the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We disapprove the proposed disposition.

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

Here, the disposition was submitted to us on May 1, 1998. The statutory 30th day following the submission is June 2, 1998. Claimant filed his request for disapproval of the disposition on May 8, 1998. Accordingly, we disapprove the disposition. Id.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
TIMOTHY W. STONE, Claimant
WCB Case No. 97-03891
ORDER ON REVIEW
Bischoff, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Tenenbaum's order that granted permanent total disability, whereas an Order on Reconsideration awarded no unscheduled permanent disability and no scheduled permanent disability in addition to the 60 percent (90 degrees) for the left leg (hip) that claimant had been previously granted. On review, the issue is entitlement to permanent total disability and, potentially, extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

Claimant, age 48 at the time of hearing, was compensably injured in January 1991 when he was struck on the back of his legs by a log rolling down an embankment. He sustained serious left leg injuries which resulted in multiple surgeries and complications, including reflex sympathetic dystrophy. SAIF accepted a left hip (femur) fracture.

Claimant has a preexisting personality disorder with mixed passive-aggressive, avoidant, dependent and histrionic features and strong obsessive-compulsive components. Although a high school graduate, claimant also has learning disabilities related to reading, spelling and verbal expression. He has dyslexia, below normal arithmetic skills and bilateral low frequency hearing loss, which makes it difficult for him to comprehend written information as well as process fine distinctions in spoken sounds. Claimant's work experience has been generally medium or heavy labor-oriented and outdoors. He has also done some supervising not involving paperwork.

Since 1991, claimant has had several psychiatric evaluations in relation to his claim. He has been cooperative with psychological testing and his MMPI results have been considered valid.

In November 1991 and March 1992, claimant was evaluated by Dr. Morrell, a clinical psychologist. Dr. Morrell diagnosed adjustment reaction and anxiety and compulsive personality features. In July 1994, claimant was evaluated by Dr. Rethinger, a clinical psychologist. Dr. Rethinger found, among other things, that claimant had a strong tendency to develop somatic complaints and to downplay perceived psychological weaknesses. Dr. Rethinger noted claimant's overcontrolled anger, evasive and disjointed presentations, flight of ideas (without clear evidence of a psychotic thought process) and his resistance to attendance at a pain management program.

In December 1993, claimant was referred for vocational assistance. During 1994, claimant's vocational consultant, Jane Hagle, sought to work with claimant for training in the field of water resource management. Due to the nature of his preexisting personality disorder, claimant did not cooperate with his return-to-work plan and refused to sign a behavioral agreement. In late December 1994, SAIF terminated claimant's eligibility for vocational assistance based on his failure to cooperate. This termination was upheld by the Rehabilitation Review Unit in March 1995 and ultimately affirmed by the Director in May 1996.

Meanwhile, on January 12, 1995, claimant's attending physician, Dr. Webb, declared claimant medically stationary with regard to his compensable injuries. After reviewing the findings of a November 1994 physical capacities examination, Dr. Webb concluded that claimant was likely limited to sedentary work.

Claimant's claim was closed pursuant to a February 15, 1995 Determination Order (amended March 2, 1995) awarding claimant temporary disability through January 12, 1995 and 48 percent (72 degrees) scheduled permanent disability for loss of the left leg (hip).

On July 6, 1995, claimant was evaluated by Dr. Thompson, a psychiatrist, at SAIF's request. Dr. Thompson concluded that claimant has an obsessive compulsive personality disorder and a need to be in control, which was why he did not cooperate with his vocational assistance program or participate in any pain program. Mr. Thompson reported that claimant's personality disorder was preexisting and not worsened by the work injury, that the personality disorder did not require any treatment, nor would it respond to treatment, but that it did not impair his employability. Dr. Thompson further noted that claimant was not motivated to work and not interested in looking for work until he had further treatment for his leg or hip.

On July 19, 1995, claimant was seen by Dr. Villanueva for a neuropsychological examination. Like the other mental health experts who had evaluated claimant, Dr. Villanueva reported that claimant had pre-existing personality factors which were impacting his course of recovery, including passive-aggressive traits and unwillingness to admit the importance of psychological factors in dealing with his physical condition. Dr. Villanueva recommended that claimant return to some form of work for the sake of his psychologic health, which would help divert his attention from his symptoms.

Pursuant to an August 4, 1995 Order on Reconsideration, claimant's scheduled permanent disability award was increased to 60 percent (90 degrees) for the left leg (hip).

Following a July 1996 Opinion and Order directing SAIF to accept a consequential psychological condition and consequential mechanical low back pain, claimant's claim was reopened. In September 1996, claimant was seen by Dr. Sasser for a psychiatric evaluation and Dr. Neumann for an orthopedic evaluation. Dr. Sasser found that claimant had a personality disorder, mixed, with passive-aggressive and obsessive-compulsive traits, but that he did not currently suffer from any situational depression or adjustment reaction. Dr. Sasser reported that claimant's psychiatric condition was medically stationary on January 12, 1995, and that he had no psychiatric impairment related to his 1991 compensable injury. Dr. Neumann found claimant's low back condition medically stationary as of January 12, 1995, with some loss of range of motion in the lumbar spine related to the 1991 injury. Dr. Webb concurred with Dr. Neumann's findings, but noted he was not qualified to render an opinion on the validity of Dr. Sasser's psychiatric report.

On December 24, 1996, claimant's claim was reclosed by a Determination Order awarding 44 percent (140.8 degrees) unscheduled permanent disability for the low back in addition to his prior scheduled permanent disability award for the left leg.

Claimant requested reconsideration and, on March 15, 1997, was examined by Drs. Farris and Staver for a medical arbiter examination. With regard to claimant's low back condition, Drs. Farris and Staver found claimant's lumbar range of motion "normal for this individual." A separate psychiatric arbiter examination was conducted by Dr. Telew. Dr. Telew found claimant to have a pain disorder with associated psychological factors and a personality disorder. He opined that claimant was not motivated to make any changes in his life but, if motivated, could return to some type of sedentary employment.

In April 1997, vocational consultant Michele Nielson opined that it would be futile for claimant to seek work because of his compensable injuries, significant learning disabilities, lack of transferable skills and his perceived inability to drive to Grants Pass or Medford on a daily basis from his home in Merlin.

On the other hand, SAIF's vocational expert, Areta Sturges, opined that claimant physical limitations and learning disabilities did not preclude him from being retrained for a variety of sedentary jobs, and that it would not be futile for him to seek work or participate in vocational retraining.

A May 2, 1997 Order on Reconsideration reduced claimant's unscheduled award to zero and declined to find claimant permanently and totally disabled based on medical and non-medical factors.

CONCLUSIONS OF LAW AND OPINION

Permanent and Total Disability

The ALJ found that it would be futile for claimant to seek work and that he was permanently and totally disabled under the "odd-lot" doctrine. On review, SAIF asserts that claimant is not entitled to permanent and total disability benefits because he has not persuasively established that it would be futile to seek work nor has he shown a willingness to work. We agree with SAIF.

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." Under the "odd-lot" doctrine, a disabled person with some residual physical capacity may still be permanently and totally disabled (PTD) due to a combination of his physical condition and nonmedical factors such as age, education, work experience, adaptability to nonphysical labor, mental capacity and emotional conditions, as well as the condition of the labor market.[1] Clark v. Boise Cascade Co., 72 Or App 397 (1985). However, unless the claimant's physical incapacity in conjunction with his nonmedical factors renders a work search futile, he must also establish that he has made reasonable efforts to obtain regular gainful employment. ORS 656.206(3); SAIF v. Scholl, 92 Or App 594 (1988).

In addition, even if the claimant can establish that a work search would be futile, claimant must nevertheless prove that, but for the compensable injury, he is willing to work. SAIF v. Stephen, 308 Or 41 (1989). In other words, a finding of futility alone is not sufficient to support an award of permanent and total disability benefits, as a finding that claimant is willing to work is a prerequisite to entitlement to such benefits. See ORS 656.206(3); Champion International v. Sinclair, 106 Or App 423 (1991). Therefore, where a claimant contends that his psychological condition was part of the cause of his resistance to rehabilitation, he must nevertheless prove that he is willing to work but for his condition. Sinclair v. Champion International, 117 Or App 515 (1992).[2]

In this case, vocational consultant Nielsen specifically found that it would be futile for claimant to seek work because of his learning disabilities, residual physical disabilities, lack of transferable skills and inability to drive to nearby cities on a daily basis. (Ex. 46). On the other hand, vocational consultant Sturges concluded that, notwithstanding his physical limitations and learning disabilities, claimant could be retrained for a variety of sedentary jobs. (Ex. 48). Vocational consultant Hagle, who worked with claimant in 1994, opined in January 1995 that claimant was employable. (Ex. 22). In addition, both Dr. Thompson and Dr. Villanueva, who evaluated claimant in July 1995, opined that claimant was employable and capable of some form of work, even if he lacked the motivation to do so. (Exs. 28, 30). Dr. Telew similarly found that claimant was capable of retraining and sedentary work if he was motivated to do so. (Ex. 45-4).

Even if we were to reject the medical opinions of Drs. Thompson, Villanueva, Telew, and the vocational assessments of Ms. Sturges and Ms. Hagle and rely instead on Ms. Nielsen's determination that it would be futile for claimant to seek work, we would nevertheless conclude that claimant has not carried his burden of proving that he is willing to work but for his compensable conditions.

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[1] The parties agree that claimant is not completely physically disabled and therefore his entitlement to PTD benefits, if any, arises under the "odd lot" doctrine.

[2] In Rinaldo F. Sinclair, 42 Van Natta 174 (1990), the Board affirmed an ALJ's order granting the claimant PTD benefits based on a finding that it would be futile for the claimant to seek work. On appeal, the court reversed and remanded. Citing SAIF v. Stephen, the court held that although substantial evidence supported the finding that it would be futile to seek work, the Board made no finding concerning the claimant's willingness to work, which is a prerequisite to entitlement to PTD benefits. Champion International v. Sinclair, 106 Or App at 423. On remand, the Board found no evidence that the claimant would have been willing to return to work but for his compensable conditions, and declined to find claimant PTD. Rinaldo F. Sinclair, 43 Van Natta 1529 (1991). On appeal from the Order on Remand, the court affirmed, finding that the claimant's evidence that his psychological condition was part of the cause of his resistance to rehabilitation did not prove that he was willing to work but for the condition. Sinclair v Champion Intern. Corp., 117 Or App at 518.

Although claimant initially (in 1994) expressed a willingness to work outdoors to Dr. Rethinger and Ms. Hagle (see, e.g., Exs. 14, 18),[3] he advised Dr. Thompson in July 1995 (at a time his condition had been medically stationary for six months) that he was not interested in looking for work until he had additional treatment for his hip and leg. (Ex. 28). Dr. Thompson found that claimant was not motivated to work, which is the same conclusion reached by Dr. Telew a year and a half later. In March 1997, Dr. Telew reported that claimant was not motivated to make any changes in his life, and that in the last few years, he had undermined efforts to improve his psychosocial function. (Ex. 49).

After considering the record, we conclude that claimant has not shown that he is willing to work but for his compensable conditions. A preponderance of the evidence relating to claimant's attitude toward returning to work, particularly the most recent pronouncements, indicate that he is unmotivated to do so. As in Sinclair, claimant's evidence that his personality disorder affects his motivation and is part of the cause of his resistance to rehabilitation does not prove that he is willing to work but for his condition. 117 Or App at 518. Consequently, claimant has not established an entitlement to PTD benefits.

Extent of Unscheduled Permanent Disability

Claimant asserts that, in the event we reverse the award of PTD benefits, the Determination Order's award of 44 percent unscheduled permanent disability should be reinstated. We agree.

In evaluating claimant's permanent disability, we do not automatically rely on a medical arbiter's opinion in evaluating permanent impairment. See Raymond L. Owen, 45 Van Natta 1528 (1993) (Impairment is established by a preponderance of medical evidence, considering the medical arbiter's findings and any prior impairment findings), aff'd Roseburg Forest Products v. Owen, 129 Or App 442 (1995). Instead, we rely on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment. See Carlos S. Cobian, 45 Van Natta 1582 (1993). In addition, we generally rely on the medical opinion of the attending physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983).

In this case, Dr. Webb, claimant's attending physician, did not rate claimant's permanent impairment on the reclosing of his claim, but he did concur with the closing examination of Dr. Neumann. Therefore, Dr. Neumann's findings may be used to rate impairment. See Tektronix, Inc. v. Watson, 132 Or App 483, 487 (1995) (consulting physician's impairment findings admissible for purposes of evaluating impairment when ratified by attending physician)

Dr. Neumann found a loss of range of motion of the lumbar spine which he specifically related to the accepted mechanical back pain and altered gait secondary to the original injury. (Ex. 34-6). The medical arbiters also measured claimant's lumbar range of motion, and reported that the lumbar flexion test finding was invalid. The arbiters further noted that claimant was inactive and summarily concluded that "the ranges of motion of the lumbar spine are felt to be normal for this individual." (Ex. 44-4).

On this record, we find that Dr. Neumann provides the most thorough, complete and well-reasoned assessment of claimant's injury related impairment. The arbiters did not explain their conclusion that claimant's findings were unrelated to the compensable condition, nor why his reduced lumbar motion was felt to be normal. Consequently, we reinstate the Determination Order's award of 44 percent unscheduled disability based on Dr. Neumann's impairment findings.

Finally, although we have determined that the permanent total disability award should be reversed, we have increased claimant's unscheduled permanent disability award from the Order on Reconsideration. Under such circumstances, claimant's attorney is entitled to an "out-of-compensation" fee equal to 25 percent of the increased compensation created by our order, not to exceed $3,800. On the other hand, SAIF is entitled to credit that attorney fee award against attorney fees paid pursuant to the ALJ's order. See, e.g., Jerry R. Miller, 42 Van Natta 571, on recon, 42 Van Natta 840 (1990).

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[3] Dr. Rethinger noted that claimant "had no desire to work indoors." (Ex. 14-6).

ORDER

The ALJ's order dated September 8, 1997, as supplemented September 23, 1997, is reversed. In lieu of the ALJ's order and the Order on Reconsideration (which awarded no additional permanent disability), the Determination Order's award of 44 percent (140.8 degrees) unscheduled permanent disability is reinstated and affirmed. SAIF is authorized to offset this award by the permanent total disability benefits it has paid on this claim. Claimant's counsel is awarded an attorney fee equal to 25 percent of the unscheduled permanent disability award, not to exceed $3,800. This fee shall be credited against the attorney fee that claimant's counsel has already received from the ALJ's permanent total disability award.

May 14, 1998 Cite as 50 Van Natta 913 (1998)

In the Matter of the Compensation of
PETER J. BERARDINELLI, Claimant
WCB Case No. 97-09665
ORDER OF DISMISSAL
Welch, Bruun, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Claimant has requested review of Administrative Law Judge (ALJ) Tenenbaum's March 23, 1998 order. The insurer has moved to dismiss based on untimely filing of the request for review. We dismiss.

FINDINGS OF FACT

On March 23, 1998, the ALJ issued an order that upheld the insurer's denial of compensability of claimant's bilateral plantar fasciitis condition. On April 23, 1998, claimant requested review of the ALJ's order. The request was accompanied by a certificate of service and mailing stating that claimant had mailed copies of the request to the Board and the parties on April 23, 1998. The Board received the request on April 24, 1998.

On April 28, 1998, the Board received the insurer's motion to dismiss the request for hearing. In moving to dismiss, the insurer asserted that the request for review was not timely filed.

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 March 23, 1998 order was Wednesday, April 22, 1998. The Board did not receive the request for hearing until April 24, 1998, more than 30 days after the ALJ's order. Consequently, claimant's request for review was not timely "filed" with the Board and we allow the insurer's motion to dismiss.[1]

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[1] Even if we were to consider the postmark date on the envelope containing claimant's request as the "filing" date, the appeal would still be untimely because April 23, 1998 (the "mailing" date) is also more than 30 days from the ALJ's March 23, 1998 order.

Accordingly, based on the foregoing reasoning, claimant's request for Board review is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
JERALD J. COOPER, Claimant
WCB Case No. 96-02211
ORDER ON RECONSIDERATION
Burt, Swanson, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Claimant requested reconsideration of our February 2, 1998 Order on Review that did not award his attorney an assessed fee under ORS 656.382(2) for services in defending against the insurer's request for authorization to offset an alleged overpayment of compensation against future disability awards. The insurer responded that there is no authority for an attorney fee for defending against an attempt to establish an overpayment, citing Strazi v. SAIF, 109 Or App 105 (1991), and Robert W. Coburn, 49 Van Natta 1778 (1997). To allow us additional time to consider claimant's motion, we abated our order on February 26, 1998. We now proceed with our reconsideration.

In Strazi, the claimant's permanent disability award had been reduced by a Determination Order. On the claimant's request, a referee reinstated the original permanent disability award and denied the employer's request for an offset of any overpayment. The referee awarded the claimant an assessed attorney fee under ORS 656.382(2) for having prevailed over the employer's offset request. On appeal, the Board reversed the assessed fee award. The court affirmed, holding that, because an approved offset merely represents amounts that a claimant was not entitled to receive and therefore does not "reduce or disallow" the claimant's award of compensation, ORS 656.382(2) does not authorize an assessed fee for the claimant's attorney's services in defending against an offset request. Id. at 108. The Board applied the Strazi analysis under similar circumstances in Robert W. Coburn, 49 Van Natta 1778 (1997), and Ernest C. Vroman, 49 Van Natta 809 (1997).

Contrasting circumstances were presented in Bowman v. Esam, Inc., 145 Or App 46 (1996). In Bowman, the insurer issued a Notice of Closure that awarded temporary disability at an erroneous wage rate. The claimant did not request reconsideration of the closure notice and it became final. Subsequently, the insurer requested ALJ approval of a future offset of overpaid temporary disability. The ALJ denied the offset request and awarded the claimant an assessed attorney fee under ORS 656.382(2) for prevailing on the offset request. On appeal, the Board reversed the assessed fee award. The court reversed the Board, holding that the parties' very dispute concerned whether the claimant's closure notice award of temporary disability included an overpayment for which the insurer may claim an offset. Id. at 50. Had the insurer prevailed on its contention that the award included an overpayment, the court reasoned, the effect would have been a reduction in the claimant's award. Id. Therefore, the Bowman court held that the claimant was entitled to an assessed fee under ORS 656.382(2). Id.

We conclude that the facts of this case are more similar to those in Strazi, Coburn and Vroman. The insurer did not contend that its alleged overpayment was included in any prior award, nor was the insurer's offset claim based on a disagreement with claimant's award. Rather, the insurer alleged that it had paid temporary disability benefits in excess of claimant's award of temporary disability. Therefore, unlike the facts in Bowman, had the insurer's offset request been approved in this case, it would not have resulted in a reduction of claimant's award. Accordingly, claimant's request for an assessed fee under ORS 656.382(2) is denied.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our February 2, 1998 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
MARIA A. JENKINS, Claimant
WCB Case No. 97-03615
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the insurer's denial of her occupational disease claim for bilateral tendinitis and lateral epicondylitis conditions. On review, the issue is compensability.

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

As the ALJ found, only Dr. Malcolm, treating physician, rendered any causation opinion regarding the bilateral tendinitis and lateral epicondylitis conditions. (Exs. 16, 17). We agree with the ALJ that the only opinion from Dr. Malcolm that could support claimant's claim is unpersuasive because it represents an unexplained change of opinion. *See Kelso v. City of Salem*, 87 Or App 630 (1987) (unexplained change of opinion renders physician's opinion unpersuasive).

On review, claimant argues that Dr. Malcolm explained that her change of opinion was based on her review of later medical records. While such an explanation could render a changed opinion persuasive, we do not agree that Dr. Malcolm presented such an explanation.

Dr. Malcolm first agreed with a conversation summary from the insurer's attorney that claimant's work activities did not cause a pathological worsening of her conditions. (Ex. 16). Dr. Malcolm also added a handwritten notation that she "would not assume to know why [claimant had] ongoing pain." (Ex. 16-1). Later, Dr. Malcolm agreed with a conversation summary from claimant's attorney that the work activities caused a pathological, albeit temporary, worsening of claimant's conditions. (Ex. 17). The second conversation summary does mention that claimant's attorney and Dr. Malcolm "reviewed other medical records" and "reviewed Dr. Tsai's IME." (Ex. 17-2, -3). However, it is clear that the discussion of those medical records was limited to the possibility of claimant's having carpal tunnel syndrome (CTS), a condition that Dr. Malcolm did not relate to work activities on a medically probable basis, even assuming claimant had CTS, given her normal nerve conduction tests. *(Id.)* Thus, contrary to claimant's argument, Dr. Malcolm does not indicate that review of medical records is the basis of her change of opinion. Furthermore, we are unable to make such an inference, especially given the context of Dr. Malcolm's discussion of those medical records.

Claimant also argues that Dr. Malcolm's first opinion focused on claimant's possible CTS condition, so it was not inconsistent with her second opinion, which focused on the bilateral tendinitis and lateral epicondylitis conditions. However, the record does not support that argument. Dr. Malcolm's first opinion specifically identifies "tendinitis/lateral epicondylitis" as the conditions addressed in the first part of her opinion, and only mentions CTS in passing in the latter part of the opinion. (Ex. 16).

ORDER

The ALJ's order dated January 20, 1998 is affirmed.

In the Matter of the Compensation of
JEANE A. THORNBURG, Claimant
WCB Case No. 97-05809
ORDER ON RECONSIDERATION
Heiling, Dodge & Associates, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Claimant requests reconsideration of our April 20, 1998 order which upheld the self-insured employer's denial of claimant's claim for a neck and upper back condition. Specifically, claimant argues that we erred in evaluating the medical evidence.

Based on the medical record, we found Dr. Gambee's opinion more persuasive than the opinion of Dr. Johnson. Our order adequately sets out the reasons for our decision. We have nothing further to add to that opinion.

Our April 20, 1998 order is withdrawn. As supplemented herein, we republish our April 20, 1998 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID L. ALLISON, Claimant
WCB Case No. 97-03991
ORDER ON REVIEW
John M. Hoadley, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that upheld the SAIF Corporation's denial of responsibility for claimant's occupational disease claim for a right shoulder condition. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

Claimant was 36 years of age at the time of hearing. He has worked as a carpenter for the employer in California, Washington and Oregon for the past 10 years. In early 1995, claimant experienced the gradual onset of right shoulder pain. He did not miss time from work, but his symptoms continued and gradually worsened to the point that he sought medical treatment on February 17, 1996. Claimant was ultimately diagnosed with a right shoulder impingement syndrome.

When claimant's right shoulder symptoms first began in early 1995, he was working for the employer in California. In November 1995, the employer transferred claimant to a job in Oregon, and he continued to work in Oregon through February 2, 1996. Claimant then worked for the employer in Washington from February 9 through 16, 1996, was off work when he first sought medical treatment on February 17, 1996, and next worked for the employer in Washington from March 8, 1996 through June 21, 1996. Claimant then began a new job for the employer in Oregon on June 28, 1996, and he has continued to work for the employer in Oregon since that time.

When claimant worked for the employer in California and Washington, it provided workers' compensation coverage in those states. When claimant worked for the employer in Oregon, it provided workers' compensation coverage through SAIF. Claimant filed an occupational disease (OD) claim for his right shoulder condition with SAIF, and it issued a responsibility denial on April 25, 1997.

CONCLUSIONS OF LAW AND OPINION

The pivotal issue on review is whether claimant's work for the employer in Washington can be considered in determining responsibility for his OD claim under the last injurious exposure rule (LIER). Specifically, claimant challenges the ALJ's ruling that SAIF is not responsible for claimant's compensable right shoulder condition because his work for the employer in Washington is the most recent potentially causal employment prior to the onset of disability.

There are at least two aspects of LIER: proof of a compensable claim and assignment of liability between carriers. Bracke v. Baza'r, 293 Or 239, 245 and n. 1 (1982). As a rule of proof, LIER allows the claimant to establish compensability based on employment-related exposure without proving actual causation against any particular carrier. Id. at 246. Once work relatedness is established or conceded, the rule assigns initial responsibility to the last employment that could cause the claimed condition over some indefinite period of time. Fosse v. SAIF, 293 Or 252, 256 (1982); Bracke, 293 Or at 248. The carrier on the risk for that employment can then shift responsibility backward by showing that it was impossible for its employment to have caused the condition, or that a prior employment was the sole cause of the condition. See Roseburg Forest Products v. Long, 325 Or 305, 313 (1997). Alternatively, the initially responsible carrier can transfer liability to a subsequent employment that actually contributed to a worsening of the condition. Oregon Boiler Works v. Lott, 115 Or App 70, 74 (1992). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke, 293 Or at 248. If a claimant received medical treatment before experiencing time loss, the date the claimant first received treatment is the triggering date for the initial assignment of responsibility. Timm v. Maley, 125 Or App 396, 401 (1993).

Here, claimant's first medical treatment on February 17, 1996 is considered as the onset of disability. The ALJ assigned initial responsibility to claimant's Washington employment from February 9 through 16, 1996. The ALJ also found that claimant's subsequent work in Oregon did not actually contribute to a worsening of his right shoulder impingement syndrome. Thus, the ALJ concluded that SAIF was not responsible for the condition.

We reach a different result based on the rationale expressed in Progress Quarries v. Vaandering, 80 Or App 160 (1986). In that case, compensability of the claimant's hearing loss was conceded, and the only issue was which carrier was responsible for the claim. The court concluded that the claimant's Oregon carrier could not use LIER defensively to shift responsibility to an out-of-state employment that was the last potentially causal employment prior to the onset of disability. In reaching that decision, the court reasoned that basic overall fairness can be achieved only if application of LIER as a rule of liability remains under control of the Oregon workers' compensation system. Thus, the court concluded that responsibility rested with the last injurious and potentially causal Oregon employment. Accord Silveira v. Larch Enterprises, 133 Or App 297 (1995) ("for the Oregon employer to be held responsible, the Oregon employment must be injurious and a potential cause of the disease").

Consistent with the decision in Progress Quarries, claimant's out-of-state employment cannot be considered in assigning responsibility. Thus, SAIF is responsible if claimant's Oregon employment through February 2, 1996 was injurious and could have contributed to his right shoulder condition. In an unrebutted medical opinion, Dr. Dordevich stated that any one of claimant's projects for the employer could have caused his right shoulder problem, including his work in Oregon through February 2, 1996. Dr. Dordevich's opinion establishes that claimant's work for the employer in Oregon was injurious and provided "potentially causal" conditions for his right shoulder impingement syndrome.

Accordingly, under the rationale set forth in Progress Quarries, SAIF is responsible for claimant's right shoulder condition. We disagree with the ALJ's conclusion that a different result is mandated by the decisions in United Parcel Service v. Likos, 143 Or App 486 (1996), and Charles Scott, 48 Van Natta 2592 (1996), aff'd mem 151 Or App 200 (1997).

In Likos, the claimant's carpal tunnel syndrome (CTS) first became disabling during a period of self-employment that was not covered by Oregon workers' compensation. The claimant then returned to work for an Oregon employer with workers' compensation coverage, and he filed a claim for the CTS with that employer. Litigation ensued, and the claimant relied on the period of self-employment to establish the work relatedness of the CTS. On the responsibility issue, the court concluded that the carrier could rely on LIER to shift responsibility to the noncovered self-employment. In reaching that decision, the court distinguished its ruling in Progress Quarries because the Progress Quarries claimant had not relied on out-of-state employment to establish compensability.

The Board relied on the Likos ruling in rendering its decision in Charles Scott. The claimant in Scott sustained a torn rotator cuff tear that first became disabling when the claimant was engaged in out-of-state employment. The claimant subsequently received further treatment for his right shoulder during a period of Oregon employment, and he ultimately filed a claim for his condition while working for another out-of-state employer. The Scott Board concluded that the previous Oregon employer could transfer responsibility to the out-of-state employment under LIER. In distinguishing its ruling from the decision in Progress Quarries, the Scott Board relied on its factual finding that the claimant had used the out-of-state employment to establish compensability.

Here, SAIF argues that the decisions in Likos and Scott are controlling because claimant relied on his out-of state employment to establish compensability. We disagree. The ALJ's order clearly states that work relatedness was conceded by SAIF, and that responsibility was the only issue. The ALJ's statement of the issues is consistent with SAIF's April 25, 1997 responsibility denial, which does not deny that claimant's right shoulder condition was caused by his work activity for the employer. Furthermore, the opening remarks at hearing do not establish that compensability was raised as an issue at hearing. On this record, we conclude that SAIF conceded compensability and cannot now argue that claimant relied on the out-of-state employment to establish the work relatedness of his claim. Consequently, the decisions in Likos and Scott are not controlling, and SAIF is responsible for claimant's right shoulder condition under the rationale expressed in Progress Quarries. Accord Richard W. Branchcomb, 48 Van Natta 16 (1996) (employment covered under LHWCA cannot be considered in assigning responsibility where the parties agree that the condition is work related).

Finally, claimant's counsel appeared and actively and meaningfully participated in finally prevailing against SAIF's responsibility denial. Accordingly, we conclude that claimant is entitled to the maximum $1,000 assessed attorney fee authorized under ORS 656.308(2)(d). In awarding the maximum fee, we have considered the factors set forth in OAR 438-015-0010(4), particularly the time spent in litigating this claim at hearing and on review, the complexity of the issue, the risk that claimant's counsel might go uncompensated, and the value of the interest involved. We also note that claimant has not asserted "extraordinary circumstances" to support a larger fee than the $1,000 maximum.

ORDER

The ALJ's August 14, 1997 order is reversed. The SAIF Corporation's April 25, 1997 denial is set aside, and the claim is remanded to SAIF for further processing according to law. For services at hearing and on review, claimant is awarded a $1,000 assessed attorney fee, to be paid by SAIF.

In the Matter of the Compensation of
DOUGLAS G. ANDREWS, Claimant
WCB Case Nos. 97-06178, 97-06177 & 97-02679
ORDER ON REVIEW
Gary M. Carlson & Associates, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys
Steven T. Maher, Defense Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that: (1) upheld Bay Area Hospital's ("Bay Area") compensability and responsibility denials of his occupational disease claim for bilateral shoulder impingement syndrome, bilateral bicipital tendinitis and right lateral epicondylitis; (2) upheld the SAIF Corporation's compensability and responsibility denials of the same conditions, issued on behalf of JLR Carpet Cleaners ("JLR"); and (3) upheld the SAIF Corporation's compensability and responsibility denials of the same conditions, issued on behalf of Industrial Steel and Supply ("Industrial"). On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant did not appear to be invoking the last injurious rule for proof of causation. The ALJ concluded that claimant failed to prove a compensable claim against Bay Area, JLR or Industrial.

On review, claimant relies on the last injurious exposure rule of proof to establish compensability of his occupational disease claim for bilateral shoulder impingement syndrome, bilateral bicipital tendinitis and right lateral epicondylitis. He contends that those conditions were caused in major part by his employment activities at Bay Area, JLR and Industrial. Assuming without deciding that claimant can raise the "rule" for the first time on review, we agree with the ALJ's ultimate conclusions that the claims are not compensable.

The parties agreed that claimant was employed at Bay Area from November 1990 through September 18, 1994, at JLR from July 1, 1995 through December 14, 1995 and at Industrial from April 15, 1996 through November 22, 1996. (Tr. 1).

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 (1997) (citing Runft v. SAIF, 303 Or 493, 500 (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. The claimant need prove only that the disease was caused by employment-related exposure. Id.

Because of the multiple possible causes of claimant's disability or need for treatment, this issue presents a complex medical question that must be resolved on the basis of expert medical evidence. See Uris v. Compensation Dept., 247 Or 420 (1967); Barnett v. SAIF, 122 Or App 281 (1993). We analyze claimant's occupational disease for bilateral shoulder impingement syndrome and bilateral bicipital tendinitis separately from his claim for right lateral epicondylitis.

Bilateral Shoulder Impingement Syndrome and Bilateral Bicipital Tendinitis

To establish an occupational disease, claimant must prove that his employment conditions were the major contributing cause of his bilateral shoulder impingement syndrome and bilateral bicipital tendinitis. ORS 656.802(2)(a). 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).

Industrial, Bay Area and JLR argue that Dr. Jany's opinion is not persuasive and does not establish that claimant's work exposure was the major contributing cause of a pathological worsening of preexisting shoulder conditions.

We must first determine whether claimant has a preexisting disease or disease or 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 bilateral shoulder impingement syndrome and bilateral bicipital tendinitis were caused in major part by his employment activities at Bay Area, JLR and Industrial. This is an initial occupational disease claim for those conditions. Therefore, the onset of this occupational disease claim is November 1990, when claimant began working at Bay Area. See New Portland Meadows v. Dieringer, 153 Or App 383 (1998); Mark H. Davidson, 49 Van Natta 1918, 1920 (1997). Thus, the question is whether claimant had any shoulder or tendinitis disease or condition that preexisted the beginning of his employment in November 1990.

On March 20, 1997, Dr. Jany said that, based upon reports from Drs. Keizer and McAndrew, claimant had a preexisting condition with his shoulders, i.e., impingement syndrome, degenerative joint disease at the AC joint and bicipital tendinitis. (Ex. 34-2). Although Dr. Jany characterized these conditions as "pre-existing," the contemporaneous treatment records make no reference to any diagnosis of impingement syndrome, degenerative joint disease at the AC joint or bicipital tendinitis before November 1990.

The reports from Drs. McAndrew and Keizer referred to shoulder complaints and "degenerative changes." (Exs. 7, 10, 12). However, those physicians did not examine claimant until 1995 and their reports do not indicate that claimant had such problems before November 1990. Although Dr. Keizer's March 25, 1996 chart note refers to "pain to the right acromioclavicular joint secondary to degenerative changes" (Ex. 12-2), he did not state that the degenerative changes were present before November 1990.

None of the other medical reports indicate that claimant had shoulder or tendinitis problems before 1990. Dr. Mayhall opined that claimant had evidence of preexisting bicipital tendinitis, rotator cuff tendinitis and impingement syndrome (Ex. 29-8), but his report does not establish that those conditions were present before November 1990. Dr. James stated that claimant had a preexisting history "as noted in Dr. McAndrew's chart note of March 3, 1995, implicating the right and left shoulders." (Ex. 40-7). However, Dr. James' report does not establish that those conditions were present before November 1990. On this record, we conclude that claimant need not establish a pathological worsening under ORS 656.802(2)(b).

Claimant relies on Dr. Jany's opinion to establish compensability of his bilateral shoulder impingement syndrome and bilateral bicipital tendinitis. In evaluating the medical evidence concerning causation, we rely on opinions that are well-reasoned and based on accurate and complete information. Somers v. SAIF, 77 Or App 259 (1986). We generally rely on the opinion of a claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). For the following reasons, we are not persuaded by Dr. Jany's causation opinions.

Dr. Jany began treating claimant in June 1996. (Ex. 13). In a questionnaire from claimant's attorney signed by Dr. Jany on March 20, 1997, he was asked whether the current shoulder condition was a flare-up in symptoms or an actual worsening of the underlying condition. (Ex. 34-3). Dr. Jany replied: "Unknown." (Id.) In a later questionnaire from claimant's attorney, Dr. Jany was asked whether claimant's work for Bay Area, JLR and Industrial "constitute a series of traumatic events or

occurrences to which [claimant] would not have ordinarily been subjected or exposed to, other than during his regular employment, which required medical services[.]" (Ex. 46-3). Dr. Jany replied: "possibly." (Id.) Dr. Jany agreed that claimant's work activities for Bay Area, JLR and Industrial were the major contributing cause of claimant's current condition, diagnosed as bilateral subacromial impingement syndrome. (Id.)

In a later questionnaire from claimant's attorney signed by Dr. Jany on October 10, 1997, Dr. Jany disagreed with Dr. Mayhall's opinion that claimant shoulder condition was idiopathic. (Ex. 47-1). Dr. Jany said that it was very rare for a bilateral subacromial impingement syndrome to be idiopathic and he said that claimant's condition was not idiopathic. (Ex. 47-2). He explained that the type of work claimant had done in the past would be consistent with this type of injury, including repetitive use of the shoulder in lifting at both Bay Area, Industrial Steel, and the janitorial job, as well as overhead lifting. (Id.)

Dr. Jany was asked whether "heavy lifting and carrying would constitute a traumatic event or occurrence to the shoulder[.]" (Ex. 47-3). Dr. Jany replied:

> "Yes, the heavy lifting and carrying would constitute a series of traumatic events or occurrences which occurred over all three jobs and did cause this condition. Each of these jobs were [sic] a material contributing factor in [claimant's] developing this condition, and combined, they are not only the major contributing factor, but the cause." (Id.)

We are not persuaded by Dr. Jany's opinion on causation because it lacks adequate explanation. Dr. Jany opined that the heavy lifting and carrying at all three jobs was the major contributing factor of the shoulder condition. (Ex. 47-3). However, the medical record indicates that claimant was first treated for shoulder and tendinitis problems on March 3, 1995, when he was unemployed. (Ex. 7). At that time, claimant had not worked at Bay Area since September 18, 1994 and did not begin working at JLR until July 1995. (Tr. 1). Claimant testified that he had "twinges" in his shoulders when he worked at Bay Area. (Tr. 3). However, the medical evidence indicates he was not treated for his shoulders until March 3, 1995. Dr. Jany did not explain why, if claimant's shoulder condition was related to heavy lifting and carrying at all three jobs, his symptoms started when he had been unemployed for six months.

In addition, Dr. Jany did not explain why claimant continued to have shoulder symptoms on March 25, 1996, more than three months after he quit working at JLR (Ex. 12-2), or why claimant continued to have symptoms for several months after he stopped working at Industrial on November 22, 1996. (Exs. 26, 35). On April 9, 1997, more than four months after he left Industrial, Dr. Jany reported that claimant was "fairly miserable" with his right shoulder. (Ex. 35). Dr. Jany gave claimant an injection and mentioned that he might need surgery. (Id.)

Furthermore, Dr. Jany's opinion is not persuasive because he did not adequately explain his change of opinion. In a report signed on September 25, 1997, Dr. Jany said that claimant's work for all three employers "possibly" constituted a series of traumatic events or occurrences. (Ex. 46-3). In a later report, however, Dr. Jany agreed that heavy lifting and carrying would constitute a series of traumatic events or occurrences to the shoulder and the heavy lifting and carrying at all three jobs was "not only the major contributing factor, but the cause." (Ex. 47-3). Although Dr. Jany indicated in the later report that he was "somewhat confused by your Question No. 3" [in the previous report], " he did not offer an adequate explanation for his change of opinion. Consequently, his opinion is not persuasive. See Kelso v. City of Salem, 87 Or App 630 (1987).

Moreover, we do not find Dr. Jany's opinion persuasive because he did not have a complete and accurate history of claimant's off-work activities. On September 15, 1997, claimant's attorney informed Dr. Jany that claimant spent his leisure time working with seven llamas. (Ex. 46-2). Claimant's attorney explained:

> "While this work may be time consuming, it seldom, if ever, involves heavy lifting. It does involve combing the llamas, and then he and his wife spin the wool which is removed by the combing." (Id.)

Dr. Jany opined that no off-job activities had affected claimant's shoulder condition. (Ex. 46-2). In a later report, Dr. Jany reiterated that claimant's off-the-job activities did not contribute to his shoulder condition. (Ex. 47-2). He explained:

> "While [claimant] may have gotten jerked occasionally in leading his llamas, or even butted, these would not have been the type of incidents which would have led to this condition; they do not have the type of repetitiveness that his on the job activities had." (Id.)

The record indicates that claimant sought medical treatment from Dr. Keizer on December 29, 1995 for a shoulder injury he sustained while working with a llama. (Ex. 12-1). At that time, claimant was unemployed. Dr. Keizer reported:

> "[Claimant] had sustained a recurrent injury to his right shoulder when he was working with a llama at home over the past week. He has sprained his shoulder and has aggravation of the biceps tendonitis and also the subacromial joint tendonitis." (Id.)

At hearing, claimant was asked about the llama incident. He said that a llama knocked him into a fence backwards and "I landed on my butt." (Tr. 11). Claimant testified that he did not strike his shoulder or hit it in any way. (Id.) In light of Dr. Keizer's chart note that indicated that claimant had sprained his shoulder as a result of the llama incident, we are not persuaded by claimant's testimony that his shoulder was not injured in the incident. Moreover, we are not persuaded that Dr. Jany had an accurate history of the llama incident. We find no evidence that Dr. Jany had reviewed Dr. Keizer's December 29, 1995 chart note, which indicated claimant was working with a llama and sustained an injury to his shoulder that resulted in a sprain and an aggravation of tendonitis. Because we are not persuaded that Dr. Jany had a complete and accurate history of claimant's prior non-work-related shoulder injury, his opinion is not persuasive. See Miller v. Granite Construction Co., 28 Or App 473 (1977).

The remaining medical opinions do not establish that claimant's work activities at all three employers was the major contributing cause of his bilateral shoulder impingement syndrome and bilateral bicipital tendinitis. Dr. Mayhall found that claimant had inconsistencies and pain behavior on examination, as well as an inconsistent history. (Ex. 29-7). He did not believe claimant's work exposure from April 1996 through November 1996 was the major contributing cause of his shoulder conditions, and he believed his difficulties were preexisting. (Ex. 29-9). Dr. Keizer, a previous treating physician, concurred with Dr. Mayhall's opinion. (Ex. 33). In a later report, Dr. Mayhall agreed that claimant's shoulder problems were idiopathic and claimant was an unreliable historian. (Ex. 44). Dr. James concluded that claimant's work at JLR was a material contributing cause of his shoulder and right arm conditions and his work at Industrial was also a material cause. (Ex. 40-7, -8). However, his opinion does not establish that claimant's work at all three employments was the major contributing cause of the impingement syndrome and tendinitis. We conclude that claimant has not established compensability of bilateral shoulder impingement syndrome and bilateral bicipital tendinitis.

Right Lateral Epicondylitis

Claimant also relies on the last injurious exposure rule of proof to establish compensability of his occupational disease claim for right lateral epicondylitis. He contends that the epicondylitis was caused in major part by his employment activities at Bay Area, JLR and Industrial and he relies on the opinion of Dr. Jany. For the following reasons, we are not persuaded by Dr. Jany's causation opinions regarding claimant's epicondylitis.

The ALJ found that claimant's right elbow symptoms arose when he was not working. On the other hand, claimant testified that he first noticed a problem with his right elbow condition when he was working at Industrial. (Tr. 9, 10). He said he never had any elbow problems before working at Industrial. (Tr. 10).

The medical reports indicate that claimant first mentioned elbow pain during an examination by Dr. Jany on June 26, 1996. (Ex. 13). Dr. Jany reported:

> "The patient is a 40-year-old male seen today because of a problem with his right arm for the past 4 months. He has been trying to take care of his elbow and arm pain with some ice and medication, but it is not working. When he lifts anything, hammers something, when he has to grab a tool, he has excruciating pain down the outside part of the arm and drops things. He is also getting some numbness and tingling into the right hand and that is also occurring at night. Denies any neck discomfort or shoulder discomfort." (Id.)

Dr. Jany diagnosed right elbow lateral epicondlytis. (Id.)

Dr. Jany's chart note is inconsistent with claimant's testimony. Dr. Jany indicated that claimant had been experiencing elbow and arm pain for four months, which meant his symptoms began approximately February 1996 when he was not working. Claimant's job with JLR ended on December 14, 1995 and he did not begin working at Industrial until April 15, 1996. (Tr. 1). At hearing, claimant was asked about Dr. Jany's chart note and he said Dr. Jany's reference to the "right arm" was probably the elbow and the shoulder. (Tr. 10). However, Dr. Jany specifically reported that claimant denied any shoulder discomfort on June 26, 1996. (Ex. 13).

In a questionnaire from claimant's attorney signed by Dr. Jany on September 25, 1997, he was asked whether claimant's work activities at Bay Area, JLR and Industrial were the major contributing cause of his lateral epicondylitis. (Ex. 46-3). Dr. Jany responded: "-possibly- that came on between jobs & very hard to pinpoint one or another employer." (Id.) Dr. Jany's report that claimant's epicondylitis condition arose when claimant was between jobs is consistent with his June 26, 1996 chart note.

In a later questionnaire from claimant's attorney signed by Dr. Jany on October 10, 1997, Dr. Jany was asked whether claimant's work for all three employers combined to be the major contributing cause of his elbow condition. (Ex. 47-3). Dr. Jany responded:

> "This should have been probably, not possibly; yes, the three combined would be the major contributing cause. What I meant when I indicated possibly is that you could not say this employer or the other was the major contributing cause." (Ex. 47-4).

Dr. Jany opined that claimant's work for each employer would be a material contributing cause of the current elbow condition. (Id.) He also said that claimant's "previous jobs would have caused the [right elbow] condition, and the work at Industrial Steel aggravated, to cause the need for medical services." (Id.)

If we assume that claimant's testimony about his right elbow condition is accurate, i.e., he did not have any elbow problems before working at Industrial, Dr. Jany's causation opinion is not persuasive because he did not have an accurate history of claimant's symptoms. However, if Dr. Jany had an accurate history of claimant's elbow symptoms, his causation opinion is not persuasive because it lacks adequate explanation and is inconsistent. Based on Dr. Jany's June 26, 1996 chart note and the report he signed on September 25, 1997, claimant's elbow condition arose in February 1996, when he was in between jobs. (Exs. 13, 46-3). Dr. Jany later said that each of claimant's jobs at Bay Area, JLR and Industrial was a material contributing cause of his current elbow condition. (Ex. 47-4). He also said that claimant's "previous jobs would have caused the [right elbow] condition, and the work at Industrial Steel aggravated, to cause the need for medical services." (Id.) Claimant worked at Bay Area from November 1990 through September 18, 1994 and at JLR from July 1, 1995 through December 14, 1995. (Tr. 1). Dr. Jany did not explain how Bay Area and JLR could have caused the elbow condition when claimant did not have any elbow symptoms until February 1996, after he quit working at those jobs. Dr. Jany's opinion is not persuasive because it lacks adequate explanation and is inconsistent.

Moreover, we are not persuaded by Dr. Jany's opinion because he did not explain his change of opinion. Dr. Jany initially said that claimant's work activities at Bay Area, JLR and Industrial "possibly" were the major contributing cause of his lateral epicondylitis. (Ex. 46-3). He noted that the epicondylitis "came on between jobs & very hard to pinpoint one or another employer." (Id.) However, in a later opinion, Dr. Jany indicated that claimant's work activities at Bay Area, JLR and Industrial "probably" were the major contributing cause of his lateral epicondylitis. (Ex. 47-3, -4). He explained that when he said "possibly" in the earlier opinion, he meant that he could not say which employer was the major contributing cause. (Ex. 47-4). However, Dr. Jany did not explain why, if all three employments caused the epicondylitis, claimant's elbow symptoms began when he was not working. Because Dr. Jany did not adequately explain his change of opinion, it is not persuasive. See Kelso v. City of Salem, 87 Or App 630 (1987).

The remaining medical reports do not establish that claimant's work activities for all three employers were the major contributing cause of his right lateral epicondylitis. In particular, we note that Dr. James reported that claimant's right elbow "appears to have come on in-between jobs" and he did not believe that condition was related to his employment. (Ex. 40-7).

ORDER

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

May 15, 1998 Cite as 50 Van Natta 924 (1998)

In the Matter of the Compensation of
JAMES R. ANSON, Claimant
WCB Case No. 97-06824
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Herman's order that affirmed an Order on Reconsideration which awarded claimant 27 percent (86.4 degrees) unscheduled permanent disability benefits for his right shoulder condition. Alternatively, the employer contends that the Order on Reconsideration is invalid. On review, the issues are extent of unscheduled permanent disability and the validity of the Order on Reconsideration.

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

On review, the employer disagrees with claimant's contention that the employer has the burden of proof in this case. However, consistent with our decision in Roberto Rodriguez, 46 Van Natta 1722 (1994), we agree with claimant that, because the employer sought a reduction of claimant's permanent disability award, it has the burden of proof. See also Maria Jolley, 48 Van Natta 2316 (1996). Moreover, we agree with the ALJ's reasoning and conclusion on the issue of extent of permanent disability.

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

ORDER

The ALJ's order dated February 2, 1998 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,200, to be paid by the employer.

In the Matter of the Compensation of
SHAWN M. DREW, Claimant
WCB Case No. 97-05691
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) T. Lavere Johnson's order that: (1) upheld the SAIF Corporation's denial of his aggravation claim for a low back condition; and (2) awarded interim compensation from April 18, 1997 to May 2, 1997. On review, the issues are aggravation and interim compensation. We affirm in part and reverse in part.

FINDINGS OF FACT

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

In the third paragraph on page 2, we delete the last sentence and citations. In the second sentence of the fourth paragraph on page 2, we change "(Ex. 15)" to read "(Ex. 16)." In the fourth paragraph on page 2, we delete the last sentence and citations. In the first full paragraph on page 3, we change the second sentence to read: "He was bending down to pick up a power tool weighing about 25 pounds and he straightened up and felt severe low back pain. (Exs. 24A, 27A, 27B, 31-2)."

In the second full paragraph on page 3, we delete the second sentence and replace it with the following:

> "Dr. Gallant authorized time loss benefits from March 8, 1997 to March 19, 1997 (Exs. 22, 24), and beginning April 7, 1997. (Ex. 26). Claimant testified that he did not receive any time loss benefits. (Tr. 9)."

In the last sentence of the first full paragraph on page 3, we change "(Ex. 26)" to read "(Ex. 25A)."

CONCLUSIONS OF LAW AND OPINION

Aggravation

The ALJ found that claimant's aggravation claim was based on mechanical low back pain "with disc involvement," even though no claim was made for degenerative disc disease, disc bulges or herniations. The ALJ determined that claimant's August 17, 1995 accepted low back injury had resolved by January 1996 and claimant had returned to work without incident. The ALJ concluded that claimant failed to establish legal and medical causation for his aggravation claim.

Claimant relies on Dr. Gallant's opinion to establish a compensable aggravation claim. He asserts that he is not making a claim pursuant to ORS 656.005(7) and is not making a claim for compensability of degenerative disc disease, disc herniation or disc bulge.

Under ORS 656.273(1), a worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings. Two elements are necessary to establish a compensable aggravation: (1) a compensable condition; and (2) an "actual worsening." Gloria T. Olson, 47 Van Natta 2348, 2350 (1995). If the allegedly worsened condition is not a compensable condition, compensability must first be established under ORS 656.005(7)(a). Id.

We begin our analysis with a determination of whether claimant's current low back condition is a compensable condition. SAIF accepted a disabling lumbosacral strain resulting from the August 17, 1995 injury. (Ex. 19). A January 26, 1996 Notice of Closure did not award any permanent disability. (Ex. 21).

On March 8, 1997, claimant bent down to pick up a power tool weighing 25 pounds and felt severe low back pain when he straightened up. (Exs. 24A, 27A, 27B, 31-2). Claimant's treating physician, Dr. Gallant, made several diagnoses. On March 31, 1997, he considered "discogenic pain and radiculopathy, LS region[.]" (Ex. 24A). On April 7, 1997, Dr. Gallant diagnosed "[d]egenerative disease

with disk herniation and bulging." (Ex. 25A). Later in the month, he wrote to SAIF, stating that claimant had "mechanical back pain with disk involvement." (Ex. 28-1). On May 2, 1997, Dr. Gallant diagnosed "[c]hronic mechanical back pain, discogenic." (Ex. 30A). One month later, he diagnosed "[c]hronic mechanic back pain with waxing and waning symptoms" and "LS strain/sprain with underlying DJD." (Ex. 33).

Because Dr. Gallant's diagnoses of claimant's current low back condition contain elements of "disk involvement," discogenic pain and degenerative disease, we conclude that claimant's current low back condition is not the same as his accepted 1995 lumbosacral strain. Therefore, claimant must first establish that his current low back condition is a compensable condition.[1]

As a fact finder, it is our obligation to apply the appropriate legal standards to determine the compensability of a worker's claim. Daniel S. Field, 47 Van Natta 1457 (1995) (citing Hewlett-Packard v. Renalds, 132 Or App 288 (1995)).

Claimant acknowledges that he has preexisting degenerative changes in his back, but he contends they were not identified in 1995 and were not part of the claims processing in 1995. Claimant argues that the "law of the case" is that he has no preexisting condition for purposes of assessing the compensability of the aggravation claim. We disagree.

We are not analyzing compensability of the 1995 injury. Rather, the issue is whether claimant's current low back condition is compensable. The "law of the case" doctrine does not apply because there has not yet been a binding and conclusive determination of whether claimant's current low back condition is compensable. See Blanchard v. Kaiser Foundation Health Plan, 136 Or App 466, 470, rev den 322 Or 362 (1995) (explaining law of the case rule).[2]

We proceed to decide the appropriate legal standards. Dr. Tsai reported that claimant had preexisting degenerative lumbosacral disc disease, of long duration. (Ex. 31-9). Dr. Gallant agreed with Dr. Tsai that claimant had preexisting degenerative changes in his back. (Ex. 36-2). We conclude that the medical evidence establishes that claimant's degenerative disc disease in the low back constitutes a "preexisting condition" with respect to the current condition claim.[3]

On April 7, 1997, Dr. Gallant diagnosed "[d]egenerative disease with disk herniation and bulging." (Ex. 25A). In June 1997, he diagnosed "[c]hronic mechanic back pain with waxing and waning symptoms" and "LS strain/sprain with underlying DJD." (Ex. 33). In light of Dr. Gallant's references to degenerative disease in the diagnoses, we interpret his opinion to mean that claimant's current low back condition combined with the preexisting degenerative disease in the lumbar spine. Therefore, ORS 656.005(7)(a)(B) applies to this case. To establish compensability, claimant must establish that the August 1995 compensable injury was the major contributing cause of the disability or need for treatment of his current combined condition. ORS 656.005(7)(a)(B). See William R. Shapton, 49 Van Natta 1369 (1997); Gloria T. Olson, 47 Van Natta at 2350-51.

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[1] Despite claimant's assertion that he is not making a claim pursuant to ORS 656.005(7), we must first establish the compensability of his current low back condition before determining whether there is an "actual worsening" pursuant to ORS 656.273. See Gloria T. Olson, 47 Van Natta at 2350. To the extent that claimant's aggravation claim is based on a worsening of the August 1995 lumbosacral strain, we are not persuaded that claimant has sustained an "actual worsening" of that condition.

[2] The court explained that the law of the case doctrine

" 'is a general principle of law and one well recognized in this state that when a ruling or decision has been once made in a particular case by an appellate court, while it may be overruled in other cases, it is binding and conclusive both upon the inferior court in any further steps or proceedings in the same litigation and upon the appellate court itself in any subsequent appeal or other proceeding for review.' " Blanchard, 136 Or App at 470 (quoting State v. Pratt, 316 Or 561, 569, cert den 510 U.S. 969 (1993) (citations omitted)).

[3] Under ORS 656.005(24), a "preexisting condition" means "any injury, disease, congenital abnormality, personality disorder or similar condition that contributes or predisposes a worker to disability or need for treatment and that precedes the onset of an initial claim for an injury or occupational disease or that precedes a claim for worsening pursuant to ORS 656.273." Based on Dr. Tsai's opinion, as supported by Dr. Gallant, we conclude that claimant's degenerative disc disease preexisted the "claim for worsening pursuant to ORS 656.273" and, therefore, constitutes a "preexisting condition."

On April 25, 1997, Dr. Gallant reported that claimant

> "initially injured his back in August of 1995, at which time he was seen by chiropractors and x-rays were obtained, but an MRI was never performed. He improved and then on 03/08/97 while picking up tools at 8:00 a.m. in the morning he experienced significant pain and had to leave work early and go to the chiropractor." (Ex. 28-1).

Dr. Gallant reported that claimant was initially evaluated by chiropractic physicians in August 1995 and "has required some intermittent chiropractic care since then with a characteristic waxing and waning that one would see in mechanical back pain." (Ex. 28-2).

In a concurrence letter from claimant's attorney signed on August 15, 1997, Dr. Gallant agreed with the following paragraph:

> "However, you agree with Dr. Tsai that [claimant] does have pre-existing degenerative changes in his back, as well as documented pre-existing psychiatric conditions. In your medical opinion, when these conditions combine with [claimant's] 1995 on the job injury, the major contributing cause of the combined condition and [claimant's] disability and need for treatment remains the 1995 on the job injury. In your opinion, the pre-existing conditions identified by Dr. Tsai play a role in this case, yet a much less significant role than the on the job injury of 1995." (Ex. 36-2).

At hearing, claimant was asked whether he had any periodic flare ups of back pain between claim closure in January 1996 and the March 8, 1997 injury, and he replied, "No, nothing of any consequence." (Tr. 7). He testified that he did not receive any medical treatment or take any time off from work for his back before March 8, 1997. (Tr. 8).

In light of claimant's testimony that he did not receive any medical treatment for his back between the January 26, 1996 claim closure and the March 8, 1997 injury, we conclude that Dr. Gallant had an inaccurate history of claimant's symptoms. Dr. Gallant incorrectly believed that claimant had continuing symptoms after the August 1995 injury and had required intermittent chiropractic care since that time. Furthermore, Dr. Gallant was not aware of claimant's earlier back injury in 1994. When SAIF provided Dr. Gallant with records pertaining to claimant's treatment for the 1994 injury, Dr. Gallant did not recall having seen them before and he was unable to distinguish between the injury in 1994 and in 1995. (Ex. 30). We are not persuaded by Dr. Gallant's opinion because it was based on an inaccurate history. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

There are no other medical opinions in the record that establish that the 1995 compensable injury was the major contributing cause of claimant's disability or need for treatment of his current combined condition. Dr. Tsai reported that claimant's August 1995 injury became medically stationary, but his degenerative disc disease had been progressive. (Ex. 31-11). He concluded that the preexisting degenerative lumbar disc disease was the major contributing cause of claimant's current low back condition. (Ex. 31-10).

Because claimant has not established a compensable condition, we need not address whether he has established an "actual worsening" pursuant to ORS 656.273. See Gloria T. Olson, 47 Van Natta at 2351.

Interim Compensation

The ALJ found that claimant's aggravation claim was perfected on May 2, 1997 and claimant returned to work on that date. Although Dr. Gallant first authorized time loss benefits on March 8, 1997, the ALJ applied ORS 656.262(4)(f) and concluded that claimant was entitled to interim compensation from April 18, 1997 to May 2, 1997.

Claimant contends that he is entitled to interim compensation from March 8, 1997 to May 2, 1997. He asserts that Dr. Gallant first authorized time loss benefits on March 8, 1997 and SAIF had knowledge of his inability to work on that date.

On the other hand, SAIF argues that the ALJ erred in awarding any retroactive interim compensation. SAIF contends that the ALJ correctly concluded that claimant's entitlement to interim compensation did not begin until he actually perfected his claim, which was on May 2, 1997. The ALJ found that claimant returned to work on May 2, 1997.

ORS 656.273(3) requires that the 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 statute further provides that the aggravation claim "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." Claimant's entitlement to interim compensation depends upon whether the carrier received notice or knowledge of a medically verified inability to work in a medical report that satisfies the requirements of ORS 656.273(3) (and thus constitutes prima facie evidence in the form of objective findings that claimant's compensable condition has worsened). Susan R. Foster, 49 Van Natta 2026, 2027 (1997) (citing ORS 656.273(6)).

The first issue is whether the ALJ correctly found that the aggravation claim was perfected on May 2, 1997. Dr. Gallant and claimant signed a "Notice of Claim for Aggravation of Occupational Injury or Disease" on March 18, 1997. (Ex. 22). Dr. Gallant indicated that time loss was authorized beginning March 8, 1997. (Id.) The record does not indicate whether the aggravation claim form included any additional documents. Both Dr. Gallant and claimant signed a "Change of Attending Physician" form on March 18, 1997. (Ex. 23). That form described claimant's current complaints as "aggravation of previous workmen's compensation injury[.]" (Id.)

On March 18, 1997, Dr. Gallant indicated that claimant could return to work March 19, 1997. (Ex. 24). On April 8, 1997, Dr. Gallant authorized time loss beginning April 7, 1997. (Ex. 26).

On April 8, 1997, SAIF wrote to Dr. Gallant, acknowledging receipt of the aggravation form and requesting further clarification. (Ex. 27). On April 25, 1997, Dr. Gallant responded to SAIF's questions, indicating, among other things, that claimant had mechanical back pain with disc involvement that was an "aggravation of previous back injury directly related to his work." (Ex. 28-1).

On May 2, 1997, Dr. Gallant signed a concurrence letter from claimant's attorney. (Ex. 29). Dr. Gallant agreed that claimant had "sustained an aggravation, or a pathological worsening of his August 17, 1995, on-the-job injury" and he agreed that he had "identified objective findings of tenderness, abnormal deep tendon reflexes, weakness, straight leg raising, as well as the MRI scan showing L4-5 and L5-S1 disc herniations." (Id.) On May 2, 1997, SAIF wrote to Dr. Gallant and indicated it had just received his response to SAIF's letter, as well as a confirmation of Dr. Gallant's discussion with claimant's attorney. (Ex. 30).

We are not persuaded by claimant's assertion that the aggravation claim was perfected as early as March 8, 1997. Although Dr. Gallant authorized time loss beginning March 8, 1997, the aggravation claim form was not signed until March 18, 1997. Moreover, there is no evidence that the aggravation claim form was accompanied by a medical report satisfying the requirements of ORS 656.273(3). See Laura D. Girard, 49 Van Natta 1417 (1997).

We agree with the ALJ that the claim was perfected on May 2, 1997. On that date, SAIF acknowledged it had received Dr. Gallant's response to SAIF's letter, as well as a confirmation of Dr. Gallant's discussion with claimant's attorney. (Ex. 30).

When the claim was perfected on May 2, 1997, SAIF's claim processing obligations under ORS 656.273(6) were triggered. 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."

Thus, SAIF was required to begin the payment of interim compensation within 14 days from its May 2, 1997 receipt. See Ronda G. Prewitt, 49 Van Natta 831, 834 (1997); see also Ronda G. Prewitt, 50 Van Natta 390 (1998).

In this case, the ALJ found, and the parties do not dispute, that claimant returned to work on May 2, 1997. A worker is entitled to interim compensation if he or 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). Here, because claimant had returned to work on the same day that the aggravation claim was perfected, he did not suffer a loss of earnings as a result of a work-related injury or disease. Therefore, SAIF was not required to begin payment of interim compensation.

The ALJ found that claimant was entitled to a penalty for SAIF's failure to pay interim compensation. The ALJ assessed a penalty in the amount of 25 percent of the monetary value of the interim compensation benefits. However, we have concluded that claimant is not entitled to interim compensation. In light of our disposition, there are no "amounts then due" on which to base a penalty and no unreasonable resistance to the payment of compensation to support a penalty-related attorney fee. See Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991); Randall v. Liberty Northwest Ins. Corp., 107 Or App 599 (1991). Accordingly, no penalties or related attorney fees are warranted.

ORDER

The ALJ's order dated November 14, 1997 is affirmed in part and reversed in part. That portion of the ALJ's order that directed SAIF to pay claimant interim compensation from April 18, 1997 to May 2, 1997 is reversed. The portion of the ALJ's order that directed SAIF to pay a penalty equal to the 25 percent of the interim compensation benefits payable to claimant is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
ERIC S. GUNN, Claimant
WCB Case No. 97-00901
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Charles L. Lisle, Defense Attorney

Reviewed by Board Members Moller and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Brown's order that: (1) set aside its partial denial of claimant's injury claim for left shoulder rotator cuff tendinitis and subacromial bursitis; and (2) awarded interim compensation through February 6, 1997. On review, the issues are compensability and entitlement to interim compensation. We reverse in part, modify in part, and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings" with the following correction. Dr. Webb's diagnosis of rotator cuff tendinitis and subacromial bursitis was unqualified, rather than a "possible" diagnosis.

We make the following supplemental findings.

When claimant initially injured his left shoulder in October 1996, he experienced the immediate onset of pain which continued up until the time of the lifting incident on November 8, 1996. In the interim between these two incidents, claimant continued to perform his regular work for the employer, although he experienced increased pain with this activity.

Claimant had no preexisting history of left shoulder injuries, conditions or symptoms.

After Dr. Naugle released claimant to light duty work on November 8, 1996, claimant performed modified work for the employer for a short period. At some point, claimant requested a transfer to a different department, and the employer put claimant on "lay-off" status until a new position opened up. Claimant's last day of work for the employer was on November 12, 1996. Light duty work was no longer available to claimant after that date. By the time Dr. Naugle released claimant to regular work on December 13, 1996, claimant's regular position was no longer available due to seasonal lay-offs.

When claimant experienced increased pain while playing pool in January 1997, his left shoulder popped as it did at the time of the October 1996 incident.

Dr. Fuller, orthopedic surgeon, examined claimant for the employer on February 12, 1997.

A March 28, 1997 left shoulder arthrogram was negative for a rotator cuff tear.

STIPULATION

At hearing, the employer accepted claimant's injury claim as a left shoulder sprain.

CONCLUSIONS OF LAW AND OPINION

Compensability

On review, the employer contends that the ALJ erred in setting aside its denial of the tendinitis and bursitis conditions diagnosed by Dr. Webb. We agree.

Resolution of this compensability 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). 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). Here, the record contains causation opinions from the insurer's medical examiner, Dr. Fuller, and the treating physician, Dr. Webb.

Dr. Fuller examined claimant in mid-February 1997 and opined that he had no objective left shoulder diagnosis or abnormality, exhibited symptom magnification, and had recovered from any strain injury he might have experienced as a result of the October 1996 and November 1996 work incidents. Dr. Fuller further opined that the acromioclavicular joint and the rotator cuff tendon are extremely strong and cannot be disrupted with simple pushing or lifting activity, and that the described mechanism of injury was too minimal to injure either the acromioclavicular joint or rotator cuff.

Dr. Webb responded to Dr. Fuller's opinion with the following observation:

> "The issue clearly is related to the amount of force [claimant], necessarily, applied to the box in the conveyer belt when he was trying to push it free in a back hand maneuver on the day of injury. If, indeed, the box was quite heavy and lodged tightly within the conveyer belt mechanism, I can envision a significant amount of force being used and applied quite suddenly in attempt to free it from this fixed position. *Conceivably*, it would be entirely *possible* to have such an event cause the development of a rotator cuff tendinitis problem as well as a subacromial bursitis condition[.] I have no reason to disbelief [claimant] at this point and would assume the amount of force applied was significant and, therefore, *capable* of producing rotator cuff injury. I would, in this regard, respectfully disagree with the comments made by Dr. Fuller pertaining to causation." (Ex. 20, emphases supplied).

The ALJ discounted Dr. Fuller's opinion, finding that he did not address the tendinitis and bursitis diagnoses and incorrectly assumed that claimant's October 1996 work incident did not involve significant force. However, claimant cannot carry his burden of proof merely by discounting opposing medical opinion. Claimant must present medical opinion that affirmatively establishes the compensability of his claim *by a preponderance of the evidence.* Dr. Webb's medical opinion merely discusses the October 1996 work incident as a possible causal factor. Moreover, we disagree with the ALJ's conclusion that the requisite probable causal relationship is established by the fact that Dr. Webb disagreed with Dr. Fuller's causation opinion. The latter did not opine that the October 1996 incident was a possible, but not a probable causal factor. Rather, Dr. Fuller did not characterize the work incident with the tape machine as even a possible contributing cause.

Accordingly, we conclude that Dr. Webb's opinion merely supports a possible causal relationship between the work incidents and claimant's tendinitis/bursitis. There is no other medical opinion in the record supporting compensability of these conditions. Consequently, we conclude that claimant has not established a compensable claim for these additional diagnoses.

Temporary Disability Benefits

The ALJ awarded claimant interim compensation through the date of the employer's February 6, 1997 denial. In so doing, the ALJ rejected the employer's argument that claimant is not entitled to interim compensation because he voluntarily left his modified employment with the employer. On review, the employer reiterates this same argument. We adopt and affirm the ALJ's conclusion and analysis on this issue with the following supplementation.

Claimant testified that he returned to light duty work for the employer the day after the November 8, 1996 incident, and that November 12, 1996 was his last day of work for the employer. On November 15, 1996, Dr. Naugle reported that claimant was waiting for a department change and was not currently working for the employer because there was no light duty in his current department. On February 12, 1997, Dr. Fuller reported that claimant was told that he would have to be on lay-off status while waiting for a position to open up in a different department. Dr. Fuller also noted claimant's report that, by the time he was released to regular work in mid-December 1996, his regular position was no longer available due to seasonal lay-offs.

This evidence supports a finding that further, suitable modified work was not available to claimant after November 12, 1996, when he quit working for the employer. There is no persuasive evidence to the contrary. The company nurse did offer hearsay testimony that claimant stated that he had requested a transfer to another department because he was not getting along with his current co-workers. However, that testimony does not establish that light duty work was available to claimant after his last day of work on November 12, 1996.

ORDER

The ALJ's order dated November 20, 1997 is reversed in part, modified in part, and affirmed in part. That portion of the order that set aside the self-insured employer's denial of claimant's left shoulder rotator cuff tendinitis and subacromial bursitis is reversed, and the denial of these conditions is reinstated and upheld. The ALJ's award of a $3,600 assessed attorney fee is reduced to $1,800. The remainder of the ALJ's order is affirmed.

May 15, 1998 Cite as 50 Van Natta 931 (1998)

In the Matter of the Compensation of
CHARLES L. KITZ, Claimant
WCB Case No. 97-05063
ORDER ON REVIEW
Mitchell & Associates, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by the Board en banc.

Claimant requests review of Administrative Law Judge (ALJ) Tenenbaum's order that upheld the insurer's denial of claimant's injury claim. On review, the issue is subjectivity. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except for the last two sentences.

CONCLUSIONS OF LAW AND OPINION

The following facts are not disputed.

Claimant was employed by the insured as a lead carpenter until late August 1996.

On August 19, 1996, claimant registered as a contractor with the Oregon Construction Contractors Board, under the name "Commando Contracting, Inc." (Commando). (Ex. 2A; Tr. 71).

On August 20, 1996, claimant filed articles of incorporation for Commando, as a business corporation, with the Oregon Secretary of State. (Ex. 2A; Tr. 72). Claimant and his wife are the only people involved in Commando.

On August 22, 1996, claimant and the insured executed a separation agreement and letter of understanding setting out the terms and conditions of claimant/Commando's future work for the insured. (Exs. 3, 4, see Ex. 4A).

Claimant's work for the insured has always involved demolition, carpentry, framing, sheetrocking, and work of that nature. On November 27, 1996, claimant was injured while working on a contract demolition job for the insured. He filed an injury claim, which the insurer denied.

The ALJ upheld the denial, reasoning that claimant was not a subject worker under former ORS 656.005(28) and the "right to control" test. See S-W Floor Covering Shop v. National Council on Compensation Insurance, 318 Or 614 (1994); Woody v. Waibel, 276 Or 189 (1976). We reach a similar result, based on the following reasoning.

In the S-W Floor case, the Supreme Court applied the statutes in effect before the 1995 amendments to the Workers' Compensation Law. The Court concluded:

> "[T]he statutes [former ORS 656.027 and former ORS 656.005(28)] work together in the following manner. A determination first is made as to whether one is a 'worker' before a determination is made as to whether that 'worker' is a 'nonsubject worker' pursuant to one of the exemptions of ORS 656.027. The initial determination of whether one is a 'worker' under ORS 656.005(28) continues to incorporate the judicially created 'right to control' test. One who is not a 'worker' under that test is not subject to the workers' compensation coverage, and the inquiry ends. The 'nonsubject worker' provisions of ORS 656.027 never come into play. If the initial determination made under ORS 656.005(28) is that one is a worker because one is subject to direction and control under the judicially created 'right to control' test, then one goes on to determine under ORS 656.027 whether the worker is 'nonsubject' under one of the exceptions of that statute." 318 Or at 630-31 (emphasis in original).

ORS 656.027 continues to provide that all workers are subject to ORS Chapter 656 except for those nonsubject workers enumerated in the statute's subsections. Current ORS 656.027(24)(b) [1995] sets forth such an exception. It provides:

> "When labor or services are performed under contract for remuneration, notwithstanding ORS 656.005(30),[1] the corporation qualifies as an independent contractor. Any corporation registered under ORS 701.035 and involved in activities subject thereto is conclusively presumed to be an independent contractor." (Emphasis added).[2]

The amended statute applies in the present case. We construe the statute based on its text. See ORS 174.010. PGE v. Bureau of Labor and Industries, 317 Or 606, 611 (1993). The terms of the statutory independent contractor exemption (set out in ORS 656.027(24)(b)) plainly provide that independent contractor status is determined "notwithstanding ORS 656.005(30)." In other words, we must now apply the statutory test regarding the independent contractor exemption without reference to the definition of "worker" set out in ORS 656.005(30).

In addition, the text of ORS 656.027(24)(b) provides that corporate registration under ORS 701.035, together with involvement in activities under a contract for remuneration and subject to ORS

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[1] ORS 656.005(30) defines "worker" as "any person . . .who engages to furnish services for remuneration, subject to the direction and control of an employer. . . ."

[2] At the time of S-W Floor, the applicable subsections of ORS 656.027 did not include the phrase, "notwithstanding ORS 656.005(30)," or the conclusive presumption for registered corporations.

701.035, lead to a conclusive presumption[3] that the registrant corporation is an independent contractor.[4] Thus, the "notwithstanding" and "conclusive presumption" elements of ORS 656.027(24) together replace the common law "right to control" test (and the weighing inherent in ORS 656.005(31) and 670.600) in cases involving corporations under the circumstances specified in the statute.

Accordingly, we evaluate whether claimant/Commando was a nonsubject worker under ORS 656.027(24)(b), by determining whether the Commando Corporation was registered under ORS 701.035 and involved in activities subject to that statute when claimant was injured (without first considering whether claimant was a "worker" under ORS 656.005(30)).

Here, claimant was performing labor or services "under contract for remuneration" at the time of his injury. He was registered as a corporate independent contractor under ORS 701.035 and his activities at the time of injury involved demolition, i.e., construction work subject to 701.035. See ORS 701.035(4); 701.060(2). Consequently, claimant/Commando is "conclusively presumed" to be an independent contractor under ORS 656.027(24) and he is therefore not among those statutorily defined as subject workers. Under these circumstances, we conclude that the insurer's denial must be upheld.

ORDER

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

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[3] "Although presumptions are generally considered to be evidentiary rules, Wiebe v. Seely, Administrator, 215 Or 331, 359 (1959), a conclusive presumption is not an evidentiary rule, but a rule of substantive law. State v. Elliott, 234 Or 522, 526-527, (1963); accord McCormick, Evidence, Sec. 342 (3rd ed. 1984). It is substantive because, once the basic fact giving rise to a conclusive presumption is established, the presumed fact must be taken as true and the adverse party is prohibited from disputing the presumed fact." State ex rel. Juvenile Dept. of Deschutes County v. Merritt, 83 Or App 378 (1987) (final citations omitted).

[4] We consider the context of ORS 656.027(24), as well as its text. See PGE v. Bureau of Labor and Industries, 317 Or at 611. In so doing, we note that ORS 656.005(31) defines "independent contractor" with reference to ORS 670.600 (and the latter statute essentially mirrors the "right to control" test). We do not find the definition controlling in the present case because ORS 656.027(24)(b) is specific to corporations registered under ORS 701.035 (such as Commando), while the former statute is general. See ORS 174.020; Smith v. Multnomah County Board of Commissioners, 318 Or 302, 309 (1994) (specific statute takes precedence over an inconsistent general statute related to the same subject). See also S-W Floor, 318 Or at 631 (giving no effect to potentially inconsistent related statutes); Parker Furniture v. National Council on Compensation Ins., 128 Or App 466, 469 n. 2 (1994).

Board Member Hall specially concurring.

I agree with the majority that claimant is an independent contractor, not a subject worker, because of the conclusive presumption created by ORS 656.027(24)(b). However, I disagree with the majority's evaluation of the statute's context, specifically the definition of "independent contractor" in ORS 656.005(31). (*See* n. 4, *supra*, and accompanying text).

I would not suggest that the "right to control" test set out in the ORS 656.005(31) "independent contractor" definition is potentially inconsistent with the conclusive presumption imposed by ORS 656.027(24)(b). Rather, I would say that, under the latter statute, certain registered "independent contractors" are nonsubject workers because the statutory presumption *satisfies* the "right to control" test in the former statute. Nonetheless, because my interpretation of the statutes would not affect the outcome, I concur in the result.

In the Matter of the Compensation of
DARWIN K. SAUNDERS, Claimant
WCB Case Nos. 97-05332 & 97-05331
ORDER ON REVIEW
Nancy Meserow, Defense Attorney

Reviewed by Board Members Moller and Biehl.

Claimant, pro se, requests review of those portions of Administrative Law Judge (ALJ) Herman's order that: (1) declined to award penalties for the insurer's allegedly late payment of scheduled permanent disability; (2) found that claimant was barred by claim preclusion from raising the issue of sanctions for the insurer's allegedly "malicious" filing of a request for hearing on an Order on Reconsideration; (3) found that claimant was barred by claim preclusion from requesting a penalty for the insurer's alleged failure to provide discovery in a prior proceeding; (4) found that the Hearings Division had no jurisdiction over the medical services issues raised by claimant; (5) found that the Hearings Division had no jurisdiction over payment of additional temporary disability benefits; (6) held that claimant was barred by claim preclusion from raising the issue of the rate of temporary disability; (7) declined to award penalties for alleged discovery violations in the present case; and (8) declined to order reimbursement of claimant's alleged litigation costs. In his brief, claimant contends that, alternatively, these issues should be remanded for a new hearing before ALJ Hoguet. On review, the issues are remand, penalties, res judicata, jurisdiction, and costs. We deny the motion for remand, and affirm.

FINDINGS OF FACT

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

In December 1994, claimant compensably injured both thumbs. The claim was closed on April 17, 1995 by Determination Order, which awarded temporary disability from December 29, 1994 through February 1, 1995, and no permanent disability. (Ex. 22A). Each party requested reconsideration. An August 3, 1995 Order on Reconsideration modified the temporary disability award to the period December 29, 1994 through January 6, 1995, and awarded 7 percent scheduled permanent disability for the left hand and 7 percent scheduled permanent disability for the right thumb. (Ex. 51). Each party requested a hearing. The insurer stayed payment of permanent disability.

Meanwhile, on January 16, 1995, claimant compensably injured his back and neck. The insurer accepted "cervico thoracic and lumbar strain." (Ex. 22). On March 1, 1995, claimant filed a claim for a left shoulder injury. On July 28, 1995, the insurer denied claimant's current back and neck condition on the basis that the January 1995 injury was no longer the major contributing cause of his current need for treatment and disability. (Ex. 48). The insurer terminated temporary disability effective that date. On October 20, 1995, the insurer denied claimant's left shoulder claim. On January 29, 1996, the insurer amended its July 28, 1995 denial to partially deny claimant's diagnosed degenerative conditions. (Ex. 65).

A hearing on the Order on Reconsideration's scheduled permanent disability award for claimant's thumbs and the insurer's denials of the shoulder, back and neck claims convened before ALJ Hoguet on July 10, 1996 and closed February 21, 1997. A March 19, 1997 Opinion and Order, as amended May 22, 1997, affirmed the Order on Reconsideration and upheld the insurer's October 20, 1995 left shoulder denial in its entirety. ALJ Hoguet upheld the July 28, 1995 denial, as amended, which he construed as a partial denial solely of claimant's current neck conditions. (Exs. 70, 76). This order was not appealed. On June 18, 1997, the insurer issued a check in payment of the compensation ordered by the Order on Reconsideration.

Claimant's back claim was closed by a June 18, 1997 Determination Order that awarded 5 percent unscheduled permanent disability and temporary disability for the periods from January 16, 1995 through February 1, 1995 and from March 13, 1995 through July 27, 1995. (Ex. 82). Neither party requested reconsideration.

On June 26, 1997, claimant filed a request for hearing raising the issue of entitlement to temporary disability on the back claim for the period July 28, 1995 through October 1, 1995, the date he was released to regular work.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that: (1) the insurer had timely paid claimant's permanent disability award from the August 3, 1995 Order on Reconsideration on the thumb claim and, therefore, claimant was not entitled to a penalty for the insurer's allegedly late payment; (2) claimant was barred by claim preclusion from raising the issue of sanctions for the insurer's appeal of the permanent disability award on the thumb claim; and (3) claimant was barred by claim preclusion from raising the issue of the insurer's alleged failure to provide documents in the earlier proceeding before ALJ Hoguet.

In regard to the back claim, the ALJ found that: (1) the Director, not the Hearings Division, had jurisdiction over claimant's medical services issues; (2) claimant was precluded from contesting the temporary disability award granted by the June 18, 1997 Determination Order or from disputing the rate at which such benefits were paid by virtue of his failure to request reconsideration; and (3) no penalty was due for the insurer's alleged failure to provide discovery. On review, claimant disagrees with the ALJ's opinion on each of the above issues.[1] We affirm the ALJ.

Remand

Claimant requests that, if he does not prevail on review (and he does not), we remand this case to a different ALJ for a new hearing to address the issues upon which he was allegedly not allowed to present evidence or argument at hearing. Claimant has also appended a number of documents to his Appellant's Brief. Because we have no authority to consider evidence not admitted at hearing, we treat claimant's submission of additional documentary evidence as a motion to remand to the ALJ for admission of the documents. We address each motion separately and deny remand.

We interpret claimant's first motion for remand as a contention that this matter should be remanded on the basis that he did not receive a fair and meaningful hearing.

We may remand to the ALJ should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5).

In this case, claimant, who was unrepresented by counsel,[2] had a hearing before ALJ Herman. Claimant raised a number of issues that either should have been raised at the prior proceeding before ALJ Hoguet (allegedly "frivolous" appeal, failure to provide documents, additional procedural temporary disability benefits) or were issues over which the ALJ had no jurisdiction (medical services, substantive temporary disability benefits, and temporary disability rate). The ALJ explained to claimant why she was unable to address those issues. (Tr. 6, 7, 10, 14, 18, 25, 27, 28, 31). The ALJ also informed claimant that she would respond in her opinion to each and every issue he had raised. Thereafter, the ALJ issued an opinion on each issue claimant had raised, relying on the record and a transcript of the hearing.

In the ALJ's order, claimant prevailed on a number of issues but not on others, including those which should have been raised at the prior proceeding and those over which the ALJ had no jurisdiction. Under these circumstances, we are not persuaded that claimant did not receive a fair and meaningful hearing on all the issues, including the ones on which he did not prevail. See Roderick A. Mespelt, 42 Van Natta 531 (1990). Accordingly, we do not find that the record has been improperly, incompletely or otherwise insufficiently developed and decline to remand the matter for a new hearing on these grounds.

We may also 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); Bailey v. SAIF, 296 Or 41, 45 n. 3 (1985). In order to satisfy this standard, a compelling reason must be shown for remanding. A compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986). We examine the proffered evidence only to determine if remand would be appropriate.

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[1] Claimant also raises the issue of the insurer's failure to pay for 4 hours of time loss while attending the April 18, 1997 arbiter examination. Claimant admits that payment has been made. (Appellant's Brief at 4). Accordingly, the issue is moot.

[2] The ALJ asked claimant more than once during the hearing if he wished to obtain counsel. Claimant clearly declined to be represented in the case. (Tr. 2, 31, 38).

We find that all but one of the documents submitted by claimant existed at the time of the hearing. (Exs. A1 through A28 and A30). Thus, these documents either were obtainable at the time of hearing or were admitted into the record. The post-hearing report (Ex. A29) consists of a November 26, 1997 letter from the insurer's counsel to the Oregon State Bar. This document contains insurer's counsel's assertion that all claims documents in her possession were timely provided to opposing counsel or to claimant himself, which is cumulative of the evidence already in the record. Moreover, the admission of the document would not change our conclusion that the insurer timely provided the documents requested. Thus, admission of the document would not affect the outcome of the case and we find no compelling reason to remand for admission of this evidence. Accordingly, claimant's motion is denied.

Bilateral Thumb Claim

Penalty for Untimely Payment of the August 3, 1995 Order on Reconsideration

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

Sanctions for Insurer's Allegedly "Malicious" Filing of Request for Hearing on the August 3, 1995 Order on Reconsideration

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

After our review of the record, we conclude that the ALJ correctly decided the issue by applying the doctrine of claim preclusion. That doctrine bars litigation of a claim based on a set of facts which was or could have been litigated between the parties in a prior proceeding. Drews v. EBI Companies, 310 Or 134, 140 (1990); SAIF Corp. v. Hansen, 126 Or App 662, 665 (1994).

Claimant had the opportunity to raise the claim for sanctions at the July 1996 hearing before ALJ Hoguet. Claimant's entitlement to the scheduled permanent disability benefits granted by the August 3, 1995 Order on Reconsideration was raised and litigated at that hearing. The same parties were present and the ALJ considered evidence concerning claimant's permanent impairment. The ALJ also considered the persuasiveness of the arguments presented by the insurer in contesting that award. Claimant's request for sanctions arose out of the same set of facts and would have involved consideration of the same evidence. Claimant could have pursued his claim for sanctions at that time. He did not. Therefore, he was barred from doing so at this proceeding.[3] Consequently, because claimant could have raised the claim for sanctions at the prior hearing, he is now barred from prosecuting that claim against the same insurer in this action.[4]

Penalty for Insurer's Alleged Failure to Provide Discovery at Prior Hearing

For the same reasons given above, claimant is barred by the doctrine of claim preclusion from raising the penalty request at this proceeding.

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[3] Claimant's citations to authorities in support of his argument that ALJ Herman improperly applied claim preclusion principles to this and other issues do not support his position. Claimant's citations are to authorities which state that issue preclusion bars only issues that were actually determined and essential to the prior litigation. Issue preclusion and claim preclusion, while similar, are two entirely distinct doctrines which apply under different circumstances. In contrast to issue preclusion, which applies only to issues previously litigated, claim preclusion applies to all claims that could have been raised and litigated at a prior proceeding.

[4] Even if claimant was not barred from prosecuting the claim for sanctions against the same insurer in this action, there is no evidence that the insurer's request for hearing on the Order on Reconsideration was frivolous or filed in bad faith or for the purpose of harassment. See ORS 656.390(1). "Frivolous" means the matter is not supported by substantial evidence or is initiated without reasonable prospect of prevailing. ORS 656.390(2). The insurer presented a colorable argument at the prior hearing that was sufficiently developed so as to create a reasonable prospect of prevailing on the merits. While the insurer's argument on review did not ultimately prevail, we cannot say it was "frivolous." Jack B. Hooper, 49 Van Natta 669 (1997); Donald M. Criss, 48 Van Natta 1569 (1996). Accordingly, had claimant not been barred from bringing the sanctions claim in this proceeding, we would in any case deny claimant's request.

Cervical, Thoracic and Lumbar Strain Claim

Medical Services

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

The issue of the compensability of claimant's current neck condition was decided in the prior proceeding. In the case before us, claimant raised the issue of insurer's alleged failure to pay medical bills and other medical services issues in his requests for hearing. Thus, because the issue before the ALJ at hearing was claims for medical services only, and did not involve a formal denial of the underlying condition, the ALJ had no jurisdiction to address the issue. ORS 656.245(6); SAIF v. Shipley, 326 Or 557 (1998) (Board does not have authority to conduct a hearing involving a medical services dispute).

Entitlement to Temporary Disability and Rate of Temporary Disability

We adopt and affirm the ALJ's opinions on these issues.[5]

Discovery

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

Request to Recover Costs

Claimant contends that he is entitled to reimbursement for various costs associated with his pursuit of this litigation. He cites no authority for such an award. We have previously held that litigation expenses generally must be borne by the parties. Marilyn Keener, 49 Van Natta 110, 113 (1997) (costs incurred by an attorney in pursuing a matter on behalf of a party are not included in amounts that the Board can authorize an opposing party to pay); see also Stephanie J. Thomas, 43 Van Natta 1129 (1991). Consequently, we decline to order the insurer to pay claimant's costs.

ORDER

The ALJ's order dated November 26, 1997 is affirmed.

[5] We acknowledge that ALJ Hoguet construed the insurer's denial of July 28, 1995, as amended January 29, 1996, to apply solely to the cervical strain component of claimant's compensable condition, and stated that the thoracic and lumbar components of claimant's compensable condition were not affected in any way by the March 19, 1997 order, as amended May 22, 1997. (Exs. 70-8, -9; 76-2). This clarification, however, has no effect on the ALJ's conclusion that there was no enforcement action to bring, as the issue of reinstatement of temporary disability was not before ALJ Hoguet.

May 15, 1998 Cite as 50 Van Natta 937 (1998)

In the Matter of the Compensation of
MICHAEL C. LEGGETT, Claimant
WCB Case No. 96-07715
ORDER ON RECONSIDERATION
Popick & Merkel, Claimant Attorneys
VavRosky, et al, Defense Attorneys

Claimant requested abatement and reconsideration of our February 11, 1998 order that affirmed an Administrative Law Judge's (ALJ's) order that found claimant medically stationary on April 25, 1996, declined to award additional temporary disability benefits, and affirmed an Order on Reconsideration that did not award permanent disability. Claimant contended that our reconsideration of a companion case, *Michael C. Leggett*, WCB No. 96-04719, which was abated at the employer's request, was likely to affect our deliberations concerning the claim closure in this case.

In order to further consider this matter, we withdrew our February 11, 1998 order. Our Order on Reconsideration in WCB No. 96-04719 issued on April 16, 1998. *Michael C. Leggett*, 50 Van Natta 754 (1998). To assist us in conducting our reconsideration, the parties were granted an opportunity to submit supplemental briefs. The briefing schedule for submitting such briefs has expired. Thus, we have proceeded with our reconsideration without benefit of further argument from the parties.

For the reasons set forth in our prior order, we remain persuaded that claimant became medically stationary on April 25, 1996 and that no award of additional temporary or permanent disability is appropriate.

On reconsideration, as supplemented herein, we adhere to and republish our February 11, 1998 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

May 18, 1998 Cite as 50 Van Natta 938 (1998)

In the Matter of the Compensation of
DEBRA L. COTTON, Claimant
WCB Case No. 97-07748
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Menashe's order that directed it to pay claimant interim compensation. On review, the issue is interim compensation.

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

On review, the employer contends that claimant was not in the work force at the time of her disability in July 1997. We disagree. A claimant is in the work force if: (1) the claimant is engaged in regular gainful employment; (2) the claimant, although not employed, is willing to work and making reasonable efforts to obtain employment; or (3) the claimant is willing to work, although not employed and not making reasonable efforts to obtain employment because of a work-related injury, where such efforts would be futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

Claimant has an accepted claim for bilateral carpal tunnel syndrome. After her claim was closed in 1995, claimant developed increasing pain in the upper extremities. She sought treatment from Dr. Long on July 7, 1997; he released her for only "very light, non-repetitive hand work" and declared that she was unable to perform her regular job. (Ex. 17-5). Prior to seeing Dr. Long in July 1997, claimant last worked as a motel housekeeper from December 1996 to mid-February 1997. She testified that she quit the motel job because of upper extremity pain and did not look for work because her arms were hurting all the time. (Tr. 8). She further testified that, if her upper extremities had not been hurting, she would still be working. (Tr. 8-9).

Claimant's testimony is not rebutted and is consistent with Dr. Long's July 1997 report that claimant expressed concern that if she attempted to work again, she would not be able to maintain productive employment. (Ex. 17-2). Therefore, based on claimant's unrebutted testimony, we find that claimant's efforts to obtain work, such as the motel job, prior to her disability in July 1997, were reasonable under the circumstances. Furthermore, even if we were to find that claimant's job-seeking efforts were not reasonable, we would find that such efforts were futile because of claimant's increasing pain in the upper extremities, a condition that Dr. Long declared to be disabling in July 1997. Accordingly, we agree with, and adopt, the ALJ's finding that claimant was in the work force at the time of her disability and is therefore entitled to interim compensation.

The employer argues that claimant's testimony alone is not sufficient to prove that work search efforts were futile.[1] However, as we noted above, claimant's testimony was supported by Dr. Long's

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[1] In support of this argument, the employer cites to three orders issued by the Board pursuant to its "own motion" authority under ORS 656.278: *Earl J. Prettyman*, 46 Van Natta 1137 (1994), *Ben L. Davis*, 47 Van Natta 2001 (1995), and *Gene A. Sevey*, 50 Van Natta 242 (1998). In each of those "own motion" cases, the claimant failed to provide either medical/vocational evidence or sworn testimony to support his allegations (*e.g.*, regarding willingness to obtain work). By contrast, in this case, claimant presented both medical evidence and sworn testimony to carry her burden of proof on the work force issue.

assessment that claimant's upper extremity symptoms restricted her to "very light, non-repetitive hand work." (Ex. 17-5). Dr. Long's expert medical assessment establishes that claimant's symptoms in the upper extremities were disabling and therefore rendered any work search efforts futile.

Finally, the employer argues that claimant's entitlement to interim compensation is contingent on her proving the compensability of her current upper extremity condition. Asserting that claimant's current condition has been found noncompensable by another ALJ, and that claimant has not yet requested review of that ALJ's order, the employer argues that claimant is not entitled to interim compensation. However, it is well-settled law that the purpose of interim compensation is to compensate an injured worker for leaving work prior to the acceptance or denial of the claim, even if the worker left work due to a noncompensable condition. *See Bono v. SAIF*, 298 Or 405, 410 (1984). Accordingly, claimant is entitled to the payment of interim compensation.

Claimant's attorney is entitled to an assessed fee for services on review. *See* ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable attorney fee for claimant's services on review is $850, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 8, 1998, as reconsidered on February 9, 1998, is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $850, payable by the self-insured employer.

May 18, 1998 Cite as 50 Van Natta 939 (1998)

In the Matter of the Compensation of
ATHER FRAZIER, Claimant
WCB Case No. 97-0076M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Martin Alvey, Claimant Attorney
Reinisch, et al., Defense Attorneys

Claimant requests review of the insurer's January 30, 1998 Notice of Closure which closed his claim with an award of temporary disability compensation from March 17, 1997 through December 23, 1997. The insurer declared claimant medically stationary as of December 23, 1997. Claimant contends that he 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 he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the January 30, 1998 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).

The insurer relies on a December 23, 1997 doctor's report from claimant's treating physician, Dr. Strudwick, to support its contention that claimant was medically stationary on December 23, 1997. In his report, Dr. Strudwick opined that:

> "[Claimant] has reached his maximum improvement with respect to his knee, according to the therapist."
>
> "He is now permanent and stationary, maximally medically improved, and ratable."

However, subsequent to the January 30, 1998 claim closure, Dr. Strudwick examined claimant on February 11, 1998. On April 29, 1998, he authored a report wherein he changed his opinion regarding claimant's medically stationary status. Dr. Strudwick explained his change of opinion as follows:

> "When I initially saw [claimant] on December 23, 1997, I felt that he had more or less plateaued over the preceding weeks prior to that visit. When I filled out the form dated December 9, 1997, I had last seen him on 10/21/97. At that time, I felt that he would become maximally, medically improved by approximately 2/1/98. But when I saw him on December 23, 1997, I felt that he had continued to have the same approximate range of motion that he had had on my previous examination.
>
> "However, subsequent to that I had seen him and noted that he did improve in his condition. Therefore, retrospectively, I would say and although I have not seen [claimant] in the last few weeks, I believe that he did become permanent and stationary and maximally medically improved at approximately one year following his surgery which was on 4/7/97 which would make him maximally medically improved on 4/7/98.
>
> "That would mean that he is permanent and stationary at this time and that my note on December 23, 1997 should be considered revised. I last saw [claimant] on February 11, 1998, according to my records and felt that he had gained almost full extension and was up to 95 degrees in flexion. That demonstrates his progress from the time that I had originally thought he may have been maximally medically improved on December 23, 1997."

Evidence that was not available at the time of closure may be considered to the extent the evidence addresses the condition at the time of closure. *Scheuning v. J.R. Simplot & Co.*, 84 Or App 622, 625 (1987). Here, Dr. Strudwick's retracted his earlier opinion that claimant was medically stationary on December 23, 1997 and opined that claimant's condition had materially improved since that examination. Dr. Strudwick's April 29, 1998 opinion was based on a medical examination conducted on February 11, 1998, just 12 days after the insurer closed the claim. We conclude that claimant's condition on February 11, 1998 was essentially the same as it was at the January 30, 1998 claim closure. *See Scheuning v. J.R. Simplot & Co.*, 84 Or App at 622. Further, Dr. Strudwick used objective findings to support his change of opinion. Finally, Dr. Strudwick's opinion is unrebutted. Thus, we find that Dr. Strudwick persuasively explained his change of opinion regarding claimant's medically stationary status. Thus, we conclude that claimant was not medically stationary on January 30, 1998 when his claim was closed by the insurer.

Therefore, we set aside the insurer's January 30, 1998 Notice of Closure. When it is appropriate, the claim shall be closed by the insurer pursuant to OAR 438-012-0055.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
DANIEL W. GARRIS, Claimant
WCB Case No. 97-05760
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Galton's order that: (1) found that the Hearings Division had jurisdiction over the temporary disability issue; and (2) directed the employer to pay procedural temporary total disability compensation from January 27, 1997 through June 30, 1997. On review, the issues are jurisdiction and temporary disability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the following correction, summary and supplementation. Although claimant saw Ms. Jane Jones at Kaiser, she was not identified as a physician. (Ex. 17).

Claimant sustained a compensable low back injury on May 22, 1996. The employer accepted the claim as a "low back strain, rule out herniated nucleus pulposus." (Ex. 18-2). On November 4, 1996, the claim was closed by Determination Order. Id.

On November 6, 1996, claimant began treating with Dr. Gambee, who took claimant off work. (Ex. 18-2). Dr. Gambee became claimant's attending physician on November 18, 1996. (Ex. 18-2). On November 19, 1996, Dr. Gambee filed an aggravation claim on claimant's behalf and continued the off-work authorization, noting that time-loss was authorized from "11-6-96 thru present & continuing." (Exs. 7, 18-2). Dr. Gambee also noted that claimant was scheduled for a follow-up exam on November 20, 1996. Id. Subsequently, Dr. Gambee ordered a MRI, which was performed on December 17, 1996. (Ex. 10).

The employer paid interim compensation at temporary total disability rates through December 20, 1996, at which time it denied compensability of both claimant's aggravation claim and his then-current condition.

On December 26, 1996, Dr. Gambee re-examined claimant and reviewed the MRI scan. (Ex. 11, 18-3). Dr. Gambee reported that he would recheck claimant's progress in a month and gave claimant a modified "work release with no lifting more than 30 lbs. and no repetitive bending, stooping or twisting." (Ex. 11). The employer did not offer claimant any modified work at that time. (Tr. 9-10).

Upon learning that he would be responsible for any post-denial medical bills if the denial was not reversed, claimant began treating at Kaiser, his private insurance carrier. (Tr. 9).

By order dated June 13, 1997, a prior ALJ set aside the employer's December 20, 1996 denial, finding both the aggravation claim and claimant's current condition compensable. (Ex. 18).

On June 26, 1997, the employer offered claimant modified work. (Ex. 19). Claimant reported to the modified job on June 30, 1997, as directed. (Tr. 10).

On June 27, 1997, the employer paid claimant for temporary disability from December 21, 1996 through January 26, 1997 "per Dr. Gambee's chart note of Dec[ember] 26, 1996." (Ex. 20). The employer also notified claimant that Kaiser physicians did not qualify as attending physicians, because they were not members of the employer's MCO. Id.

On July 1, 1997, claimant returned to Dr. Gambee, who gave him a modified/light duty work release with restrictions of "no lifting more than 40 lbs., not repetitive bending, stooping, twisting." (Ex. 22).

Claimant requested a hearing, seeking temporary total disability from January 27, 1997 through June 30, 1997.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

At hearing, the employer argued that Atchley v. GTE Metal Erectors 149 Or App 581, rev den 326 Or 133 (1997), compelled a finding that the temporary disability benefits claimant was seeking were substantive temporary disability benefits, and, as such, original jurisdiction was with the Director under the reconsideration process. The ALJ rejected the employer's argument. Relying on Alfredo Martinez, 49 Van Natta 68 (1997), the ALJ reasoned that, because claimant's aggravation claim was in open status, the temporary disability benefits he sought were procedural benefits, not substantive benefits. Therefore, the ALJ concluded that the Hearings Division had jurisdiction over claimant's claim for procedural temporary disability benefits. We agree.

On review, the employer notes that, whereas our decision in Martinez divides substantive benefits from procedural benefits on the basis of whether the claim is open or closed, Atchley bases the distinction on whether the benefit "is made explicit and unconditional by statute," or "is conditional, arising solely from the vagaries of claim processing." The employer argues that the Atchley holding requires an analysis of whether the benefits sought are conditional or unconditional. The employer further argues that the benefits claimant seeks are unconditional and, therefore, pursuant to Atchley, those benefits are substantive benefits, which must first go through the reconsideration process under the jurisdiction of the Director. Thus, the employer argues, the Hearings Division and the Board do not have jurisdiction over this issue. We disagree.

The employer questions whether any distinction remains between substantive and procedural temporary disability benefits. In Kenneth P. Bundy, 48 Van Natta 2501 (1996), we determined that the distinction between substantive and procedural temporary disability benefits remains viable after the 1995 legislative changes.[1]

In addition, the court has consistently recognized the distinction between procedural and substantive temporary disability benefits. Santos v. Caryall Transport, 152 Or App 322 (1998); Foster Wheeler Constructors, Inc. v. Parker, 148 Or App 6, 11-12 (1997); Vega v. Express Services, 144 Or App 602, 605-08, rev den 325 Or 446 (1997); Lebanon Plywood v. Seiber, 113 Or App 651 (1992). In fact, in Atchley, the court continued to recognize that distinction and explained that "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." 149 Or App at 585.

In Atchley, a Determination Order awarded the claimant temporary disability during the time he participated in an authorized training program (ATP). However, the claimant contended that, under the terms of former OAR 436-60-040(3), he was also substantively entitled to temporary disability from the date the ATP ended until the Determination Order was issued by the Department. The Board disagreed. Characterizing the claimant's right to temporary disability benefits during the period in question as procedural rather than substantive, the Board applied Lebanon Plywood v. Seiber and declined to award further temporary disability benefits.

The court reversed, agreeing with the claimant that former OAR 436-60-040(3) provided substantive entitlement to temporary disability benefits. In reaching its decision, the court relied on Roseburg Forest Products v. McDonald, 116 Or App 448 (1992), and Anodizing, Inc. v. Heath, 129 Or App 352 (1994). In Roseburg Forest Products the court held 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. In Anodizing, Inc., the court held that, because the current version of ORS 656.313(1)(a)(A) unconditionally entitles a claimant to temporary disability benefits that accrue during the pendency of an appeal, a claimant is entitled to those benefits regardless of the outcome of the appeal. The court reasoned that, unlike Lebanon Plywood, no overpayment of benefits results because an employer would not be entitled to recoup those benefits if successful in obtaining a reversal of the order on reconsideration.

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[1] The employer questions the viability of our decision in Bundy, noting that that decision is currently before the Court of Appeals. Nevertheless, unless and until our holding in Bundy is overturned, it remains good law.

The Atchley court found that the case before it resulted in a substantive entitlement to temporary disability benefits because, unlike Lebanon Plywood, but similar to Roseburg Forest Products and Anodizing, Inc., the entitlement to benefits was explicit in that former OAR 436-60-040(3) mandated the continued payment of temporary disability benefits for a specified period. Atchley, 149 Or App at 585. The court found that, if the requirements of former OAR 436-60-040(3) were met, the rule made unconditional the payment of temporary disability until issuance of the redetermination order. Thus, the court concluded that such payment was a substantive entitlement. Because claimant's situation during the period in question was "exactly as described in the rule," the court found that the claimant was entitled substantively to temporary disability payments during that period. Atchley, 149 Or App at 586. Accordingly, the court concluded that the Board erred in applying Lebanon Plywood and denying the claimant those temporary disability benefits.

Here, the employer argues that the requested benefits are unconditional in that, if claimant meets the statutory criteria, i.e., obtains pre-authorization for time loss from an attending physician, he will get temporary disability benefits. We disagree with the employer's analysis.

In the first place, under the employer's analysis, the distinction between procedural and substantive benefits would be eliminated. In this regard, whenever a claimant meets the statutory criteria for obtaining a benefit, he or she is entitled to that benefit. Therefore, under the employer's analysis, all entitlement to benefits would constitute substantive entitlement. However, as addressed above, the court has continued to find a distinction between procedural and substantive benefits.

Furthermore, contrary to the employer's argument, Atchley did not limit the analysis of procedural and substantive benefits solely to whether the benefit was conditional or unconditional. Instead, as quoted above, the court held that a substantive benefit is one that a statute makes "explicit and unconditional," whereas a procedural benefit is conditional and arises "solely from the vagaries of claim processing." 149 Or App at 585 (emphasis added). This distinction is made clear by examining the facts of Atchley, Roseburg Forest Products, and Anodizing, Inc. In those cases, once the terms of the applicable statute or rule were met, the applicable statute or rule made payment of benefits explicit and unconditional. That is, in Roseburg Forest Products, and Anodizing, Inc., the applicable statutes explicitly required payment of temporary disability benefits during the pendency of an appeal, with no resulting overpayment regardless of the outcome of the appeal. In Atchley, the applicable rule explicitly required payment of temporary disability benefits from the end of the ATP until redetermination by the Department, with no resulting overpayment.

In contrast, here, the applicable statute provides for payment of temporary disability benefits if authorized by an attending physician; however, no explicit benefit period is provided by statute. ORS 656.262. Furthermore, at claim closure, claimant's entitlement to temporary disability benefits will be determined pursuant to ORS 656.210 and 656.212 and is proven by a preponderance of the evidence in the entire record showing that claimant was disabled due to the compensable injury before being declared medically stationary. Lebanon Plywood v. Seiber, 113 Or App at 654; Kenneth P. Bundy, 48 Van Natta at 2503. Therefore, at claim closure, it could be determined that claimant was overpaid temporary disability benefits during the time his claim was open. This possibility demonstrates that, contrary to the employer's argument, the payment of temporary disability benefits in an open claim is conditional and arises "solely from the vagaries of claim processing." Thus, pursuant to the reasoning in Atchley, claimant's entitlement to temporary disability benefits in his open claim constitutes a procedural entitlement and, as such, is within the jurisdiction of the Hearings Division and the Board. Therefore, we proceed to the merits.

Temporary Disability Benefits

The ALJ awarded claimant procedural temporary total disability from January 27, 1997 through June 30, 1997. We adopt the ALJ's reasoning and conclusions on this issue, with the following supplementation.

Temporary disability compensation is payable if authorized by the attending physician. ORS 656.262(4)(a). All parties agree that Dr. Gambee was claimant's attending physician at the time of the employer's December 20, 1996 denial of claimant's aggravation claim and claimant's follow-up exam on December 26, 1996.

After the denial, upon learning that he would be responsible for any post-denial medical bills if the denial was not reversed, claimant began treating at Kaiser, his private insurance carrier. However, it is not clear that claimant obtained an attending physician at Kaiser.[2] Nevertheless, because we find that Dr. Gambee establishes claimant's entitlement to temporary disability benefits during the period in question, we need not consider whether claimant obtained an attending physician at Kaiser during the period his aggravation claim remained denied.

The employer argues that claimant does not meet the requirements of OAR 436-060-0020(11)[3] that would entitle him to temporary disability benefits for the period in question. Specifically, the employer argues that Dr. Gambee's time loss authorization was not open ended at the time of the denial. We disagree.

On November 18, 1996, Dr. Gambee released claimant from all work from November 6, 1996 through November 20, 1996. (Ex. 6). However, on November 19, 1996, Dr. Gambee filed an aggravation claim on claimant's behalf and continued the off-work authorization, noting that time-loss was authorized from "11-6-96 thru present & continuing." (Exs. 7, 18-2). Dr. Gambee also noted that claimant was scheduled for a follow-up exam on November 20, 1996. Id. Subsequently, Dr. Gambee ordered an MRI, which was performed on December 17, 1996. (Ex. 10) On December 20, 1996, the employer denied compensability of both claimant's aggravation claim and his then-current condition.

We find that the November 19, 1996 aggravation form was Dr. Gambee's last word on claimant's ability to work prior to the December 20, 1996 denial. Furthermore, that time loss authorization was open ended. In addition, there is no indication that claimant missed the November 20, 1996 follow-up exam. Moreover, the fact that an MRI ordered by Dr. Gambee was performed on December 17, 1996 indicates that Dr. Gambee saw claimant before that date. Finally, claimant next saw Dr. Gambee on December 27, 1996, at which time he was released to modified work "with no lifting more than 30 lbs. and no repetitive bending, stooping or twisting." (Ex. 11). There is no evidence that Dr. Gambee changed claimant's release from work between November 19, 1996 and December 20, 1996, the date of the aggravation denial. Therefore, we find that claimant's time loss was open ended at the time of the denial. Accordingly, pursuant to OAR 436-060-0020(11), claimant is entitled to temporary disability, unless there are other lawful bases to terminate it.

Following the reversal of its aggravation denial, the employer paid temporary total disability from December 21, 1996 through January 26, 1997 based on Dr. Gambee's December 26, 1996 chart note. (Ex. 20). The employer apparently terminated temporary disability benefits as of January 26, 1997 based on Dr. Gambee's notation that he would recheck claimant's progress in a month. (Ex. 11). However, as noted above, claimant began treating at Kaiser following the denial. In any event, the notation of a recheck of claimant's progress in a month, without more, does not establish that the work restrictions were limited to a one month period. In fact, subsequent events establish that the modified work restriction was ongoing.

Following reversal of the denial, claimant returned to Dr. Gambee, who continued claimant's modified work release and concluded that it was his opinion "all along that [claimant was] capable of

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[2] An "attending physician" is the physician who is primarily responsible for the treatment of a worker's compensable injury. ORS 656.005(12)(b). ORS 656.005(12) requires an attending physician to be a medical doctor licensed under ORS 677.100 to 677.228. Although claimant was seen by at least one physician's assistant at Kaiser, it appears that he was seen only once by a physician (Dr. Peacock), who advised claimant to find a primary care physician or pursue his claim with workers' compensation, but not to return to Kaiser's occupational health clinic until he decided which he was doing. (Ex. 17). Thus, it appears that Dr. Peacock did not assume the duties of an attending physician. Moreover, we decline claimant's invitation to find that the physician's assistant was claimant's attending physician.

[3] OAR 436-060-0020(11) provides:

"If a denied claim has been determined to be compensable, the insurer shall begin temporary disability payments pursuant to ORS 656.262, including retroactive periods, if the time loss authorization was open ended at the time of denial, and there are no other lawful bases to terminate temporary disability."

working with a lifting restriction of 30 [pounds]."[4] (Exs. 23, 23A, 24G, 25, 29). The employer argues that Dr. Gambee's post-denial opinion regarding claimant's modified work restriction is an authorization for retroactive temporary disability benefits exceeding 14 days, which is prohibited by ORS 656.262(4). We disagree. Under the facts of this case, we find that Dr. Gambee's comments establish a continuation of work restrictions during the period in question, not a retroactive authorization of such restrictions.

Finally, on December 27, 1996, Dr. Gambee reduced his open-ended time loss authorization from a full release from work to a release to modified work. (Ex. 11). However, because the employer did not offer claimant any modified work, claimant remained entitled to temporary total disability. ORS 656.268(3). Accordingly, there being no other lawful basis for the employer to terminate the temporary total disability benefits, claimant is entitled to those benefits for the period from January 27, 1997 through June 30, 1997. OAR 436-060-0020(11).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review 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 December 12, 1997 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,500, payable by the self-insured employer.

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[4] Citing Exhibit 29, the employer argues that "Dr. Gambee made it clear that he never intended to take claimant off work." Employer's Opening Brief, page 6. We disagree with that interpretation of Dr. Gambee's statement that "I, in fact, never took [claimant] off work." (Ex. 29). Given Dr. Gambee's prior explicit releases from work, this is clearly a misstatement. (Exs. 6, 7, 23A).

In the Matter of the Compensation of
KATHRYN C. LOEKS, Claimant
Own Motion No. 96-0571M
OWN MOTION ORDER DENYING REVIEW OF CARRIER CLOSURE
Kemper Ins. Co., Insurance Carrier

Claimant requests review of the insurer's January 29, 1998 Notice of Closure which closed her claim with an award of temporary disability compensation from December 18, 1996 through May 6, 1997. The insurer declared claimant medically stationary as of January 29, 1998.

Claimant submitted her request for review on April 9, 1998, 70 days after the mailing of the Notice of Closure. To be considered, the request for review must be filed with the Board within 60 days from the date of mailing of the notice of closure, or within 180 days after the mailing date if claimant can establish good cause for the failure to file the request within 60 days. *See* OAR 438-012-0060(1).

Here, claimant contends that she contacted the insurer's representative and was told that she "was not entitled to any further compensation." Further, claimant states that "Since this call just 2 weeks ago my right foot has gone completely knumb [sic] and I am having significant pain on the right side of my back and down my leg."

We are not persuaded that claimant's allegation regarding the insurer representative's statement constitutes good cause for the untimely filing. Rather, it would appear that claimant did not seek

review of her closure until her condition apparently worsened, which was beyond the 60-day appeal period.[1] Therefore, claimant's request is untimely, and the closure is final by law.

IT IS SO ORDERED.

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[1] If claimant's compensable condition has worsened to the extent that surgery and/or inpatient hospitalization is eventually required, she may again request reopening of her claim for the payment of temporary disability. *See* ORS 656.278(1).

Further, it appears from claimant's request that she is unclear as to her rights and benefits under the Workers' Compensation laws. 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, since claimant is unrepresented, she 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

In the Matter of the Compensation of
JOB G. LOPEZ, Claimant
Own Motion No. 97-0561M
OWN MOTION ORDER DENYING RECONSIDERATION
Emmons, Kropp, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our January 20, 1998 Own Motion Order, which denied his request for reopening of his 1988 injury claim for the payment of temporary disability benefits because he failed to establish that he was in the work force at the time of the current disability.

Pursuant to *former* OAR 438-12-065(2), a reconsideration request must be filed within 30 days after the mailing date of the order, or within 60 days after the mailing date if there was good cause for the failure to file within 30 days. Former OAR 438-12-065(2) also provides that "[a] motion for reconsideration shall be denied as untimely if filed more than 60 days after the mailing date of the final order, or more than 30 days after that mailing date and the party requesting reconsideration has not demonstrated good cause for the untimely filing."

Here, claimant's February 25, 1998 request for reconsideration was received by the Board on February 27, 1998 and referred to the Own Motion Section on April 24, 1998[1], after it was discovered to have been initially inadvertently routed to the Hearings Division. The misrouting of claimant's February 25, 1998 request does not alter the fact that the request is untimely. Claimant's February 25, 1998 request was filed more than 30 days after the issuance of our January 20, 1998 order. Claimant offers no explanation for this untimely filing. Finally, claimant does not represent that there are extraordinary circumstances to warrant the reconsideration of our prior order.

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[1] On April 20, 1998, claimant's attorney wrote to the Board's Own Motion Section and advised of a February 25, 1998 letter which claimant had filed "which, essentially, should be construed as a request for reconsideration of the Own Motion Order ... The February 25, 1998 letter, ..., was treated as a Request for Hearing and a hearing has now been scheduled ... . However, we, again, ask that the February 25, 1998 letter be considered as reconsideration of the Board's Own Motion Order." Claimant's attorney further advised that claimant was conceding that the SAIF Corporation's Motion to Dismiss the hearing should be granted. An Order of Dismissal was entered on May 1, 1998.

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

IT IS SO ORDERED.

May 20, 1998 Cite as 50 Van Natta 947 (1998)

In the Matter of the Compensation of
BEVERLY ARVIZU, Claimant
WCB Case No. C8-00899
ORDER REPUBLISHING ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Bischoff & Strooband, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Member Biehl and Haynes.

On April 27, 1998, we approved 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 released certain rights to future workers' compensation benefits, except medical services, for the compensable injury.

Page 2 of the CDA, as originally submitted by the parties, provided that the workers' compensation carrier was "The Travelers Companies" (Travelers). On April 27, 1998, the Board mailed the postcards which were supplied by the parties announcing approval of the CDA. OAR 438-009-0028(1). On May 5, 1998, one of the postcards, which had been addressed to "Travelers," was returned to the Board with an accompanying letter stating that the claim did not "appear to be a Traveler's claim."

On May 8, 1998, the Board received a letter dated May 6, 1998, from the attorney for the workers' compensation carrier indicating that Travelers was inadvertently listed as the insurer on the CDA. The letter further indicated that the insurer should have been listed in the CDA as Kemper Insurance Company (Kemper). Included with the letter was a corrected version of page 2 of the CDA providing that Kemper was the insurer and giving the correct address.

ORS 656.236(2) provides that an order approving a CDA is not subject to review.[1] OAR 438-009-0035(1) provides that a motion for reconsideration of final orders issued by the Board under ORS 656.236 shall be filed within 10 days of the date of mailing of the order.[2] Pursuant to OAR 438-009-0028(1), "Announcement of CDA Approval Order" postcards shall be mailed by the Board to *all parties and their attorneys* if the CDA is approved. (Emphasis supplied).

Based on this record, we find that Kemper, the workers' compensation carrier and a party to the CDA, was not mailed a postcard announcing approval of the CDA. Inasmuch as the finality of an approved CDA is expressly contingent on the mailing of an "Announcement of CDA Approval Order" postcard to all parties, it follows that our prior approval of the CDA is not a final order. Under such circumstances, we retain jurisdiction to republish our decision. *See Darren D. Hayes*, 50 Van Natta 127 (1998). Likewise, in republishing our approval order, we are also authorized to correct the identity of the insurer to Kemper Insurance.

Accordingly, as corrected and supplemented herein, we republish our April 27, 1998 order approving the CDA in its entirety.

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[1] However, an order disapproving a disposition is subject to review pursuant to ORS 656.298.

[2] Here, the carrier's counsel's letter requesting correction of the CDA was filed with the Board on May 8, 1998, more than 10 days after the postcards announcing approval of the CDA were mailed. Thus, if the CDA postcards had been mailed to all parties, any motion for reconsideration of the CDA would have been rejected as untimely filed.

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.

May 18, 1998 Cite as 50 Van Natta 948 (1998)

In the Matter of the Compensation of
MARYLEE PUGH, Claimant
Own Motion No. 98-0167M
OWN MOTION ORDER
Robert Guarrasi, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable lumbar strain. Claimant's aggravation rights expired on August 3, 1989. SAIF opposes the reopening of the claim on the grounds that: (1) no surgery or hospitalization has been requested; and (2) claimant is not in 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.*

SAIF has submitted medical records regarding claimant's current condition. In an October 28, 1997 chart note, Dr. Matteri, claimant's treating physician, opined that:

> "We are going to schedule the [claimant] for a series of ESIs. She will call in a week after the first one. If this does not take care of her, then probably we will give some consideration to surgery. She might well be a candidate for a [sic] anterior cage."

Dr. LaGrange saw claimant on a consultation visit on November 4, 1997 wherein he performed a caudal epidural steroid injection. He noted that:

> "If the [claimant] does not respond to this procedure, restarting her on Prozac as well as starting Neurotin 300 mg po t.i.d. may be some relief prior to undergoing surgery."

Finally, claimant has represented, without opposition, that she underwent surgery on March 9, 1998. Under such circumstances, we conclude that claimant's compensable condition worsened requiring surgery.

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

SAIF contends that claimant was not in the work force at the time of the current disability. Claimant responded by letter dated April 27, 1998 to SAIF's work force contention and attached a copy of her 1997 W-2 form. However, we have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction,[1] is the date she enters the hospital for the proposed surgery. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). The relevant time period for which claimant must establish she was

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[1] The Board in its own motion jurisdiction can only authorize temporary disability from the time of surgery or hospitalization. *See* ORS 656.278(1)(a).

in the work force is the time prior to her March 9, 1998 surgery, when her condition worsened requiring that surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App at 273; *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997); *Michael C. Batori*, 49 Van Natta 535 (1997); *Kenneth C. Felton*, 48 Van Natta 725 (1996).

Claimant's 1997 W-2 form demonstrates that she was working at the time her condition worsened requiring surgery. Additionally, in a December 11, 1997 chart note, Dr. Matteri stated that:

> "We have agreed that [claimant] is going to see Dr. Steve McGirr regarding her back and leg pain. If this does not eventuate in any relief, then probably she is going to have to think about cutting back on her work level and perhaps going onto Social Security disability. I am giving her a note indicating that she is not to work until notice."

Thus, we are persuaded that the record establishes that claimant was working at the time her current condition worsened requiring surgery.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning March 9, 1998, the date she was hospitalized for surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
TERRY L. COLE, Claimant
WCB Case No. 97-07924
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Reinisch, Mckenzie, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that upheld the self-insured employer's denial of claimant's injury claim for mucous membrane exposure and gastroenteritis conditions. On review, the issue is compensability.

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

Even assuming that at least the initial claim is a "simple case," (where expert evidence is not required to prove medical causation) it would be excluded as a "compensable injury" under ORS 656.005(7)(B)(b).[1] We reach this conclusion because we find that "personal pleasure" was the primary purpose of claimant's "watermelon-eating" activity. *See Kaiel v. Cultural Homestay Institute*, 129 Or App 471, 478 (1994); *see also* (1996); *Theodore A. Combs*, 47 Van Natta 1556, 1557 (1995) (Where the claim was not compensable under ORS 656.005(7)(b)(B), Board did not reach the "work connection" test); *Michael W. Hardenbrook*, 44 Van Natta 529, *aff'd mem Hardenbrook v. Liberty Northwest Insurance Corporation*, 117 Or App 543 (1992) (a statutory exclusion analysis must precede any unitary work connection analysis when ORS 656.005(7)(b)(B) applies). Consequently, we agree with the ALJ that the employer's denial must be upheld.

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[1] ORS 656.005(7)(b)(B) provides that the definition of a "compensable injury" does not include an

"[i]njury incurred while engaging in or performing, or as the result of engaging in or performing, any recreational or social activity primarily for the worker's personal pleasure[."]

ORDER

The ALJ's order dated January 29, 1998 is affirmed.

In the Matter of the Compensation of
ROBERT M. CILENTI, Claimant
WCB Case Nos. 97-07146 & 97-04537
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Biehl, Bock, and Moller.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Thye's order that set aside its denial of claimant's new injury claim for a low back 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 regarding the compensability issue is $1,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 13, 1997 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the employer.

Board Member Moller dissenting.

The majority affirms without opinion the ALJ's order that found claimant sustained a new compensable injury on April 15, 1997. Because I find the medical opinion of the physician (Dr. Thomas) on whom the ALJ primarily relied to be unpersuasive, I would reverse the ALJ's order and conclude that claimant's medical treatment should be processed as part of a prior compensable injury claim in 1995.

I begin by briefly summarizing the factual background of the claim. Claimant sustained a compensable low back strain on June 30, 1995, after opening the hood of a truck at work and noticing a "pop" in his low back. A Determination Order subsequently issued, which did not award any permanent disability. Claimant requested reconsideration, which resulted in a medical arbiter's examination. Although the arbiter concluded that claimant's lumbar sprain had "resolved," claimant still complained of continuing symptoms. (Ex. 9). A March 22, 1996 Order on Reconsideration awarded 8 percent unscheduled permanent disability. (Ex. 10).

On April 15, 1997, claimant's back again popped as he was pulling on a tie strap at work. The company nurse referred claimant to an occupational medicine specialist, Dr. Yarusso, who diagnosed a flare-up of claimant's previous low back strain. (Ex. 15). Claimant subsequently reported pain in the right posterior thigh and buttock. (Ex. 16). An MRI revealed a small right L5-S1 disc herniation. (Ex. 17).

Dr. Yarusso referred claimant to Dr. Rosenbaum, who examined claimant on April 27, 1997 and concluded that claimant had symptoms that were consistent with a herniated disc, but they were resolving. (Ex. 20-2). Continued conservative treatment was recommended.

On May 12, 1997, Dr. Yarusso opined that there had been no "true aggravation" of the preexisting condition, but rather only a flare-up of the June 1995 injury. (Ex. 22). Dr. Yarusso would later opine, however, that the April 1997 incident was consistent with a new injury. (Ex. 25). On August 6, 1997, the employer denied the claim on the ground that the April 15, 1997 incident was not the major contributing cause of claimant's need for treatment. (Ex. 31).

In the meantime, Dr. Thomas had assumed claimant's treatment on June 17, 1997. On August 21, 1997, Dr. Thomas opined that the April 15, 1997 injury was the major contributing cause of a disc herniation and claimant's need for treatment. (Ex. 33).

As previously noted, the ALJ found that the April 1997 incident was compensable as a new injury claim, a finding based largely on Dr. Thomas' opinion. I agree with the employer, however, that Dr. Thomas' opinion is not sufficient to establish a "new injury."

First, Dr. Thomas' opinion consists merely of a signature on a summary prepared by claimant's counsel. (Ex. 33). Dr. Thomas was informed that claimant's 1995 injury had "resolved." However, this history is questionable because claimant reported to the medical arbiter in March 1996 that he had "steady low back pain." (Ex. 9-1). Claimant, himself, testified to occasional back pain prior to the April 1997 incident. (Tr. 30). Although Dr. Thomas was aware of claimant's permanent disability award for the 1995 injury, Dr. Thomas' concurrence report does not contain any comment regarding its impact on the causation issue. Because Dr. Thomas mistakenly assumed that claimant's 1985 injury had "resolved," despite substantial evidence to the contrary, and because his opinion is poorly reasoned, I agree with the employer that Dr. Thomas' opinion is unreliable.

Second, Dr. Thomas' opinion was "especially" supported by the "popping" that occurred on April 15, 1997 when claimant experienced his flare-up of pain. (Ex. 33-2). However, Dr. Thomas' report contains no mention of the fact that the 1995 injury also featured a "pop." In addition, both the 1995 and 1997 incidents resulted in right-sided radicular symptoms, a fact not mentioned in the summary to which Dr. Thomas agreed. (Exs. 4, 6, 20). Thus, Dr. Thomas' opinion fails to recognize, much less discuss, the striking similarities between the two injuries.

In conclusion, I find Dr. Yarusso's opinion to be inconsistent. Because, for the reasons previously delineated, Dr. Thomas' opinion is unpersuasive, I would find that claimant failed to sustain his burden of proving that the April 1997 incident should be processed as a new injury. Instead, the employer properly accepted the April 1997 incident as part of the compensable 1995 claim. Accordingly, I would reverse the ALJ's order.

In the Matter of the Compensation of
DAVID F. CORN, Claimant
WCB Case No. 97-04511
ORDER ON REVIEW
Kirkpatrick & Zeitz, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Herman's order that: (1) found that the Hearings Division had jurisdiction over the SAIF Corporation's appeal from a May 5, 1997 Determination Order; and (2) decreased claimant's unscheduled permanent disability award for a right shoulder condition from 27 percent (86.4 degrees), as awarded by a Determination Order, to 16 percent (51.2 degrees). On review, the issues are jurisdiction and extent of unscheduled permanent disability.

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

The May 5, 1997 Determination Order was issued as a result of claimant's completion of his authorized training program (ATP). SAIF appealed that Determination Order directly to the Hearings Division, contending that the permanent disability award should be reduced. At hearing and on review, claimant argues that the Hearings Division has no jurisdiction over this appeal because SAIF did not first request reconsideration under ORS 656.268(4)(e).

In *Richard La France*, 48 Van Natta 427 (1996), we held that, in light of Section 66(4) of SB 369, which expressly states that the amendments to ORS 656.268(9) shall apply only to claims that became medically stationary on or after the effective date of the Act, the former versions of ORS 656.268(8) and (9) continued to apply to claims that became medically stationary before the Act's effective date (June 7, 1995). Thus, for those claims medically stationary before June 7, 1995, the method for appeal from a "post-ATP" determination order or notice of closure is to request a hearing within 180 days from the date the order or notice was mailed. *Former* ORS 268(8) and (9); *Weyerhaeuser v. Purdy*, 130 Or App 322 (1994) (holding that, under *former* ORS 656.268(9), reconsideration review was not a prerequisite to a request for hearing on a "post-ATP" notice of closure or determination order); *Mary A. Longoria*, 48 Van Natta 2466 (1996).

Here, claimant's condition was medically stationary as of March 27, 1995, well before the effective date of the 1995 amendments. Furthermore, SAIF requested a hearing on June 2, 1997, which is within 180 days of the May 5, 1997 Determination Order. Therefore, the ALJ correctly determined that the post-ATP closure was not required to go through the reconsideration process and, consequently, the Hearings Division had jurisdiction over the matter.

ORDER

The ALJ's order dated November 5, 1997 is affirmed.

May 20, 1998 Cite as 50 Van Natta 952 (1998)

In the Matter of the Compensation of
MICHAEL B. CRAMER, Claimant
WCB Case No. 97-01819
ORDER ON REVIEW
Thomas O. Carter, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that upheld the SAIF Corporation's denial of claimant's injury claim for a lipoma. On review, the issue is compensability.

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

We do not adopt the last sentence.

The first sentence of the final paragraph of the "Findings of Fact," is corrected to read: "The lipoma preexisted the March 1996 accident."

Claimant contends that Dr. Serres' opinion establishes that the work injury made claimant's preexisting lipoma symptomatic and, because these symptoms caused his need for medical treatment, the claim is compensable. (See Exs. 25, 33).

Even assuming (without deciding) that Dr. Serres opined that injury-related symptoms were the major contributing cause of claimant's need for surgery, we would not find Dr. Serres' opinion persuasive because it is inadequately explained. See Richard A. Longbotham, 48 Van Natta 1257 (1996) (Because a finding of major causation requires a comparison of off-work and work-related causes, but the doctor performed no such analysis, his conclusion was inadequately supported) (citing Dietz v. Ramuda, 130 Or App 397 (1994)); Barbara J. James, 44 Van Natta 888 (1992), aff'd mem James v. O'Rourke, 117 Or App 594 (1993) (Considering the preexisting condition, doctor's conclusion unpersuasive because based solely on the nature and timing of the claimant's post-injury symptoms).

ORDER

The ALJ's order dated January 9, 1998 is affirmed.

In the Matter of the Compensation of
DESI N. CULMANN, Claimant
WCB Case No. 97-01043
ORDER ON REVIEW
Schneider & Hooton, Claimant Attorneys
Wallace, Klor & Mann PC, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that upheld the insurer's denial of claimant's claim for a C5-6 disc protrusion. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," and we make the following additional findings.

On September 12, 1996, claimant hooked and unhooked trailers, but he did not load or unload his truck.

After the initial onset of symptoms on September 12, 1996, claimant's objective findings gradually increased and ultimately included left triceps weakness, reduced triceps reflexes, and tingling in all fingers in the left hand.

The October 2, 1996 MRI revealed preexisting degenerative disc disease at multiple levels of claimant's cervical spine.

CONCLUSIONS OF LAW AND OPINION

On review, claimant challenges the ALJ's statement that "[c]laimant is contending that the C5-6 disc protrusion itself is compensable, and not merely the need for treatment or disability resulting from the combined condition." Claimant argues that he made no such concession and, instead, contended that his C5-6 disk protrusion is a compensable combined condition under ORS 656.005(7)(a)(B). Accordingly, claimant argues that he need only prove that the work activity is the major contributing cause of the current disability and/or need for treatment. Id. In response, the insurer argues that claimant must establish compensability of his claim as a consequential condition under ORS 656.005(7)(a)(A). Thus, the insurer argues that claimant must prove that his work activity is the major contributing cause of the C5-6 disc protrusion.

We need not resolve this dispute, as the record does not establish that claimant's work activity is the major cause of either the C5-6 disc protrusion or claimant's current disability and/or need for treatment. Claimant relies on the medical opinions of Drs. Ordonez, Maness, Farris and Martens. We agree with the ALJ's assessment of these opinions as conclusory and poorly reasoned. In particular, these doctors do not address Dr. Seres' contrary opinion, which we find to be consistent with claimant's symptoms and examination findings, including: the intermittent nature of claimant's initial symptoms; findings suggestive of a C7 radiculopathy rather than C6 involvement; and the resolution of symptoms after a relatively short period of conservative treatment.

On this record, we conclude that claimant has not carried his burden of establishing that his work activity was the major contributing cause of either the C5-6 disc protrusion or claimant's current disability and/or need for treatment.

ORDER

The ALJ's order, dated November 26, 1997, is affirmed.

In the Matter of the Compensation of
JOHN J. DRONKERS, Claimant
WCB Case No. 97-05107
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
William J. Blitz, Defense Attorney

Reviewed by Board Members Moller and Biehl.

Claimant requests review, and the self-insured employer cross-requests review, of Administrative Law Judge (ALJ) Crumme's order that: (1) increased claimant's scheduled permanent disability award for the loss of use or function of his right forearm from 25 percent (37.5 degrees), as granted by an Order on Reconsideration, to 27 percent (40.5 degrees); and (2) affirmed an Order on Reconsideration that awarded 25 percent (37.5 degrees) scheduled permanent disability for loss of use or function of the left forearm. The employer also moves to dismiss claimant's request for review on timeliness grounds. On review, the issues are timeliness of claimant's request for review and extent of scheduled permanent disability.

We adopt and affirm the ALJ's order with the following supplemental findings and analysis in response to the employer's motion to dismiss.

On December 24, 1997, claimant filed a request for review which referenced claimant, a November 26, 1997 Opinion and Order, the employer, the claims processing agent, and the employer's attorney of record. That request for review did not identify the ALJ, and it referenced incorrect case and claim numbers. On December 31, 1997, claimant filed an amended request for review which referenced the correct case and claim numbers. On that same day, the employer filed a motion for dismissal of claimant's December 24, 1997 request for review on timeliness grounds. The employer relies on the fact that claimant did not file a request for review referencing the correct case number, claim number and ALJ within thirty days of the ALJ's order. See ORS 656.289(3).

The employer's request for dismissal is denied. It is well-established that the Board's appellate authority is based on appealed ALJ orders, not case or claim numbers. See ORS 656.295(1) (request for review need only state that party requests review of "the order"); Dorothy I. Adams, 48 Van Natta 2190 (1996). That authority necessarily includes determining the order to which claimant's appeal was directed (irrespective of whether the case and claim numbers noted in the request correspond to the numbers listed in the ALJ's order). Id. Here, claimant's December 24, 1997 request for review clearly references a November 26, 1997 Opinion and Order relating to claimant, the employer, the claims processing agent and the employer's attorney of record. While the request did not identify the ALJ or reference the correct case or claim numbers, WCB Case No. 97-05107 is claimant's only Board case with a November 26, 1997 Opinion and Order. Moreover, the employer's December 31, 1997 letter to the Board establishes that it was aware that claimant's December 24, 1997 request for review was filed in regard to WCB Case No. 97-05107. Accordingly, claimant's failure to reference the ALJ and the correct case and claim numbers on his initial request for review is not fatal to his appeal. Accord Grover Johnson, 41 Van Natta 88 (1989) (request for review with incorrect case number timely where only one of claimant's Board cases involved an order issued on the date identified in the request for review).

Claimant's attorney is entitled to an assessed attorney fee for prevailing over the employer's motion to dismiss and cross-request for reduction of the ALJ's award of scheduled permanent 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 in this regard is $1,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to addressing the employer's motion and cross-request (as represented by the discussion of these issues in the briefs filed by claimant on review), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated November 26, 1997 is affirmed. The self-insured employer's motion to dismiss is denied. For services on review regarding the employer's motion to dismiss and cross-request for reduction of claimant's scheduled permanent partial disability award, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the employer.

In the Matter of the Compensation of
ARON W. FERTSCH, Claimant
WCB Case No. 97-00072
ORDER ON REVIEW
Coughlin, Leuenberger & Moon PC, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Tenenbaum's order that upheld the self-insured employer's denial of claimant's current low back condition. On review, the issue is compensability.

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

The ALJ found that the employer remains responsible for future medical treatment and benefits related to the accepted compensable injury, i.e., the accepted lumbosacral strain and disabling synovial cyst at L5-S1. The parties do not dispute that finding. In addition, there is no dispute regarding the compensability of the February 29, 1996 surgery, which consisted of a left L5 hemilaminectomy and removal of the synovial cyst at L5-S1. (Exs. 121, 123). However, the ALJ also upheld the employer's December 23, 1996 denial "with respect to [the] need for the October [24,] 1996 surgery," finding that claimant "failed to sustain his burden of proving that his then-current condition continued to be the major cause of his need for treatment and disability, including the second surgery." Opinion and Order, page 6. It is this second finding that claimant disputes on review.

While we agree with claimant that the scar tissue revealed during the second surgery was caused by the compensable February 29, 1996 surgery, we do not find that that helps claimant's position. In this regard, the persuasive medical evidence establishes that claimant's current low back condition and the need for the second surgery was caused by his preexisting congenital and degenerative conditions, not the compensable lumbosacral strain and synovial cyst [which was removed during the first surgery and did not recur], or any residuals from the compensable surgery, including the scar tissue.

Given claimant's preexisting congenital and degenerative spinal conditions, the cause of claimant's current condition and need for the second surgery presents a complex medical question which must be resolved on the basis of expert medical evidence. *Uris v. Compensation Dept.*, 247 Or 420, 427 (1967); *Barnett v. SAIF*, 122 Or App 279, 283 (1993). Claimant relies on the opinions of his treating surgeons for the second surgery, Drs. Henbest and Zimmerman. We agree with the ALJ that those opinions fail to meet claimant's burden of proof.

We rely on those medical opinions which are well-reasoned and based on accurate and complete histories. *Somers v. SAIF*, 77 Or app 259 (1986). In addition, we generally give greater weight to the opinion of a worker's treating physician unless there are persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810, 814 (1983). Here, we find persuasive reasons not to rely on the opinions of Drs. Henbest and Zimmerman.

Although Drs. Henbest and Zimmerman initially thought that claimant's synovial cyst had recurred, the medical evidence, including an MRI and a pathology report, conclusively determined that claimant had no recurrent synovial cyst. (Exs. 138, 140, 144, 146, 148, 149, 150). Dr. Henbest eventually acknowledged there was no recurrent or worsened synovial cyst. (Ex. 156). However, Dr. Zimmerman continued to rely on a mistaken belief that claimant had a recurrent synovial cyst. (Ex. 159). Because Dr. Zimmerman's causation opinion was not based on an accurate history, we do not find it persuasive.

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[1] In reaching this decision, we note that we do not adopt the ALJ's discussion of *Roller v. Weyerhaeuser Co.*, 67 Or App 583, *mod* 68 Or App 743, *rev den* 297 Or 124 (1984). On review, the parties do not challenge the ALJ's decision regarding the procedural propriety of the employer's current condition denial. Instead, claimant solely challenges the merits of the ALJ's compensability decision. Based on this challenge, our review is limited to the merits of the compensability issue.

Regarding Dr. Henbest's opinion, only in his final causation opinion did he concede that claimant's synovial cyst did not recur or worsen. (Ex. 156-1). Nevertheless, even though Dr. Henbest had an accurate history regarding the synovial cyst, he had an inaccurate history that claimant's spondylolysis was not apparent until the October 1996 surgery. (Ex. 156). Based on this history, Dr. Henbest opined that claimant's "degenerative process therefore was precipitated by an initial insult, presumably the December 1995 work accident which progressed despite decompressing of the nerve roots." (Ex. 156-1). However, the record establishes that claimant's spondylolysis was apparent as early as 1984. (Ex. 4). Finally, much of Dr. Henbest's opinion is rendered in terms of possibility rather than probability. *See Gormley v. SAIF*, 52 Or App 1055 (1981) (probability, not possibility, is the requisite standard of proof). Accordingly, we do not find Dr. Henbest's opinion persuasive.

Dr. Rosenbaum, examining neurologist, provided the only other medical opinion regarding causation. (Exs. 152, 153, 158). Dr. Rosenbaum had a correct history and persuasively explained that claimant's current low back condition and his need for the second surgery was caused by his preexisting congenital and degenerative low back conditions and not the work injury. (*Id.*). Thus, no persuasive medical opinion supports claimant's position.

For the above reasons, and those addressed by the ALJ, we find that claimant failed to establish compensability of his current low back condition.

ORDER

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

May 20, 1998 Cite as 50 Van Natta 956 (1998)

In the Matter of the Compensation of
LINDA IMAN, Claimant
WCB Case Nos. 97-07721 & 97-00894
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Reinisch, Mckenzie, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

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

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

We agree with the ALJ that the persuasive medical evidence shows that claimant's October 1996 injury was the major contributing cause of the need for treatment and disability of the jaw condition. *See* ORS 656.005(7)(a)(B). In particular, we find Dr. Kelley, examining dentist, to be reliable. He based his opinion on an accurate history in that he correctly understood that claimant underwent a "jaw thrust technique." (Ex. 101-19). Dr. Kelley explained that this incident "caused reinjury to the internal discal soft tissues of the temporomandibular joints" thereby causing an "exacerbation of the pre-existing temporomandibular joint disease." (*Id.*) According to Dr. Kelley, the new injury combined with the preexisting TMJ condition; although referring to the preexisting condition as having "contributed significantly," Dr. Kelley thought that the injury was "a major contributing factor in her combined condition."[1] (*Id.* at 20-21).

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[1] Although Dr. Kelley referred to the "new injury" as *a* major contributing cause, we find that his opinion satifies the burden of proof under ORS 656.005(7)(a)(B). Dr. Kelley provided his answer in response to whether the injury was "the major contributing cause" of the combined condition. (Ex. 101-21). Furthermore, Dr. Kelley characterized contribution from the preexisting condition as "significant." Consequently, although Dr. Kelley did not use the "magic words," we find his opinion as supporting the conclusion that the injury was *the* major contributing cause.

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 $1,600, 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 January 20, 1998 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,600, to be paid by the self-insured employer.

May 20, 1998 Cite as 50 Van Natta 957 (1998)

In the Matter of the Compensation of
CECILIA KUCHABSKY, Claimant
WCB Case No. C801076
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Michael A. Bliven, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Member Biehl and Haynes.

On May 8, 1998, 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 CDA.

The first page of the CDA provides that the total due claimant is $26,026 and the total due claimant's attorney is $4,975, for a total consideration of $31,000. However, we note that these amounts actually total $31,001, rather than $31,000. Page 2, number 12, of the CDA also provides that the consideration is $31,000. Additionally, page 3, number 13 provides that the total due claimant's attorney is $4,975. Finally, page 3, number 14 calculates claimant's total consideration, broken down per week using the amount of $26,025, rather than $26,026 as the total due claimant.

Based on the above, we are persuaded that the first page of the CDA contains a clerical error and that the total consideration for the CDA is $31,000, rather than $31,001, and that $26,025 (rather than $26,026) of the $31,000 is payable to claimant and that $4,975 is payable to claimant's counsel as an attorney fee.

As interpreted herein, the CDA is in accordance with the terms and conditions prescribed by the Board. See ORS 656.236(1). Accordingly, the parties' CDA is approved. An attorney fee of $4,975, 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
LARK L. LAMBERT, Claimant
WCB Case No. 97-02847
ORDER ON RECONSIDERATION
Steven M. Schoenfeld, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Claimant requests reconsideration of our April 23, 1998 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order that upheld the insurer's denial of claimant's rib and nerve injury claim. On reconsideration, claimant contends that, because we affirmed and adopted the ALJ's order, claimant did not receive a "thorough discussion of the evidence...."

By adopting the ALJ's reasoning and conclusion, we have found that the ALJ's order sufficiently responds to claimant's contentions, has correctly applied the law, and has reached the appropriate result under the facts of this case. In other words, the ALJ's order contains a thorough discussion of the evidence.

Claimant also contends that the present case is controlled by our decisions in Robert J. Ruch, 48 Van Natta 1579 (1996) and Kip D. Breitmeyer, 49 Van Natta 1776 (1997). We disagree.

In Ruch, the ALJ found the claimant credible. Here, however, the ALJ did not make a credibility finding with respect to claimant. Moreover, in Ruch, we concluded that the claimant's reporting of the injury was consistent with his testimony and there was corroborating testimony from the claimant's co-worker. In the present case, however, claimant told two individuals that she hurt herself at home and she told the employer that she had back discomfort from a prior injury. Additionally, although claimant testified that she told co-workers that she was injured at work, no one corroborated this testimony. Furthermore, the office manager testified that claimant called in to work that day to say she was not coming in. As the ALJ concluded, we find it unlikely that four individuals conspired in this case to defeat claimant's claim.

Claimant also relies on Breitmeyer, supra. In Breitmeyer, we found that the claimant's testimony was credible. However, in Breitmeyer, the issues involved whether the claimant failed to report his injury or whether he had failed to display pain behavior consistent with his injury. Here, on the other hand, several witnesses provided testimony that directly contradicted claimant's testimony regarding an injury on the job. Those witnesses testified that claimant told them that she was injured at home, which is contrary to claimant's testimony. Again, we do not find that claimant's testimony in this case is sufficient to overcome the testimony provided by the employer's witnesses. As noted by the ALJ, the case is further defeated by claimant's failure to promptly report her injury.

Consequently, we conclude that the cases cited by claimant are not on point. We therefore adhere to our prior decision.

Accordingly, we withdraw our April 23, 1998 order. On reconsideration, as supplemented herein, we adhere to and republish our prior order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
SERGIO MADRIGAL, Claimant
WCB Case Nos. 96-11456 & 96-09187
ORDER ON REVIEW
Max Rae, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Poland's order that awarded claimant temporary partial disability benefits for the period from January 11, 1996 through May 17, 1996. Claimant cross-requests review of that portion of the ALJ's order that upheld the insurer's partial denial of claimant's low back conditions (lumbosacral strain and L5-S1 disc bulge). On review, the issues are compensability and temporary disability. We affirm.

FINDINGS OF FACT

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

We find that claimant was at least partially disabled due to his compensable left ankle condition from January 29, 1996 through May 17, 1996.

CONCLUSIONS OF LAW AND OPINION

Compensability

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

Temporary Disability Benefits

We adopt and affirm the ALJ's opinion on this issue,[1] with the following supplementation.

Claimant suffered a compensable disabling left ankle injury on January 11, 1996. Claimant's attending physician, Dr. Stringham, authorized his return to a light duty job as a seedling trimmer that was to begin January 29, 1996 and end on March 1, 1996. On or about February 7, 1996, the employer terminated claimant's employment because he failed to return to work. The insurer stopped paying "procedural" temporary disability benefits[2] as of January 28, 1996.

Claimant requested a hearing on the termination of his temporary disability benefits. A September 12, 1996 Opinion and Order issued finding that claimant had refused a written offer of suitable modified work under ORS 656.268(3)(c), and that the insurer had properly terminated claimant's procedural temporary disability benefits (both total and partial) as of January 28, 1996. The Board affirmed the order and it became final.

Meanwhile, claimant's left ankle claim was closed by an August 12, 1996 Determination Order that awarded "substantive" temporary disability from January 11, 1996 through January 28, 1996. Claimant requested reconsideration. An October 25, 1996 Order on Reconsideration affirmed the Determination Order's temporary disability award. Claimant requested a hearing.

The ALJ found that claimant had proven, by the preponderance of the evidence in the entire record, that he was at least partially disabled due to the compensable left ankle injury until May 17, 1996 and accordingly awarded "substantive" temporary partial benefits (TPD) through that date. The ALJ also distinguished Safeway Stores v. Owsley, 91 Or App 475 (1988) and Dawes v. Summer, 118 Or App 15 (1993), reasoning that claimant was terminated from his employment for reasons related to his compensable injury.

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[1] We note that the parties do not dispute the Order on Reconsideration's award of temporary disability prior to January 28, 1996. Consequently, the issue is whether claimant is entitled to additional substantive temporary disability benefits for the period from January 29, 1996 through May 17, 1996, the date he was declared medically stationary.

[2] "Procedural" temporary disability is temporary disability that is payable while the claim is in open status, whereas "substantive" temporary disability is temporary disability that is awarded at the time of claim closure. Shaw v. Rebholz, 152 Or App 328, 333 (1998).

On review, the insurer makes two arguments. First, it argues that the prior ALJ's order, finding that the insurer had properly terminated claimant's procedural temporary disability benefits as of January 28, 1996, establishes that claimant is not entitled to any substantive temporary disability beyond January 28, 1996. Second, relying on Safeway Stores v. Owsley, the insurer argues that, because claimant refused a suitable modified job for reasons other than his injury, he is not entitled to any time loss beyond January 28, 1996 and his proposed return-to-work wage was the same wage that claimant was paid at the time of injury. Claimant, in contrast, contends that he was entitled to temporary total disability (TTD) payments after January 28, 1996, or, alternatively, that he was entitled to the resumption of TTD payments after March 1, 1996, because the employer's offer of modified work was withdrawn as of that date. We agree with the ALJ's conclusion that claimant is entitled to TPD from January 29, 1996 through May 17, 1996.

We begin with the preclusive effect of the earlier proceeding, in which we concluded that the insurer properly terminated claimant's procedural temporary disability benefits as of January 29, 1996 and was under no obligation to reinstate such benefits on March 1, 1996, the date the modified job was scheduled to end.

The court addressed a similar issue in Shaw v. Rebholz, 152 Or App 328 (1998). In Shaw, the claimant contended that we were precluded from determining that he was not entitled to benefits after he became medically stationary because, in an earlier proceeding, we concluded that the carrier had improperly terminated his temporary disability benefits and ordered the carrier to continue paying benefits until properly terminated by law.

Applying the criteria set forth by the Supreme Court in Washington Cty. Police Officers v. Washington Cty., 321 Or 430, 435 (1995), the Shaw court concluded that the sole issue on which we made any findings and expressed any conclusion in the earlier proceeding was whether the employer had satisfied the requirements of the law for unilaterally terminating procedural temporary total disability benefits, specifically, whether the claimant had been released for regular work by his attending physician.

In the second proceeding, the court found that the issue concerned the determination of the amount of the claimant's substantive temporary disability benefits at the time of closure, which is based on the extent to which a claimant demonstrates continuing disability during the pendency of the open claim, which demonstration occurs only after the claim is closed. The court found that the carrier was not required to litigate, while the claim was still open, an issue that did not arise until the claim was closed. Finally, the court rejected the claimant's argument that the distinction between "substantive" and "procedural" entitlements had been legislatively overruled, citing Santos v. Caryall Transport, 152 Or App 322 (1998).

In this case, as in Shaw, the first proceeding concerned procedural temporary disability, which was based on meeting the statutory conditions for termination. See Shaw, 152 Or App at 332. The issue in the second proceeding (the one before us) is substantive temporary disability, which is based on the extent to which claimant was actually disabled beyond January 28, 1996, and which could not have been litigated in the earlier proceeding. Accordingly, under these circumstances, we are not precluded from examining the extent to which claimant was actually disabled after January 28, 1996, in this proceeding.

After our review of the record, we agree with the ALJ's finding that claimant continued to be restricted to modified work due to his left ankle injury through May 17, 1996, the date he was released to regular work. Dr. Stringham placed claimant on light duty work on January 15, 1996. (Ex. 5). Dr. Stringham continued to restrict claimant from regular work until May 17, 1996. (Exs. 6, 6A, 6B, 9, 10, 12A, 13, 15, 15A, 18A, 19A). Therefore, claimant was at least partially disabled during that period of time.

The ALJ also found that claimant was terminated for reasons related to his work injury. We do not adopt that finding because, by virtue of Dr. Stringham's modified work release, we conclude that claimant was at least partially disabled from January 29, 1996 through May 17, 1996. Kenneth P. Bundy, 48 Van Natta at 2501. Since the Owsley and Dawes decisions, the court has clarified the "substantive temporary disability" analysis in Santos and Shaw. In Shaw, the court held that the determination of

substantive entitlement is "based on the extent to which [a] claimant demonstrates continuing disability during the pendency of the open claim, which demonstration occurs only after the claim is closed." Shaw, 158 Or App at 332. Here, even if claimant was terminated from employment for reasons unrelated to the injury, by virtue of Dr. Stringham's modified work release, claimant nevertheless remained partially disabled as a result of the compensable injury during that period of time.[3]

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

ORDER

The ALJ's order dated July 28, 1997, as corrected July 29, 1997, is affirmed. For services on review concerning the temporary disability issue, claimant's counsel is awarded a reasonable assessed attorney fee of $1,500, payable by the insurer.

[3] We note that claimant's entitlement to TPD is "theoretical," in the sense that, if claimant was to receive his regular wage or more for performing modified work, TPD would be calculated at a rate of zero, both while employed and thereafter until the medically stationary date. See Safeway Stores v. Owsley, 91 Or App at 475 (1988) (regardless of whether the claimant was terminated for reasons related to his work injury, because her wage was greater than her wage at injury, she would be entitled to temporary disability benefits at a rate of zero).

May 20, 1998 Cite as 50 Van Natta 961 (1998)

In the Matter of the Compensation of
ANDREW B. KAUFFMAN, Claimant
WCB Case No. 97-09153
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that affirmed an Order on Reconsideration that did not award any permanent disability. On review, the issue is extent of unscheduled permanent disability.

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

Claimant contends that there is no evidence in the record of any preexisting back problems. He relies on the history given to his treating physician (Ex. 9), the medical arbiter panel (Ex. 23-1) and the history in a questionnaire. (Ex. 8-3). However, the April 17, 1997 report from Drs. Rich and Marble described claimant's past medical history as follows: "In the past, he recalls numerous episodes of 'muscle strain' affecting his low back. He never sought medical attention for any of these self-limited episodes." (Ex. 12-2). Although the medical arbiter panel reported that "[n]o other history of back problems or injuries was provided by the examinee or mentioned in the medical record" (Ex. 23-3), they apparently did not read the April 17, 1997 report from Drs. Rich and Marble. For the reasons expressed by the ALJ, we agree that there is insufficient evidence to establish that claimant has any permanent disability as a result of his industrial accident.

ORDER

The ALJ's order dated February 13, 1998 is affirmed.

In the Matter of the Compensation of
RUTH L. McINTIRE (aka HOLTZ), Claimant
WCB Case Nos. 97-05025 & 97-01888
ORDER ON REVIEW
Robert J. Guarrasi, Claimant Attorney
Lundeen, et al, Defense Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Liberty Northwest Insurance Corporation requests review of Administrative Law Judge (ALJ) McWilliams' order that: (1) set aside its denial of claimant's "new injury" claim for her current right shoulder condition; and (2) upheld the SAIF Corporation's denial of claimant's aggravation claim for the same condition. In its brief, Liberty contends that claimant did not timely file injury claims for two incidents sustained with its insured. On review, the issues are timeliness and responsibility. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Responsibility

The ALJ found that ORS 656.308(1) applied, and that the condition accepted by SAIF was the "same condition" as claimant's current right shoulder impingement syndrome. We agree and adopt the ALJ's reasoning on that issue. We add the following supplementation.

We acknowledge that SAIF actually accepted a right shoulder "strain." Nevertheless, we agree with the ALJ that the persuasive medical opinions establish that the current condition is the "same condition" that was initially accepted by SAIF.

Alternatively, for the reasons expressed below, we conclude that, whether responsibility in this case is determined pursuant to ORS 656.308(1) or the last injurious exposure rule, the outcome would be the same.

The ALJ relied on the opinions of claimant's treating doctor, Dr. Schroeder, and an examining physician, Dr. Colletti, and found that SAIF had proven that claimant's injuries with Liberty's insured were the major cause of a pathological worsening of her condition. Consequently, the ALJ assigned responsibility to Liberty. For the following reasons, however, we do not find that the opinions of Drs. Schroeder and Colletti are persuasive.

Claimant's treating doctor, Dr. Schroeder, opined that claimant's current condition was primarily related to her work exposure at Taco Time (Liberty's insured). Dr. Schroeder based his conclusion on his "understanding [that] the patient had to do a lot of lifting and reaching with food items." (Ex. 53-1). However, claimant testified that, while working at Taco Time, she limited herself to only occasional lifting of 12 to 15 pounds. (Tr. 12). Claimant also testified that she asked for help lifting items that were too heavy. (Tr. 12). Moreover, claimant took measures to protect her right shoulder by using other methods for lifting. (Tr. 40). Finally, claimant's supervisor testified that he was aware of claimant's lifting restrictions at the time of her hire, and claimant was not required to perform a lot of repetitive lifting. (Tr. 51).

Under the circumstances, we conclude that Dr. Schroeder did not have an accurate history with respect to the frequency of lifting by claimant at Taco Time. See Weiland v. SAIF, 64 Or App 810 (1983). Therefore, we find persuasive reasons not to accept the opinion of claimant's treating physician.

We are also not persuaded that Dr. Colletti had an accurate history. Although Dr. Colletti acknowledged that claimant was not symptom-free when she began working for Taco Time, he reported that claimant was "doing well" with respect to her shoulder. However, claimant testified that after the injury with SAIF's insured, she "always had problems with it hurting, aching, knots in pressure-point

areas." (Tr. 10). Following the closure of her claim, claimant did not take medications, but she "used other methods to get rid of my pain." (Tr. 33). Claimant also testified that she had "never not had shoulder pain since the time of the original injury with Eugene Direct Mailing Services [SAIF's insured]." (Tr. 33).

Accordingly, for the aforementioned reasons, we do not find that Drs. Schroeder and Colletti relied on accurate histories. Therefore, we do not find their opinions to be persuasive. See Miller v. Granite Construction Co., 28 Or App 473, (1977). On the other hand, we find that Dr. Donahoo has provided an accurate and well-reasoned opinion.

Dr. Donahoo took a history that described claimant's ongoing symptoms following claim closure. (Ex. 49-2). Dr. Donahoo also took a history of claimant's work at Taco Time with lifting restrictions of 12 - 15 pounds on an occasional basis. (Ex. 49-3). Dr. Donahoo noted that claimant remained symptomatic since the original injury and that her history was compatible with an ongoing low grade impingement syndrome. Dr. Donahoo did not find that an ultrasound showed either a complete or partial tear, and he opined that claimant's current condition was a waxing and waning of symptoms which were primarily related to the original injury.

We therefore rely on Dr. Donahoo's opinion as it is based on an accurate history and provides a well-reasoned explanation. Consequently, we conclude that it has not been proven that claimant's injuries with Liberty's insured were the major contributing cause of her disability or need for treatment of the combined condition. Under the circumstances, we find that, pursuant to ORS 656.308(1), SAIF has failed to shift responsibility.

Alternatively, we conclude that the result in this case would not change if the last injurious exposure rule is applied, rather than ORS 656.308(1). The rule provides that when a worker proves that an occupational disease was caused by work conditions that existed when more than one carrier was on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238, 241 (1984). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke, 293 Or at 248. If a claimant receives treatment for a compensable condition before experiencing time loss due to the condition, the date the claimant first began to receive treatment related to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim. Timm v. Maley, 125 Or App 396, 401 (1993), rev den 319 Or 81 (1994).

Here, claimant first received treatment for her right shoulder condition on November 7, 1994 from Dr. Buchanan. As noted above, we agree with the ALJ that claimant's current condition is the same condition accepted by SAIF. Consequently, because claimant first sought treatment related to the compensable condition while she was employed by SAIF's insured, SAIF is assigned initial responsibility for that condition.

In order to shift responsibility to a later carrier, the later employment conditions must "contribute to the cause of, aggravate, or exacerbate the underlying disease." Bracke, 293 Or at 250; Oregon Boiler Works v. Lott, 115 Or App 70, 74 (1992) (later employment conditions must have actually contributed to a worsening of the condition). A claimant must suffer more than a mere increase in symptoms. Timm v. Maley, 134 Or App 245, 249 (1995).

Again, based on Dr. Donahoo's opinion that claimant's current condition was merely a waxing and waning of symptoms which were primarily related to the original injury, we conclude that SAIF has also failed to shift responsibility under the last injurious exposure rule. Therefore, under this alternative analysis, SAIF also remains responsible for claimant's right shoulder condition.

Accordingly, we reverse the ALJ's order and SAIF is assigned responsibility for claimant's current condition. SAIF is also responsible for the attorney fee assessed by the ALJ.

Timeliness

Because we find the medical evidence supports shifting responsibility to SAIF, we need not address Liberty's issue regarding timeliness of claim filing.

ORDER

The ALJ's order dated November 7, 1997 is reversed. The SAIF Corporation's February 25, 1997 denial is set aside and the claim is remanded to SAIF for processing. The ALJ's assessed attorney fee award of $3,800 for claimant's counsel's services at hearing is payable by SAIF, rather than Liberty. Liberty Northwest Insurance Corporation's denial dated June 20, 1997 is reinstated and upheld.

In the Matter of the Compensation of
ELVA M. PHILLIPS, Claimant
WCB Case No. 97-07542
ORDER ON REVIEW
J.R. Perkins III, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that found that the Hearings Division lacked jurisdiction to consider claimant's contention that her temporary disability rate had been incorrectly calculated, because she had not raised the issue during a reconsideration proceeding. On review, the issues are jurisdiction and rate of temporary disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following exception, supplementation, and summary. We do not adopt the last sentence of the findings of fact.

Claimant sustained a compensable occupational disease, which was diagnosed as lateral epicondylitis, right elbow. This condition was accepted and temporary disability (TTD) benefits were paid. (Ex. 5).

On March 19, 1997, the insurer notified claimant that her TTD had been incorrectly calculated using an average weekly wage of $424.20, whereas the correct average weekly wage was $313.15. (Ex. 9). The insurer advised claimant that this incorrect calculation had resulted in an overpayment that would be recovered through a 25 percent reduction in claimant's current TTD benefits. The insurer also advised claimant that, if her claim was closed before the total overpayment was recovered, any permanent disability award could be taken to recover any remaining overpayment. (*Id.*).

On July 16, 1997, claimant's claim was closed by a Determination Order that awarded temporary disability from November 18, 1995 through August 6, 1996 and from October 1, 1996 through June 26, 1997. (Ex. 11). Claimant was also awarded 5 percent scheduled permanent disability for loss of use or function of her right arm. Although the rate for the permanent disability award was listed, the rate for the temporary disability award was not. The Determination Order authorized the recovery of overpaid benefits from benefits due the worker. The Determination Order advised that claimant could request a reconsideration within 60 days from the mailing date of the Determination Order. (*Id.*).

Claimant did not seek reconsideration. Instead, on September 15, 1997, she requested a hearing and raised the issues of rate of temporary disability benefits, penalties, and attorney fees.

A September 29, 1997 audit work sheet indicated that, after the overpayment was deducted from the permanent disability benefits awarded by the Determination Order, there still remained an overpayment of $275.76.

At all relevant times, claimant was employed as a fruit packer for the employer. As a fruit packer, claimant was paid by the piece and was subject to seasonal layoffs. (Exs. A, 14). A Collective Bargaining Agreement governed the piece rate paid to fruit packers, and that rate increased on June 1, 1995. (Ex. A-4).

Claimant became disabled due to the occupational disease on November 18, 1995. During the period from June 1, 1995 to November 18, 1995, claimant actually worked 18 weeks and earned $6,989.76 in gross, regular wages. (Ex. 14).

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

Relying on our decision in *William T. Masters*, 48 Van Natta 1788 (1996), the ALJ found that the Hearings Division lacked jurisdiction to address the issue of temporary disability rate.

Subsequent to the date of the ALJ's order, we re-examined the issue presented by this case in *Blaine P. Hosey*, 50 Van Natta 360 (1998). In *Hosey*, after the closure order, but before the reconsideration proceeding, the insurer notified the claimant that it had allegedly miscalculated the claimant's temporary disability rate, which resulted in an alleged overpayment. The rate issue had arisen in the course of an audit the insurer conducted separate from the closure. However, the temporary disability rate was not manifest in the closure document itself. Instead, the closure document had merely awarded certain dates of temporary disability and indicated that deduction of overpaid disability benefits was allowed. Under those circumstances, we found that the claimant's failure to raise the rate issue during the reconsideration proceeding did not prohibit him from raising the temporary disability rate issue at hearing under ORS 656.283(7).[1]

The insurer argues that *Hosey* is distinguishable from the current case in that, here, the insurer notified claimant that it had allegedly miscalculated claimant's temporary disability rate *before* claim closure, whereas the insurer in *Hosey* did not provide this notification until *after* claim closure. However, we find this a distinction without a difference. In *Hosey*, the audit from which the rate issue arose occurred following closure. Nonetheless, the determinative factor was that the closure order itself did not specify the rate of claimant's temporary disability benefits. Here, as in *Hosey*, the rate issue was not manifest in the closure document itself. Consequently, we find that it was not necessary for claimant to raise the temporary disability rate issue in a reconsideration proceeding in order to preserve the issue at hearing. *See Blaine P. Hosey*, 50 Van Natta at 361,[2] *Bryan M. Fitzsimmons*, 50 Van Natta 433 (1998).

Rate of Temporary Disability

Former OAR 436-60-025(1) provides that the rate of compensation regarding occupational disease claims is based on the wage as outlined in ORS 656.210(2)(b)(B), which provides that temporary disability is calculated based on the wage of the worker at the time there is medical verification that the worker is unable to work because of disability caused by the occupational disease. The parties do not dispute that claimant was first unable to work because of disability caused by the occupational disease on November 18, 1995. (Ex. 11). Therefore, WCD Admin. Order 94-055, effective August 28, 1994, provides the applicable rules regarding calculation of claimant's temporary disability rate.

Claimant argues that, because *former* OAR 436-60-025(1) refers to ORS 656.210(2) for calculation of a temporary disability rate regarding an occupational disease claim, her rate should be calculated based solely on ORS 656.210(2), without reference to the Director's rules. In this regard, claimant argues that the Director's rules at *former* OAR 436-60-025(2) *et seq.* apply only to calculation of temporary disability rate for *injury* claims, not *occupational disease* claims. Applying this reasoning, claimant argues that her temporary disability rate should be based on $627.82, her last weekly wage before becoming disabled. We disagree.

ORS 656.210(2)(c) specifically provides that, for workers not regularly employed and for workers with no remuneration or whose remuneration is not based solely upon daily or weekly wages, the Director is authorized to prescribe by rule methods for establishing the worker's weekly wage. *Former* OAR 436-60-025(5).

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[1] ORS 656.283(7) provides, in part:

"Evidence on *an issue regarding a notice of closure or determination order* that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing, and issues that were not raised by a party to the reconsideration may not be raised at hearing unless the issue arises out of the reconsideration order itself." (Emphasis added).

[2] In Hosey, we disavowed the William T. Masters decision to the extent that it was inconsistent with our holding.

At the time she became disabled due to the occupational disease, claimant was employed as a fruit packer, was paid by the piece, and was subject to seasonal layoffs. (Exs. A, 14). Thus, claimant's remuneration is not based solely upon daily or weekly wages. Therefore, the Director's rules are applicable in determining claimant's rate. ORS 656.210(2)(c). In other words, claimant's temporary disability rate is calculated based on her earnings at the time she first became disabled as a result of the occupational disease, as determined applying rules prescribed by the Director. ORS 656.210(2); 656.210(2)(c).

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

"The rate of compensation for workers regularly employed, but paid on other than a daily or weekly basis, or employed with unscheduled, irregular or no earnings shall be computed on the wages determined by this rule.

" * * * * *

"(a) For workers employed on call, paid hourly, paid by piece work or with varying hours, shifts or wages, insurers shall use the worker's average weekly earnings with the employer at injury for the 52 weeks prior to the date of injury. For workers employed less than 52 weeks or where extended gaps exist and where there has been no change in the amount or method of the wage earning agreement, insurers shall use the actual weeks of employment with the employer at injury up to the previous 52 weeks. Where there has been a change in the amount or method of the wage earning agreement during the previous 52-week period, insurers shall use only the actual weeks under the wage earning agreement at time of injury. For workers employed less than four weeks, insurers shall use the intent of the most recent wage earning agreement as confirmed by the employer and the worker."

Claimant became disabled due to the occupational disease on November 18, 1995. During the previous 52-week period, there was a change in the amount of the wage earning agreement. Specifically, under the collective bargaining agreement, the rate of pay for piece work performed by fruit packers increased on June 1, 1995. (Ex. A-4). *Former* OAR 436-60-025(5)(a) provides that "[w]here there has been a change in the amount or method of the wage earning agreement during the previous 52-week period, insurers shall use only the actual weeks under the wage earning agreement at time of injury." Therefore, claimant's temporary disability rate is calculated using the actual weeks under the wage earning agreement as of November 18, 1995, the date claimant became disabled, *i.e.*, claimant's wages from June 1, 1995 to November 18, 1995. Claimant earned $6,989.76 in regular wages[3] during that period.

The next question is whether to calculate claimant's average weekly wage by dividing her wages of $6,989.76 by the number of weeks available for work during the period in question, or by the number of weeks she actually worked.

Claimant's job includes seasonal layoffs. During the period from June 1, 1995 to November 18, 1995, claimant was off work for three weeks in June, two weeks in late July and early August, and one week later in August. The insurer argues that these periods do not constitute "extended gaps." Therefore, the insurer contends, these weeks without work should be included in calculating claimant's average weekly wage. We need not determine whether these periods constitute "extended gaps" because, under the facts of this case, the rule regarding "extended gaps" does not apply. In this regard, the provision of *former* OAR 436-60-025(5)(a) that refers to "extended gaps" applies only "where there has been *no* change in the amount or method of the wage earning agreement." (Emphasis added). However, here, there was a change in the amount of the wage earning agreement; thus, the "extended gaps" provision does not apply. *Thomas R. Hellingson*, 49 Van Natta 1562 (1997).

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[3] Claimant apparently contends that the 19.6 hours of overtime she worked in the period from June 1, 1995 to November 18, 1995 should be included in calculating her average weekly wage. However, *former* OAR 436-60-025(5)(e) requires consideration of overtime hours only when the worker worked overtime on a "regular basis." That is not the case here, where claimant worked only 19.6 hours of overtime during the period in question. (Ex. 14). Therefore, we do not include claimant's overtime wages in calculating her average weekly wage.

Furthermore, where there has been a change in the amount of the wage earning agreement, the "insurers shall use only the actual weeks under the wage earning agreement." *Former* OAR 436-60-025(5)(a). Moreover, we have determined 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. *Ken T. Dyer*, 49 Van Natta 2086 (1997) (finding that interpreting "actual weeks of employment" as including only those weeks a worker is actually employed is consistent with the administrative rule and the statutory scheme); *Thomas R. Hellingson*, 49 Van Natta at 1564 (only weeks when the claimant earned wages included in "actual weeks" under wage earning agreement). During the period from June 1, 1995 to November 18, 1995, claimant actually worked 18 weeks. (Ex. 14).

Accordingly, claimant's temporary disability rate should be calculated on the basis of an average weekly wage of $388.32 ($6,989.76 ÷ 18 weeks). This, in turn, results in a weekly temporary disability rate of 258.89 (two-thirds of $388.32). ORS 656.210(1).

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. Consequently, claimant's counsel is entitled to 25 percent of any increased temporary disability benefits resulting from this order, not to exceed $3,800, payable directly to claimant's attorney.

ORDER

The ALJ's order dated January 23, 1998, as amended on January 30, 1998, is reversed. The insurer is ordered to pay temporary disability benefits based on an average weekly wage of $388.32, for a weekly temporary disability rate of $258.89. Claimant's counsel is awarded 25 percent of any increased compensation resulting from this order, not to exceed $3,800, payable directly to claimant's counsel.

May 20, 1998 Cite as 50 Van Natta 967 (1998)

In the Matter of the Compensation of
ANTONIO E. SANCHEZ, Claimant
WCB Case No. 97-03171
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

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

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld SAIF's denial of claimant's L4-5 disc herniation, finding that claimant failed to prove that his compensable October 19, 1994 injury (accepted as a lumbar strain/sprain) was a material contributing cause of his current low back condition. In doing so, the ALJ relied primarily on the medical opinion of a consulting neurosurgeon, Dr. Calhoun, who could not relate claimant's disc herniation to the compensable injury. (Ex. 20).

On review, claimant contends that the ALJ should not have relied on Dr. Calhoun's opinion because it was based on a faulty history that claimant's October 1994 injury had resolved and that claimant was asymptomatic prior to experiencing severe low back pain with left leg radiation after engaging in non-work related activity (sweeping a floor) on September 8, 1996. Claimant asserts that he

had continuous low back and left leg pain from the date of his last treatment for the October 1994 injury (December 15, 1994) until the September 1996 incident and that the medical opinion of the physicians who relied on that history should be found more persuasive. For the following reasons, we agree with claimant that he sustained his burden of proving that his L4-5 disc condition is compensable.

At the outset, we note that there is no evidence that claimant's compensable 1994 injury "combined" with a preexisting condition. See ORS 656.005(7)(a)(B). Thus, we agree with the ALJ that the appropriate legal standard is material contributing cause.[1] See Albany General Hospital v. Gasperino, 113 Or App 411 (1992); Ronald L. Ledbetter, 47 Van Natta 1461 (1995) (major contributing cause standard of ORS 656.005(7)(a)(B) applies only if there is evidence that a compensable injury combined with a preexisting condition). Considering the passage of time since the work injury, we find that the causation issue is a complex medical question which requires expert evidence for its resolution. See Barnett v. SAIF, 122 Or App 279 (1993). We rely on those medical opinions which are well-reasoned and based on accurate and complete histories. See Somers v. SAIF, 77 Or App 259 (1986).

Here, we find Dr. Calhoun's opinion unpersuasive because it was based on an inaccurate history. As previously noted, Dr. Calhoun assumed that claimant's 1994 injury had "resolved" and that he remained asymptomatic until the September 1996 off-the job activity. However, claimant credibly testified that he had experienced low back and left leg symptoms ever since the 1994 injury. (Tr. 18).

In that regard, we note that, on December 15, 1994, the date of claimant's last treatment for the 1994 injury, Dr. Weil, claimant's then-attending physician, reported that claimant was still experiencing low back symptoms. (Ex. 6). Although Dr. Weil subsequently agreed on January 19, 1995 that claimant's lumbar sprain/strain had resolved without permanent impairment (Ex. 8), we do not find that Dr. Weil's opinion necessarily establishes that claimant was asymptomatic when treatment ceased, given that claimant was still experiencing symptoms. Further, a witness (Ramirez) who worked with claimant at a restaurant in 1995 and 1996 testified that claimant appeared to have pain in his low back and leg. (Tr. 24). Moreover, prior to the denial of his claim, claimant reported ongoing symptoms to examining physicians Drs. Tesar and Bell. (Ex. 17).

We recognize that Dr. Calhoun reported that claimant was asymptomatic prior to the September 1996 flare-up. (Ex. 20). However, claimant testified that he spoke with Dr. Calhoun only two or three minutes regarding his history because of language difficulties. (Tr. 19). Thus, he was not able to give Dr. Calhoun an accurate history. We accept claimant's testimony as an adequate explanation for the history contained in Dr. Calhoun's report.

Accordingly, we find that claimant's 1994 injury did not completely resolve and that claimant experienced continuing low back and left leg symptoms in 1995 and 1996. Because Dr. Calhoun's opinion was based on an inaccurate history, we give it little weight. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977). Instead, we look elsewhere for expert medical opinion to resolve the causation issue.

Dr. Beebe, a chiropractor who treated claimant in 1994 and again in 1996, suspected in 1994 that claimant had disc pathology. (Ex. 2A-2). However, a definitive diagnostic study was not undertaken at that time. On March 18, 1997, Dr. Beebe opined that claimant's L4-5 disc was most probably injured in 1994. (Ex. 16A). Dr. Weil offered no opinion on the etiology of claimant's disc condition, but Drs. Tesar and Bell opined that claimant's activity on September 8, 1996 was the major contributing cause of the L4-5 disc condition. (Ex. 17-7).

However, the panel also stated that, if claimant continued to have intermittent symptoms since his original injury, had not been pain free for over a period of two months, and had recurrent low back pain with left leg symptoms, then the original injury would be the major contributing cause of the L4-5 disc condition. Id. In light of our finding that claimant was continuously symptomatic since the 1994 injury, we find that the Tesar/Bell report supports a conclusion that the original compensable injury is the major contributing cause of the L4-5 disc condition.

Therefore, based on our de novo review of the medical record, we conclude that claimant satisfied his burden of proving that the compensable 1994 injury is a material contributing cause of the L4-5 disc condition. Thus, we reverse the ALJ's decision to uphold SAIF's denial.

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[1] No party disputes the ALJ's application of a material causation standard.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review regarding the compensability issue is $3,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated February 4, 1998 is reversed. SAIF's April 10, 1997 denial is set aside and the claim is remanded to SAIF for processing in accordance with law. For services at hearing and on review, claimant's counsel is awarded an assessed fee of $3,500, to be paid by SAIF.

May 20, 1998 Cite as 50 Van Natta 969 (1998)

In the Matter of the Compensation of
JAMES C. STARK, Claimant
WCB Case No. 97-06489
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Menashe's order that affirmed an Order on Reconsideration awarding no scheduled permanent disability for loss of use or function of the right upper extremity. In its brief, the SAIF Corporation challenges that portion of the ALJ's order that awarded 5 percent (16 degrees) unscheduled permanent disability for a thoracic condition. On review, the issues are extent of scheduled and unscheduled permanent disability.

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

Scheduled Permanent Disability

Claimant has an accepted claim for thoracic strain. A Notice of Closure awarded no permanent disability. An Order on Reconsideration affirmed the closure notice.

The ALJ found that Dr. Gritzka, the medical arbiter, provided the most persuasive opinion concerning the extent of claimant's permanent disability. In his report, Dr. Gritzka stated that claimant "does appear to have some minor muscle weakness in his right upper extremity[.] This weakness is most probably based on disuse secondary to right shoulder and upper back pain with forceful or repetitive activity." (Ex. 21-5).

The ALJ disagreed with claimant's contention that such evidence warranted an award for loss of strength of the right arm, finding that it did not "establish a permanent condition due to the injury." Claimant challenges this portion of the ALJ's order, asserting that, because "disuse" resulted from the compensable injury, any impairment from "disuse" should also be considered as due to the industrial injury.

As noted above, claimant's accepted condition is "thoracic strain." Under ORS 656.268(16), impairment from conditions that are "direct medical sequela to the original accepted condition" are rated. We have construed the statute as applying when the record shows that an unaccepted condition is a "direct medical sequela" of the *accepted condition*, as opposed to the accidental injury from which the accepted condition arose. *See Donald D. Davis*, 49 Van Natta 2100 (1997), *recon* 50 Van Natta 357 (1998). Consequently, if claimant's "disuse" in his right upper extremity is a "direct medical sequela" of the thoracic strain, then he is entitled to a scheduled permanent disability award.

Here, Dr. Gritzka stated that "disuse" was "secondary to right shoulder and upper back pain." Because such evidence shows that "disuse" in his right arm is a "direct medical sequela" of right shoulder and upper back pain, and such condition is not the accepted thoracic strain condition, we agree with the ALJ that claimant is not entitled to a scheduled permanent disability award for his right upper extremity. *See* ORS 656.268(16).

Unscheduled Permanent Disability

In its brief, SAIF objects to the ALJ's award of 5 percent unscheduled permanent disability. We agree with the ALJ's reasoning and conclusion regarding this issue. We supplement only to address claimant's argument that, because claimant's request for review was limited to the scheduled permanent disability issue and SAIF did not file a cross-request review, SAIF is not "entitled" to challenge the unscheduled permanent disability issue.

Based on our *de novo* review, we have authority to consider matters decided by the ALJ which are raised by the parties' briefs and in the absence of a formal cross-request for review, provided that the formal request for review has not been withdrawn. *E.g., Eder v. Pilcher Construction*, 89 Or App 425, 427 (1988). Here, because claimant did not withdraw his request for review and the ALJ decided the unscheduled permanent disability, we may consider SAIF's arguments concerning this issue. After considering those arguments, we affirm the ALJ's order.

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

ORDER

The ALJ's order dated December 16, 1997 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $500, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
JOSEPH E. YATES, Claimant
WCB Case No. C8-00560
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Stephen A. Moen, Claimant Attorney
Kenneth W. Stodd, Defense Attorney

Reviewed by Board Member Biehl and Haynes.

On March 11, 1998, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We disapprove the proposed disposition.

As originally submitted, the proposed CDA provided that the consideration for the CDA was the insurer's reduction of its third party lien by the amount of $1,250, but did not provide the full amount of the insurer's lien or the amount of the settlement.

On March 25, 1998, we wrote the parties requesting an addendum providing the amount of the third party settlement and the full amount of the insurer's third party lien. In requesting this information, we noted that we generally disapprove CDAs in which the consideration consists of a carrier's reduction of a lien, but the CDA contains no information concerning the amount of the third party settlement or judgment and/or the amount of the carrier's lien. *See, e.g., Michael Salber*, 48 Van

Natta 757 (1996); *see also Kenneth Hoag*, 43 Van Natta 991 (1991). 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.*

On April 22, 1998, we received the parties' addendum to the CDA. The addendum provided that the insurer's statutory lien against claimant's third party recovery was $4,757.77 and that the insurer intended to reduce its lien by $1,250. However, the addendum did not provide the amount of the third party settlement.

On April 24, 1998, we again wrote the parties requesting that they provide the amount of the third party settlement. On May 11, 1998, we received a letter from the insurer's attorney citing *Anthony G. Allen*, 49 Van Natta 460 (1997), and asserting that since the insurer had identified the amount of its statutory lien and agreed to reduce the lien by $1,250, the "requirements of approval" set forth in *Allen* had been met. We disagree with the insurer's interpretation of the *Allen* holding.

In *Allen*, we approved a CDA which did not provide the specific settlement amount, but in which the parties represented that the insurer's statutory share would be approximately $250,000. In other words, the parties in *Allen* expressly stipulated that the insurer's $250,000 statutory lien was *recoverable* from the third party settlement. Thus, the consideration for the CDA was the insurer's waiver of $80,000 of its statutorily *recoverable* third party lien. Because the insurer in *Allen* could otherwise recover all of its $250,000 statutory share from the third party settlement, we were able to conclude that the "value" of the consideration flowing to claimant under the agreement ($80,000) was sufficiently ascertainable to gain our approval.

Here, in contrast to *Allen*, the parties have indicated only that the insurer's full lien is $4,757.77, and that the lien would be reduced by $1,250. The parties have not expressly stipulated that the $4,757.77 lien or any specific portion of the lien is *recoverable* from the third party settlement. Where a CDA lacks the amount of the third party settlement, and where the parties have not stipulated that the lien would otherwise be statutorily *recoverable* from the third party settlement, we are unable to determine the value of the consideration for the CDA. Specifically, without this information, we cannot determine whether, after deduction of costs, attorney fees and claimant's 1/3 statutory share of the settlement, the carrier will be able to recover its $4,757.77 lien or any portion of the lien from the remaining balance of the third party recovery. *See* ORS 656.593(1)(a),(b) and (c).

In other words, without the aforementioned clarification, it is theoretically possible that the carrier would not be able to recover any of its lien from the third party settlement. The waiver of an unrecoverable lien would not provide any consideration for the CDA. Thus, in the absence of the amount of the settlement or an express stipulation from all of the parties that the lien is recoverable, we are unable to determine the "value" of any consideration flowing to claimant under the agreement.

Under these circumstances, we find that the CDA is unreasonable as a matter of law and we disapprove it. ORS 656.236(1)(a)(A); *Michael Salber*, 48 Van Natta 757 (1996).

Inasmuch as the proposed disposition has been disapproved, the insurer shall recommence payment of any temporary or permanent disability that was stayed by the submission of the proposed disposition. OAR 436-060-150(5)(k) and (7)(e).

Following our standard procedure, we would be willing to consider a revised agreement drafted in compliance with our rules and the matters discussed in this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
WILLIAM R. YOUNG, Deceased, Claimant
WCB Case No. 97-04470
ORDER ON REVIEW
David B. Hydes, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes, Bock, and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Herman's order that set aside its denial of claimant's fatal injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact."[1]

CONCLUSIONS OF LAW AND OPINION

Claimant began working for SAIF's insured in 1993. His job duties included checking logging operations, setting up and managing timber sales, performing timber stand evaluations, and marking trees. His work hours were flexible, but usually from 7:00 A.M. to 5:00 P.M. He drove a company truck on the job and for commuting to and from work.

Sometime between Christmas 1996 and New Year's Day 1997, claimant took out his .270 caliber rifle and laid it on the table at home. He told his wife that he had seen coyotes on his way to and from work and he intended to put the rifle in his truck.

On the morning of January 7, 1997, claimant drove toward the landing at a new logging unit on Rudio Mountain. He was carrying tree-marking paint for co-workers and his .270 caliber rifle. Between 8:30 and 9:00 A.M., claimant told David Nelson, a log truck driver, that he was looking for coyotes.

Around 10:00 A.M., Nelson saw claimant's truck along the road with the engine off and the driver's door open. Claimant's body was lying in the road perpendicular to the driver's side of the truck. His gun was on the seat of the pick-up, "where the driver would be sitting, pointing to the driver's door." (Tr. 58). Noting no pulse, Nelson summoned help.

It was determined that claimant died where he was discovered. Later, an autopsy revealed that he had been shot under the right arm with a .270 caliber rifle. After investigation, the sheriff ruled out suicide and homicide and concluded that the death was caused by accidental discharge of the weapon.

Claimant's widow filed a claim, which SAIF denied.

The ALJ concluded that the fatal injury arose out of and in the course and scope of employment, reasoning that claimant was working when he died and his activity was not primarily for his personal pleasure. We disagree.

Under ORS 656.005(7)(b)(B), a "compensable injury" does not include any injury incurred while engaging in recreational activity primarily for the worker's personal pleasure.

We have previously held that a statutory exclusion analysis is a threshold consideration when ORS 656.005(7)(b)(B) applies. See Mike R. Armstrong, 50 Van Natta 54 (1998); Michael W. Hardenbrook, 44 Van Natta 529, 530, aff'd mem Hardenbrook v. Liberty Northwest Insurance Corporation, 117 Or App 543 (1992); see also Andrews v. Tektronix, Inc., 323 Or 154, 161 n. 1 (1996) (Explaining that ORS 656.005(7)(a) "is the primary definition of compensability" and subsection (b) states "grounds for exclusion that are additional to those that are inherent in the primary definition found in paragraph (7)(a)"). The proper inquiry under ORS 656.005(7)(b)(B)[2] is an examination of the primary purpose of the activity at the time of the injury. Kaiel v. Cultural Homestay Institute, 129 Or App 471, 478 (1994).

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[1] The employer was Grant Western Lumber Company, not Prairie Wood Products. (See Tr. 38-40).

[2] We acknowledge that the statute does not automatically exclude those recreational activities that have a close work nexus and are not performed primarily for the worker's personal pleasure. See Julie A. Garcia, 48 Van Natta 775 (1996). Because we find herein that claimant was engaged in a recreational activity primarily for his personal pleasure at the time of his death, the statutory exclusion applies.

In this case, claimant was shot to death accidentally with his own gun, a .270 caliber rifle.

Nelson was the last person to see claimant alive. Before the accident, Nelson met claimant, who was stopped at a turn-out along the road, and they had a conversation. Claimant told Nelson that he was "looking for coyotes."[3] (Tr. 52-55, 61; see Tr. 35).

Wallace Kimball, who worked as a forester for the employer, inspected tracks and signs in the snow along claimant's route the day after the accident. Kimball discovered the tire tracks of a pick-up the size of claimant's truck[4] off the road and human foot tracks leading a couple hundred yards off the road in "open juniper." Based on the tracks, Kimball believed that the truck turned around at this spot and then proceeded about "a quarter to three-eighths of a mile" to the spot where it pulled out again (where Nelson and claimant conversed). Similar tire tracks turned around at another spot off the main road on the way to the Rudio Mountain landing. (Tr. 74-77).

Based on these facts, we find that it more likely than not that claimant was coyote hunting when he died. In reaching this conclusion, we note that the gun was on the seat of the truck with a bullet in the chamber, claimant was carrying his rifle because he had spotted coyotes, and claimant told Nelson that he was looking for coyotes shortly before his death. Considering claimant's tracks, his communications, and the bullet in the gun's chamber, we conclude that claimant was hunting when he died.[5]

The next question is whether claimant's hunting activities were primarily for his "personal pleasure." We find no evidence that hunting coyotes (or shooting them) was a work-related activity.[6] (See e.g., Tr. 41). Under these circumstances, we conclude that claimant was engaged in a recreational activity primarily for his personal pleasure at the time of his fatal injury. Consequently, the injury is not compensable under ORS 656.005(7)(b)(B).[7]

ORDER

The ALJ's order dated September 30, 1997 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

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[3] Claimant loved to hunt. (Tr. 72). About two weeks before his death, claimant told his wife, "I'm going to put [the ".270"] in my rig tomorrow, because I've been seeing a lot of coyotes going to and from work. . . .More than I've ever seen." (Tr. 70).

[4] The other visible tracks were those of larger trucks, such as log trucks.

[5] Unlike the dissent, we prefer not to "guess" at the nature of claimant's specific activity at the time of his death. Rather, we believe the record permits no inference other than that which we reach.

[6] There is some evidence of work-related gun use on claimant's job: He sometimes shot pinecones out of trees to inspect the seeds. However, this was done in the fall, not in January. (Tr. 27; see Tr. 47). Moreover, claimant would use a .22 caliber gun (not the ".270" he was carrying when he died) for shooting pinecones. A ".270" would demolish a pinecone. (Tr. 33).

[7] Because the threshold issue under ORS 656.005(7)(b)(B) is determinative, we do not address claimant's arguable status as a traveling employee or his arguments regarding the employer's acquiescence in hunting on the job.

Board Member Biehl dissenting.

The majority concludes that claimant's fatal injury is not compensable because claimant was hunting, an activity primarily for his "personal pleasure," when he died. I disagree.

We will never know exactly what claimant was doing or thinking just before the accident. We can only speculate. Accordingly, I would focus on the particular facts proximate to the unwitnessed incident: Claimant's truck was in the middle of the road, not on the shoulder, as one might expect if he was hunting or preparing to hunt. Claimant was outside the truck, but his gun was in the truck. He was not hunting, he was standing next to his truck.

On these facts, I would find that claimant was, at most, engaged in a neutral activity, such as rearranging the cab of the pick up. Alternatively, I would find it just as likely that claimant was preparing to inspect a stand of trees, a work related activity. Because we have no way of knowing what claimant was doing when he died, I would not infer, as the majority does, that claimant was hunting.

Moreover, it is undisputed that this claim would be compensable if claimant was not hunting when he died. We know that the employer acquiesced in employee gun carrying and use at work. Therefore, the risk of injury due to accidental discharge of a gun was clearly a risk of claimant's employment.

We also know that claimant was a "traveling employee," because travel was a necessary incident to his employment. As a traveling employee, claimant was continuously within the course and scope of his employment, unless he was engaged in a "distinct departure" on a personal errand. Because claimant was on his way to a work-related meeting when the accident happened, he is entitled to the extended coverage afforded traveling employees. There is no evidence of a personal errand in this case, only supposition.

Considering the employer's acquiescence in gun handling, there can be no reasonable finding that claimant's activity at the time of his death was a "distinct departure" from his employment. Moreover, even if claimant was engaged in a "neutral" activity, such as rearranging the cab of the truck, he had clearly not abandoned his employment when he died.

This claim would be compensable, but for the majority's inference that claimant was hunting. That inference is pure conjecture, not based on the most contemporaneous facts. I would not deny benefits based on mere speculation. Accordingly, because I would find the claim compensable, I must respectfully dissent.

In the Matter of the Compensation of
JUDITH DANSCA, Claimant
WCB Case No. 97-00010
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Hall and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Tenenbaum's order that set aside its denial of claimant's occupational disease claim for contact dermatitis. On review, the issue is compensability.

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

Citing *Bronco Cleaners v. Velazquez*, 141 Or App 295 (1996), the ALJ determined that claimant had proved that some substance encountered in the course and scope of her employment as a gift wrapper at a department store was the major contributing cause of her dermatological condition. In making this determination, the ALJ found the opinion of claimant's attending physician, Dr. Larner, which supported compensability, more persuasive than that of a panel of examining physicians, Dr. Storrs and Dr. Basler.

On review, the employer contends that *Velazquez* is distinguishable because, unlike that case, the pattern of diminishment and enhancement of the condition that correlates to the existence of or lack of exposure to the work place is much weaker here than it was in *Velazquez*. The employer emphasizes that claimant in this case spent much more time gift wrapping without problems between outbreaks of dermatitis than experiencing dermatological symptoms while gift wrapping. Moreover, the employer asserts that Dr. Larner's "tentative" opinion in support of compensability, in combination with the weak temporal relationship between claimant's symptoms and her employment, is insufficient to establish compensability, especially in light of Storrs/Basler panel's contrary opinion. For the following reasons, we disagree with the employer's contentions and conclude, based on our *de novo* review of the record, that claimant satisfied her burden of proof.

In *Velazquez*, the court held that, if the claimant had merely demonstrated that, before she worked for the employer, she did not have a condition, and now she did, that proof would be legally insufficient under ORS 656.266. However, in *Velazquez*, the evidence was sufficient to establish a compensable occupational disease because it went beyond that chronological connection and demonstrated a "pattern of diminishment and enhancement of the condition that correlates to the existence of or lack of exposure to the work place." 141 Or App at 299.

Here, we find that Dr. Larner's chart notes and deposition testimony and claimant's credible testimony demonstrate "a pattern of diminishment and enhancement" of the contact dermatitis condition that correlated to claimant's work exposure or lack thereof. (Trs. 11, 12; Exs. 4, 5, 7 pps:15, 20, 33). We acknowledge that claimant has spent the majority of her employment working without dermatological symptoms. However, Dr. Larner's deposition testimony indicates that the nature of contact dermatitis is such that outbreaks can occur for no apparent reason after significant asymptomatic periods. (Ex. 7-31, 32). Moreover, we are persuaded by the above evidence in the record that, during claimant's outbreaks, there was a definite pattern of diminishment and enhancement of the condition that correlated to the existence of or lack of exposure to the work place.

Apart from the evidence of a temporal relationship between claimant's symptoms and her employment exposure, we find Dr. Larner's opinion persuasive on the issue of medical causation. While it is clear that Dr. Larner could never identify the exact causal agent in claimant's work environment, largely because patch testing was inconclusive, identification of the precise agent is not necessary in order to establish a compensable occupational disease claim. 141 Or App at 300. Despite his uncertainty as to the precise chemical or irritant agent that caused claimant's dermatological condition, Dr. Larner opined that claimant's condition was "work-induced" and agreed that work was the major factor in claimant's condition. (Ex. 7-21). Although Dr. Larner did not use the magic words "major contributing cause," we are persuaded that his opinion establishes medical causation. *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).[1]

Accordingly, we conclude that claimant sustained her burden of proving a compensable occupational disease. Because the ALJ concluded similarly, we affirm.

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 case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 14, 1998 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the employer.

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[1] The employer's contentions notwithstanding, we do not find the Storrs/Basler panel's opinion more persuasive. They agreed that claimant's history suggested a dermatitis condition, but were unable to comment on claimant's lesions because they were unable to observe them when they occurred, nor could they observe the course of their resolution and exacerbations. (Ex. 8-3). Based on this evidence, we conclude that expert observation, such as Dr. Larner provided, is important in this case. Thus, we give greater weight to the attending physician's opinion. *See Allie v. SAIF*, 79 Or App 284, 287 (1986); *Weiland v. SAIF*, 64 Or App 810, 814 (1983).

In the Matter of the Compensation of
ANTONINA GNATIUK, Claimant
WCB Case No. 97-09056
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Martha Brown's order that: (1) upheld the SAIF Corporation's denial of her claim for a back and head injury; and (2) declined to assess a penalty or related attorney fee for an allegedly unreasonable denial. No appellate briefs were timely filed on review.[1] On review, the issues are compensability and penalties.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated February 27, 1998 is affirmed.

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[1] The parties and their attorneys were notified of the briefing schedule by letter dated April 1, 1998. The letter stated that claimant had 21 days or until April 22, 1998 to file her appellant's brief. An appellant's brief was not filed before the deadline, and SAIF waived filing of a respondent's brief. Thereafter, on April 30, 1998, claimant, through counsel, filed an "Appellant's Brief." Attaching an internal office computer print-out, claimant's attorney represents that the late filing was due to a clerical error and requests that the brief be considered on Board review. He further advises that SAIF takes no position regarding his request.

Ordinarily, the Board will not consider a brief that is untimely filed unless a request for an extension is granted. Extensions of time for filing of briefs are allowed only on written request filed no later than the date the brief is due. OAR 438-015-0020(3). Because claimant filed her extension request after the due date for her brief, we treat claimant's request as a motion to waive the Board's briefing rules. *See* OAR 438-011-0030. A motion to waive the rules may be allowed if the Board finds that extraordinary circumstances beyond the control of the moving party justify such action. *Id.* We have held that a "calendaring error," which is similar to the clerical error asserted in this case, does not constitute an extraordinary circumstance beyond the control of the moving party. *Lester E. Saunders*, 46 Van Natta 1153, 1154 (1994). Therefore, we find no extraordinary circumstances that were beyond the control of claimant and her counsel. Accordingly, claimant's motion is denied, and her untimely brief has not been considered on review.

In the Matter of the Compensation of
DAVID D. HOLBROOK, Claimant
WCB Case Nos. 97-04338 & 96-09711
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Moller and Hall.

The SAIF Corporation, on behalf of Oregon Wilbert Vault Corporation (Wilbert), requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) found that claimant's current low back condition is compensable; (2) set aside its denial of claimant's "new injury" claim for the current low back condition; and (3) upheld SAIF's partial denial, issued on behalf of Sunset Hills Memorial Park (Sunset), of claimant's claim for the same condition. In his respondent's brief, claimant contends that responsibility should be assigned to SAIF/Sunset. On review, the issues are compensability and responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

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

We supplement and summarize the ALJ's factual findings as follows. Claimant compensably injured his low back in December 1993 during a lifting incident while working for Sunset as a cemetery groundskeeper. He developed low back pain with radiating pain in the left leg. He was diagnosed with a lumbosacral strain and received conservative treatment until February 1994. SAIF/Sunset accepted his claim for a nondisabling injury.

Claimant continued to have intermittent flare-ups of low back problems, particularly while shoveling or "peeling grass." "Peeling grass" was the process in which a shovel was used to cut and "peel" the turf covering the burial plot to allow for digging of the grave. The "peeling" required claimant to get as low as he could and use the shovel to cut the turf from the ground. Occasionally, his back pain was so severe that he was unable to peel grass and co-workers would do it for him. Despite the intermittent flare-ups of pain, claimant was able to continue working and did not seek treatment for his low back.

Claimant's employment with Sunset ended in January 1996 and he began working at a similar job with Wilbert in February 1996. His Wilbert employment began in the shop pouring concrete into forms. The shop work did not require much shoveling. He was laid off in May 1996 for about a month and a half. He did not have any significant back symptoms during the time he worked in the shop and was laid off. When he returned to Wilbert following his layoff, he was assigned to the shop until his last week of employment with Wilbert, in July/August 1996. During that last week of employment, he was re-assigned to grave digging. The grave digging work, which included grass peeling, was similar to the work he performed for Sunset, except that he did not have any co-workers to assist him. The graves were dug with a backhoe and refilled using a dump truck. Claimant's back and left leg pain flared up during that last week of employment. In addition to back and leg pain, he experienced the first onset of numbness in the first two toes of his right foot.

Claimant sought treatment with Dr. Thoming on August 5, 1996 and eventually came under the care of Dr. Ward. A lumbar MRI scan showed no significant abnormalities. The diagnosis was a lumbosacral strain and treatment was conservative. Claimant filed a claim against SAIF/Sunset and a new injury/disease claim against SAIF/Wilbert. Both claims were denied and claimant requested a hearing.

We modify the ALJ's factual findings as follows. In lieu of the ALJ's "ultimate finding" that claimant's low back condition is the responsibility of SAIF/Wilbert, we do not find that claimant suffered a new compensable injury or occupational disease during his employment with SAIF/Wilbert.

CONCLUSIONS OF LAW AND OPINION

Compensability

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

Responsibility

The ALJ concluded that SAIF/Wilbert is responsible for claimant's current low back condition under ORS 656.308(1), based on the finding that claimant suffered a new occupational disease resulting from work activities with Wilbert. On review, SAIF/Wilbert and claimant contend that the ALJ incorrectly evaluated the medical evidence regarding the responsibility issue and that the greater weight of the evidence establishes that SAIF/Sunset is responsible for the current condition.

The threshold issue is whether claimant's claim against SAIF/Wilbert should be analyzed as an accidental injury or occupational disease. The ALJ analyzed the claim as an occupational disease based on the finding that claimant had a "gradual onset" of low back symptoms while working for SAIF/Wilbert in 1996. Based on our review of the record, which shows that claimant's back and leg pain in 1996 developed over the course of several days and was not precipitated by any particular event or activity, we agree with the ALJ's finding.

However, even if the claim was analyzed as an accidental injury, because the record shows that claimant's current low back condition is a "combined condition" involving the accepted 1993 injury and the employment exposure with Wilbert, the injury claim nevertheless would be subject to the "major contributing cause" standard in ORS 656.005(7)(a)(B). Thus, whether the claim against SAIF/Wilbert is analyzed as an occupational disease or injury, in order for the claim to prevail, there must be a preponderance of evidence in the record to establish that employment conditions with Wilbert were the major contributing cause of the need for treatment of the current low back condition. See ORS 656.005(7)(a)(B), 656.802(2)(b). Because there are multiple causal factors involved in claimant's condition, determining the "major" causal factor presents a complex medical question which must be resolved on the basis of expert medical evidence. See Uris v. Compensation Dept., 247 Or 420, 426 (1967); Barnett v. SAIF, 122 Or 279, 283 (1993). For the following reasons, we conclude that the record does not support the claim against SAIF/Wilbert.

The ALJ relied on the opinion of Dr. Ward in Exhibit 38. In that document, SAIF provided Dr. Ward with the following history: "The work [claimant] was doing prior to going to the doctor in 1996 was to physically use a shovel to fill in a hole." (Ex. 38-1). Based on the history provided in Exhibit 38, Dr. Ward answered "yes" to the following question posed by SAIF:

> "Considering the new appearance of right foot symptoms and the fact that the symptoms in August of 1996 did not simply resolve on their own, as prior flare-ups had done, is it probable that work activity in the summer of 1996, including shoveling by hand, is the major contributing cause of the worsened back condition in August of 1996?" (Ex. 38-2, emphasis supplied).

The emphasized portion of the history assumed in the question posed to Dr. Ward--that claimant performed shoveling by hand during his employment in the Summer of 1996--was based on claimant's pre-hearing statement to SAIF's investigator that, at the time of his flare-up of back and leg pain and the first onset of toe numbness in August 1996, he had been refilling holes (i.e., graves) "by shovel." (Ex. 29-4). At hearing, however, claimant testified that the graves were refilled by dump truck; the truck bed was lifted and the dirt was "scooped" into the hole. (Tr. 22). At the time of Exhibit 38, Dr. Ward was not aware of claimant's use of the dump truck to refill holes; he appeared to assume that claimant refilled the holes by hand shoveling dirt. In addition, although Dr. Ward was subsequently deposed and adhered to his causation opinion in Exhibit 38, he was not apprised of the correct history that claimant used a dump truck to refill holes at Wilbert. Therefore, Dr. Ward's testimony also was based on a materially inaccurate history.

Prior to receiving the inaccurate history in Exhibit 38, Dr. Ward consistently described claimant's current back condition as a continuation, or worsening, of the accepted 1993 lumbosacral strain. (Exs. 23-3, 26-1, 27-1, 30-1, 32, 36-5). Therefore, it appears that the inaccurate history regarding claimant's work activities for Wilbert was an important basis for Dr. Ward's opinion relating the current condition in major part to the Wilbert employment. Because the inaccurate history went to a material fact and was an express basis for the doctor's conclusion that the work activities at Wilbert were the major cause of claimant's current back condition, we conclude that the probative value of his causation opinion must be discounted. See Miller v. Granite Construction Co., 28 Or App 473, 478 (1977) (medical opinion based on inaccurate history is unpersuasive).

There is no other expert medical opinion in the record relating claimant's current low back condition in major part to the conditions of his employment with Wilbert. Without persuasive medical evidence to support a new injury or disease claim against Wilbert, we conclude that there is a failure of necessary proof to shift responsibility under ORS 656.308(1). Accordingly, responsibility for claimant's current low back condition shall be assigned to SAIF/Sunset.

Claimant's attorney is entitled to an assessed fee for services on review in successfully defending against SAIF/Wilbert's request for review concerning the compensability issue. See ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $700, to be paid by SAIF/Wilbert. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by claimant's respondent's brief and his attorney's statement of services[1]), the complexity of the compensability issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 25, 1997 is reversed in part and affirmed in part. Those portions of the order that set aside SAIF/Wilbert's denial of responsibility and upheld SAIF/Sunset's partial denial of responsibility are reversed. SAIF/Sunset's partial denial of responsibility is set aside and the claim for the current low back condition is remanded to SAIF/Sunset for processing according to law. SAIF/Wilbert's denial of responsibility is reinstated and upheld. The ALJ's $3,000 assessed fee award to claimant's attorney shall be paid by SAIF/Sunset. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $700, payable by SAIF/Sunset.

[1] In the statement of services, claimant's attorney requested an assessed fee of $1,400 for services devoted to the compensability and responsibility issues. We have determined that one-half of the requested fee amount is a reasonable fee for services devoted to the compensability issue.

May 21, 1998 Cite as 50 Van Natta 979 (1998)

In the Matter of the Compensation of
EDWARD R. SCHOFIELD, Claimant
WCB Case No. 97-01916
ORDER REMANDING
Greg Noble, Claimant Attorney
James Booth (Saif), Defense Attorney

The SAIF Corporation has requested Board review of Administrative Law Judge (ALJ) Baker's December 2, 1997 order that: (1) set aside SAIF's denial of claimant's occupational disease claim for a herniated L4-5 disc; and (2) upheld SAIF's denial of claimant's other claimed conditions. The hearing was electronically recorded.

Following SAIF's request for review, a transcription of the proceeding was requested. See ORS 656.295(3). However, the audio tapes used to record the October 9, 1997 hearing before ALJ Baker were found to be blank. Thereafter, the Board's staff counsel notified the parties' counsel and asked them to explore the possibility of reaching an agreement regarding the events/testimony given at the hearing.

After separate written requests from the Board's staff counsel, we have received no written communication and/or stipulation from the parties' counsel. In light of such circumstances, we find that the parties have been unable to reach a stipulation regarding the substance of the events and testimony that transpired at the hearing.

Should we determine that a case has been improperly, incompletely, or otherwise insufficiently developed, we may remand to the ALJ for further evidence taking, correction or other necessary action. See ORS 656.295(5). Considering the aforementioned circumstances, we conclude that remand is warranted.

Accordingly, the ALJ's December 2, 1997 order is vacated and this matter is remanded to the Presiding ALJ for reassignment to another ALJ. The assigned ALJ shall reopen the record, and the parties shall be entitled to present testimonial evidence concerning the issues that were addressed at the prior hearing. That evidence may be presented in any manner that the assigned ALJ deems achieves substantial justice. Only those witnesses who testified at the prior hearing shall be permitted to present evidence. Upon presentation of the evidence and closure of the record, the assigned ALJ shall issue a final, appealable, Order on Remand addressing the effect, if any, the evidence presented on remand has had upon ALJ Baker's prior order.

IT IS SO ORDERED.

In the Matter of the Compensation of
LORETTA R. DOLAN, Claimant
WCB Case No. 96-09558
ORDER ON REMAND
Bischoff, Strooband & Ousey, Claimant Attorneys
Nancy J. Meserow, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Pursuant to the court's May 14, 1998 order, we have been directed to consider the parties' settlement. The parties have submitted a proposed "Stipulation and Settlement and Order," which is intended to resolve all issues raised or raisable between them, in lieu of all prior orders.

Pursuant to the stipulation, the self-insured employer "agrees to pay the settlement sum of $2,066.33 to claimant and her attorney." The parties further stipulate that the Order on Reconsideration's award of no permanent disability was "correct." The stipulation also includes the parties' description of the extraordinary circumstances that warrant a carrier-paid attorney fee in excess of the Board's standard attorney fee for claimant's counsel's services before the Board. *See* OAR 438-015-0025. Finally, the parties agree to the dismissal of their respective appeals and requests for hearing.

We have approved the parties' settlement, thereby fully and finally resolving this dispute, in lieu of all prior orders.[1] In other words, the Order on Reconsideration is reinstated. Accordingly, this matter is dismissed.

IT IS SO ORDERED.

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[1] In granting this approval, we note that, because the parties are not resolving a bona fide dispute over compensability of the claim, their agreement is not a disputed claim settlement. ORS 656.289(4); OAR 438-009-0010. Rather, their agreement is a stipulation regarding the amount of compensation to be granted claimant under his accepted claim. Because the stipulation provides that claimant is not entitled to a permanent disability award, it follows that the compensation awarded by this stipulation is not permanent disability. Therefore, we have interpreted the $2,606.33 granted by this stipulation as additional temporary disability benefits awarded for an unspecified period beyond that listed in the Order on Reconsideration.

In the Matter of the Compensation of
KENNETH R. SMITH, Claimant
WCB Case No. 97-03810
ORDER ON REVIEW
W. Todd Westmoreland, Claimant Attorney
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that: (1) upheld the self-insured employer's *de facto* denial of claimant's occupational disease claim for a right thumb condition; and (2) declined to assess a penalty and award an attorney fee. On review, the issues are whether the claim is precluded by prior litigation and, if not, compensability, and penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

In July 1996, claimant and the employer appeared before ALJ Black for a hearing. ALJ Black's order stated that the "Issues" included "compensability of left and right sided hand/wrist/thumb conditions." ALJ Black concluded that claimant had proven compensability of his left thumb condition; the ALJ further concluded, however, that claimant's "right hand condition" was not "currently compensable" because it was "not yet at a level requiring treatment, and may never reach such a level." (Ex. 47-7). ALJ Black set aside the employer's denial of the "left hand/thumb" and "affirmed" the denial "of any right hand condition" "insofar as denial is predicated on the fact of the presence of no currently treatable condition." (Id.)

The employer requested Board review only of that portion of ALJ Black's order finding the left thumb condition compensable. (Ex. 63-1). A majority of the Board adopted and affirmed ALJ Black's order. (Id.)

The employer subsequently denied claimant's right thumb condition and claimant requested a hearing. The ALJ in this proceeding first decided that claim preclusion prevented claimant from litigating the right thumb claim. The ALJ also found, alternatively, that claimant failed to prove compensability of the right thumb. Finally, the ALJ declined to award a penalty and attorney fee.

Claimant first challenges the ALJ's decision that he is precluded from litigating compensability of the right thumb condition. Specifically, claimant disagrees with the ALJ that ALJ Black made any determination concerning compensability and, consequently, ALJ Black's order has no preclusive effect concerning this issue.

Issue preclusion applies to future litigation between the same parties of issues that were "actually litigated and determined" in a setting where "its determination was essential to" the final decision reached. Drews v. EBI Companies, 310 Or 134, 139 (1990). Claim preclusion bars litigation of a claim based on the same factual transaction that was or could have been litigated between the parties in a prior proceeding that has reached a final determination. Id. at 140. If the worker's condition has changed since the prior proceeding, however, and the second claim is supported by new facts that could not have been presented earlier, then the second claim is not precluded. Liberty Northwest Ins. Corp. v. Bird, 99 Or App 560, 564 (1989), rev den 309 Or 645 (1990).

A need for medical services is one requirement for proving an accidental injury or occupational disease. See ORS 656.005(7)(a), 656.802(1)(a). Here, ALJ Black conclusively determined that claimant's right thumb condition was not a "treatable condition" and upheld the employer's denial to the extent that it was based on "the presence of no currently treatable condition." This decision is final because it was not appealed. Thus, ALJ Black's order preclusively determined that the right thumb condition did not require medical services and, consequently, did not meet one element of a compensable occupational

disease.[1] Claimant can overcome this preclusion only by showing that his condition now requires medical services.

We agree with the ALJ that claimant did not make such a showing. Although claimant's treating physician noted that claimant complained of increased symptoms in his right thumb, he referred to the condition as a "non-treated problem[.]" (Ex. 60).

Based on such evidence, we find insufficient proof that claimant's condition now requires medical treatment. Instead, even according to claimant's treating physician, claimant continues not to require medical services. Thus, because claimant has not shown a condition that now requires medical services, the claim is still not compensable.[2]

Finally, because there are no "amounts then due," a penalty is not warranted. See ORS 656.262(11)(a).

ORDER

The ALJ's order dated August 29, 1997 is affirmed.

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[1] We find no merit to claimant's argument that ALJ Black's order does not preclude the instant claim because he wrongly decided that claimant's right thumb condition was not a "treatable condition." If ALJ Black did err, claimant had the opportunity to appeal that portion of the order. Because it was not appealed, that determination became final.

[2] In coming to this conclusion, we need not specifically decide whether or not claimant is precluded from litigating "compensability," as he sought to do during this proceeding. That is, because claimant has not established a "treatable" right thumb condition, and such a finding prevents claimant from establishing compensability whether or not work activities caused his condition, we need not address causation or any of the other elements making up a compensable claim. For the same reason, we do not address claimant's argument that ALJ Black's order precludes the employer from contesting "course and scope."

In the Matter of the Compensation of
DANIEL J. STINE, Claimant
WCB Case No. 97-02292
ORDER ON REVIEW
Myrick & Seagraves, Claimant Attorneys
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board Members Hall and Moller.

The insurer requests review of Administrative Law Judge (ALJ) Brazeau's order that set aside its denial of claimant's occupational disease claim for his right index finger condition. On review, the issue is compensability.

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

On review, the insurer argues that the ALJ found that the only identified activity that could have caused claimant's condition was his work. The insurer contends that such reasoning is contrary to ORS 656.266 and the court's reasoning in Bronco Cleaners v. Velazquez, 141 Or App 295 (1996).

In Velazquez, the court held that a claimant cannot rely solely on a temporal correlation of exposure and symptoms to satisfy the causation requirement. Here, however, the ALJ also noted that claimant had established compensability by expert medical evidence which indicated that claimant's work history (i.e., his repetitive work using his right index finger) was consistent with the development of his condition.

Because we agree with the ALJ's analysis of the expert medical opinions, we conclude that claimant has established compensability. Therefore, the insurer's denial was properly set aside.

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

ORDER

The ALJ's order dated January 27, 1998 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
PAULINE K. YOUNG, Claimant
WCB Case No. 97-07294
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Black's order that set aside its denial of claimant's injury claim for a current left wrist arthritic condition. On review, the issue is compensability.

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

We rely on Dr. Butters' opinion regarding causation, because it is well-reasoned and based on an accurate and complete history.[1] *See Somers v. SAIF*, 77 Or App 259 (1986); *compare Weiland v. SAIF*, 64 Or App 810 (1983). In reaching this conclusion, we note that Dr. Butters evaluated the cause of claimant's need for left wrist surgery with reference to the significance of the work injury, the absence of prior left wrist symptoms, and the fact that patients with injured arthritic wrists do not recover as do those with normal wrists. (Exs. 58-2, 62, 68, 70). In our view, Dr. Butters thus considered and weighed the preexisting condition's causal contribution (in light of his experience with similar patients) in forming his causation opinion. Finally, because we agree with the ALJ that the contrary opinions are less persuasive, because they are not consistent with claimant's clinical course (and her objective findings of injury), we conclude that the claim is compensable under ORS 656.005(7)(a)(B). *See SAIF v. Nehl*, 148 Or App 101, *on recon* 149 Or App 309, 311 (1997); *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev den* 321 Or 416 (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 insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 5, 1998 is affirmed. For services on review, claimant is awarded a $1,500 attorney fee, to be paid by the insurer.

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[1] We also note that Dr. Butters' conclusions are supported by Dr. Davis' accurate contemporaneous history regarding the work injury. (*See* Ex. 48).

In the Matter of the Compensation of
GREGORY P. BORELLA, Claimant
WCB Case No. 97-06187
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the insurer's denial of claimant's injury or occupational disease claim for a low back strain condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant had no low back problems before June 1997. He was 32 years old at the time of hearing.

Claimant worked for the insured wood products company "kicking out" loads "on the tail off." His work duties involved "catching" wood processed by a molder, stacking it, tying it, and moving 2,000 pound loads of the stacked wood on carts. Maneuvering the cart was like pushing a car. The wheels of claimant's loaded cart would sometimes get stuck in a crack in the floor, and he would need the help of a Hyster (forklift) to get the cart moving again.

On June 4, 1997, claimant worked his regular "swing" shift. It was a strenuous night, because many loads needed to be pushed and turned. Claimant's cart got stuck in the floor crack and John Wetzel, a co-worker, freed it for claimant with a Hyster (forklift). Wetzel was aware that claimant's back was hurting that night. He also recalled that claimant left work shortly after he arrived, on a later day.

Claimant did not remember hurting his back at work on June 4, 1997. However, he awoke the next day with "pins and needles" on his backside. He reported to work Thursday and Friday, June 5 and 6, but left early in pain both days. His back felt better over the weekend, with rest. On Monday, June 9, claimant sought treatment from Dr. Robertson.

Claimant filed a claim, which the insurer denied.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant testified credibly. However, the ALJ upheld the insurer's denial, reasoning that the opinion of Dr. Robertson, treating physician, was insufficient to establish compensability. We reverse.

We agree with the ALJ that claimant testified credibly regarding his work activities and the events of early June 1997. In reaching this conclusion, we note that the material facts are corroborated by the contemporaneous documentary record, including Dr. Robertson's chartnotes (and his eventual opinion), as well as co-worker Wetzel's testimony. (Exs. 1, 2, 5, *see* Exs. 8, 9; Tr. 4-8).

Dr. Robertson reported claimant's heavy work activities (specifically, "pushing heavy wood bars with feet," (Ex. 2)), his subsequent symptoms, and attempts to return to work. He was aware that claimant's cart had become caught "on a defect in the floor" at work the night before he awoke with low back and radiating symptoms. Dr. Robertson concluded that claimant suffered a lumbar strain, caused by his "work exposure," including pushing heavy carts loaded with wood. (Ex. 9).

Dr. Melson provided the only expert evidence contrary to Dr. Robertson's opinion. Dr. Melson opined that claimant's "disc rupture"[1] occurred "spontaneously without antecedent trauma," because there "was no history of injury or assumption of an unusually heavy load with sudden pain to make one

[1] Claimant does not have a disc rupture.

think of an industrial disc injury." (Ex. 10). Dr. Melson also commented that disc ruptures "can become apparent several days or weeks after a back injury, with slow progression of pain and neurologic symptoms, but, here, there is no back injury." (*Id*).

We do not find Dr. Melson's opinion persuasive, for the following reasons. First, claimant did have low back trauma antecedent to his low back problems: He pushed a heavily laden cart which suddenly became lodged in a crack in the floor. The fact that claimant did not remember an injurious *event* is not surprising, because his disabling pain did not begin until the next morning. (*See* Tr. 13). *See Stan J. Manser*, 44 Van Natta 733, 735 (1992) (the claimant was not charged with knowing the etiology of his medical problem). Moreover, we cannot say that an immediate onset of pain is necessary to prove this injury, especially in light of Dr. Melson's comment that a back injury may be followed by a "slow progression of pain and neurologic symptoms." (Ex. 10).

We note that Dr. Robertson consistently related claimant's low back problems after June 4, 1997 to his work, considering both the work and the onset of symptoms upon awaking at home the morning of June 5, 1997. Because we also find Dr. Robertson's opinion to be based on a more accurate history (and more consistent with that history), we find no persuasive reason to discount it. *See Weiland v. SAIF*, 64 or App 810 (1983).

The ALJ found Dr. Robertson's opinion insufficient under ORS 656.266, which provides that compensability is not proven by merely ruling out nonwork causes. The ALJ apparently focused on Dr. Robertson's reference to the absence of "known causes" other than claimant's work. We disagree.

Dr. Robertson clearly considered the nature of claimant's work and the nature of his injury and found them not only consistent (implicitly), but causally connected (explicitly). Under these circumstances, we find that Dr. Robertson did more than simply rule out off-work causes and his opinion is not legally insufficient under ORS 656.266. *See Bronco Cleaners v. Velazquez*, 141 Or App 295 (1996) (a claimant may not rely solely on exclusionary analysis to prove compensability); *Randy S. Girard*, 48 Van Natta 2167, 2169 (1996) (where the physician evaluated the nature of the work exposure, his opinion was not based merely on a temporal relationship). Accordingly, based on Dr. Robertson's persuasive opinion, we conclude that claimant has established that his work activities on June 4, 1997 caused his lumbar strain condition. ORS 656.005(7)(a).

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,750, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated November 26, 1997, as reconsidered January 12, 1998, is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant is awarded a $3,750 attorney fee, payable by the insurer.

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

Reviewed by Board Members Hall and Haynes.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Otto's order that dismissed his request for hearing as untimely. Contending that claimant failed to timely request Board review, the SAIF Corporation moves for dismissal of his request for review. On review, the issues are timeliness of filing the request for review and the propriety of the dismissal. We find the request for review to be timely filed and affirm.

FINDINGS OF FACT

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

On November 24, 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 SAIF Corporation's denial of his injury claim for a cervical spine condition; and (2) dismissed claimant's hearing request. 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 with a copy to the other parties to the proceeding within 30 days of the ALJ's order.

On Monday, December 29, 1997, the Board received claimant's letter dated December 20, 1997 that requested review of the ALJ's order. Claimant's request was mailed to the Workers' Compensation Board by certified mail bearing the stamp of the United States Postal Service (USPS) showing that the date of mailing was December 22, 1997. Claimant's letter indicated that copies had been provided to the other parties to the proceeding. SAIF does not dispute this representation.

On January 7, 1998, the Board mailed a computer-generated letter to the parties, acknowledging claimant's request for Board review.

CONCLUSIONS OF LAW AND OPINION

Timeliness of Request for Review

Noting that the Board received claimant's request for review more than 30 days after the ALJ's November 24, 1997 order[1], SAIF questions our authority to review this appeal. We hold that claimant's request satisfies the statutory requirements of ORS 656.289(3) and 656.295(2). We base this conclusion 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 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 for review be mailed or actual notice be received within the statutory period. *Argonaut Insurance Co. v. King*, 63 Or App 847, 852 (1983). The failure to timely file and serve all parties with a request for Board review requires dismissal. *Mosley v. Sacred Heart Hospital*, 113 Or App 234 (1992).

"Filing" of a request for review means the physical delivery of a thing to any permanently staffed office of the Board or the date of mailing. OAR 438-005-046(1)(a). If filing of a request for Board review of an ALJ's order is accomplished by mailing, it shall be presumed that the request was mailed on the date shown on a receipt for registered or certified mail bearing the stamp of the United States Postal Service (USPS) showing the date of mailing. OAR 438-005-046(1)(b).

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[1] We note that, although the Board's acknowledgment of the request for review states that the request was received on January 7, 1998, the Board's date stamp on the envelope in which the request was contained is December 29, 1998. This discrepancy, however, has no effect on our deliberations regarding this matter.

Here, the 30th day after the ALJ's November 24, 1997 order was December 24, 1997. Inasmuch as claimant's request for review was mailed, by certified mail, to a permanently staffed office of the Board on December 22, 1997, it was timely filed. *See* ORS 656.289(3); 656.295(2); OAR 438-005-0046(1)(b). Moreover, because claimant's representation that the other parties to the proceeding before the ALJ were provided with a copy of claimant's request for review within the statutory 30-day period is undisputed by the parties and uncontradicted by the record, we conclude that notice of claimant's request was provided to the other parties within 30 days after the ALJ's November 24, 1997 order. Accordingly, we deny SAIF's motion to dismiss claimant's request for review.

Dismissal

We adopt and affirm the ALJ's order regarding this issue, with the substitution of the following sentence for the second sentence of the last paragraph on page 4.

During that conversation, Ms. Huss informed claimant and Mrs. Croyle that SAIF had denied the claim because the evidence established that claimant had a preexisting condition related to the prior 1994 Washington claim. (Tr. 65).

ORDER

The ALJ's order dated November 24, 1997 is affirmed.

In the Matter of the Compensation of
STEVE DUNCAN, Claimant
WCB Case No. 97-06333
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Baker's order that upheld the insurer's denial of his back injury claim. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation regarding claimant's motion to file an untimely reply brief.

Six days after claimant's reply brief came due, claimant requested that he be granted an extension of time and permitted to file his untimely brief. Claimant's counsel advised the Board that the brief was untimely because of a "calendaring error" and that the insurer objected to the untimely brief.

Ordinarily, the Board will not consider a brief that is untimely filed. *See, e.g. Kenneth D. Legore*, 49 Van Natta 736 (1997) (rejecting untimely reply brief); *Tammy Locke*, 48 Van Natta 250 (1996) (same). Extensions of time for filing of briefs are allowed only on written request filed no later than the date the brief is due. OAR 438-011-0020(3). Briefing extensions will not be allowed unless the Board finds that extraordinary circumstances beyond the control of the party requesting the extension justify the extension. *Id.*

Here, claimant did not file a request for briefing extension within the requisite time period. In addition, we do not find claimant's attorney's calendaring error to constitute an extraordinary circumstance beyond the control of the requesting party.[1] *See Maria R. Fuentes*, 48 Van Natta 110 (1996); *Lester E. Saunders*, 46 Van Natta 1153, 1154 (1994). Consequently, we decline to consider claimant's reply brief on review.

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[1] The Board may also waive its rules. *See* OAR 438-011-0030. However, such an action must be based on a finding of "extraordinary circumstances beyond the control of the party requesting waiver of a rule." Inasmuch as we do not consider claimant's counsel's "calendaring error" to constitute "extraordinary circumstances," we decline to waive our "briefing" rule for acceptance of claimant's reply brief.

ORDER

The ALJ's order dated December 18, 1997 is affirmed.

May 22, 1998 Cite as 50 Van Natta 988 (1998)

In the Matter of the Compensation of
RONALD D. GROSHONG, Claimant
WCB Case Nos. 97-08476 & 97-04693
ORDER ON REVIEW
Schneider & Hooton, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Neal's order that: (1) upheld the SAIF Corporation's denials of aggravation, compensability and responsibility for his current low back conditions, including a piriformis condition; and (2) declined to award an attorney fee for Liberty Northwest Insurance Corporation's acceptance of claimant's piriformis condition. On review, the issues are compensability, responsibility and attorney fees.

We adopt and affirm the ALJ's order with the following changes and supplementation. In the first full paragraph on page 2, we change the first sentence to read: "Claimant's 1985 claim was first closed on October 18, 1985 with a 10 percent unscheduled permanent partial disability award." In the third full paragraph on page 3, we replace the first sentence with the following:

> "In September 1997, claimant's attorney made a claim with Liberty, stating that claimant's current medical problems were compensably related to the January 1985 claim. (Ex. 143A). The request for claim reopening was received by Liberty on September 8, 1997. (Ex. 145B-2). Claimant's aggravation rights expired on October 18, 1990. (Ex. 145C)."

In the last paragraph beginning on page 4, we change the last sentence in that paragraph on page 5 to read: "Claimant was treated by Dr. Buckley in 1995 for his low back and leg symptoms. Dr. Buckley referred claimant to Dr. Freeman in March 1996. (Ex. 96)."

Attorney Fees

Relying on *Charles E. Trento*, 46 Van Natta 1502 (1994), the ALJ found that Liberty's "own motion" recommendation for reopening claimant's claim did not constitute a "denial" and, therefore, claimant was not entitled to an attorney fee under ORS 656.386(1).

Claimant argues that *Trento* does not apply here because that case applied the own motion recommendation to a prior version of ORS 656.386(1). He argues that his attorney is entitled to a reasonable attorney fee for obtaining Liberty's acceptance of piriformis syndrome. We disagree.

In *Efren Quintero*, 50 Van Natta 86 (1998), we concluded that ORS 656.386(1) was not applicable to an own motion claim. We reasoned that the language of ORS 656.386(1) clearly refers to awards of assessed attorney fees relating to Board review of ALJs' orders. Because the parties' requests for own motion relief were made directly to the Board in its own motion jurisdiction, we found that those requests were not requests for review as that phrase was used in ORS 656.386(1). Therefore, we concluded that ORS 656.386(1) did not provide a basis for award of an assessed fee within the Board's own motion jurisdiction. Because there was no statutory basis for an assessed fee award under the facts of that case, we were without authority to award an assessed fee in our own motion jurisdiction.

We reach the same conclusion in this case. In September 1997, claimant's attorney made a claim with Liberty, stating that claimant's current medical problems were compensably related to the January 1985 claim. (Ex. 143A). The request for claim reopening was received by Liberty on September 8, 1997. (Ex. 145B-2). Claimant's aggravation rights had expired on October 18, 1990. (Ex. 145C). Liberty

opposed reopening the claim on several grounds. (*Id.*) The Board denied the request for own motion relief. (*Id.*) Because the request for own motion relief was made directly to the Board in its own motion jurisdiction, we find that his request was not a request for review as that phrase was used in ORS 656.386(1). Consequently, there is no statutory basis for an assessed fee award against Liberty under the facts of this case. *See Efren Quintero*, 50 Van Natta at 88-89.

ORDER

The ALJ's order dated January 26, 1998 is affirmed.

May 22, 1998 Cite as 50 Van Natta 989 (1998)

In the Matter of the Compensation of
BRADLEY R. KUBIK, Claimant
WCB Case No. 97-04637
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Mills' order that: (1) directed it to recalculate claimant's rate of temporary disability benefits; and (2) assessed a penalty for its allegedly unreasonable calculation of the temporary disability rate. On review, the issues are rate of temporary disability and penalties. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Rate of Temporary Disability

On January 27, 1997, claimant was hired by the employer as a carpenter installing decks. Claimant was scheduled to work eight hours a day, Monday through Friday, at a rate of $10 per hour, when there was work available. February 1997 was an extremely wet month and little work was performed by the employer. Available work was provided to employees more senior than claimant.

Claimant worked a total of 64 hours from January 27, 1997 to February 14, 1997. Claimant did not work for the next three weeks, from February 17, 1997 through March 7, 1997. He returned to work on March 10, 1997 and worked 76.5 hours from that date until he compensably injured his neck on March 25, 1997.

Claimant's temporary disability rate was originally calculated based upon an average weekly wage of $200. (Ex. 2). In April 1997, SAIF concluded that the temporary disability benefits based on claimant's actual income during his weeks of employment should be based on an average weekly wage of $168.36, which recalculated to a new temporary disability rate of $112.25. The recalculation was based on claimant having worked 8.29 weeks with gross earnings during that period of $1,395.00. (Ex. 9). The 8.29 weeks included a gap of three weeks in claimant's employment, from February 17, 1997 through March 7, 1997.

Applying OAR 436-060-025(5)(a)(A) (WCD Admin. Order 96-070), the ALJ determined that, under the rule, only weeks in which claimant earned wages could be used to calculate claimant's temporary disability rate. The ALJ further found that the portion of the rule pertaining to "extended gaps" is not applicable where the claimant is employed less than 52 weeks.

OAR 436-060-0025(5)(a)(A) provides, in pertinent part:

"(a) For workers employed seasonally, on call, paid hourly, paid by piecework or with varying hours, shifts or wages:

"(A) Insurers shall use the worker's average weekly earnings with the employer at injury for the 52 weeks prior to the date of injury. For workers employed less than 52 weeks or where extended gaps exist, insurers shall use the actual weeks of employment (excluding any extended gaps) with the employer at injury up to the previous 52 weeks."

On review, SAIF challenges the ALJ's statement that the version of OAR 436-060-0025(5)(a)(A) which is applicable in this case is "identical in its pertinent provisions" to the earlier version of the rule which was applied in *Thomas J. Kollen*, 48 Van Natta 2454 (1996).[1] We agree with SAIF's objection.

Subsequent to the ALJ's order, we have acknowledged that the version of the administrative rule applicable to this case is different than the rule used in *Kollen*. *Pedro Frias*, 50 Van Natta 463 (1998). As in *Frias*, SAIF argues in this case that the new version of the rule now requires the insurer to use the actual weeks of employment (excluding any extended gaps) with the employer. SAIF asserts that by inserting this language, the Director only allows exclusion of those periods which may be classified as an "extended gap." In this case, SAIF further asserts that the exclusion of "extended gaps" from "actual weeks of employment" implies that a gap other than an "extended gap," such as gaps caused by anticipated seasonal slow downs in work, were intended to be included in a worker's "actual weeks of employment."

Assuming, without deciding, that SAIF's interpretation of the current version of OAR 436-060-0025(5)(a)(A) is correct and that only "extended gaps" may be excluded, we find that the gaps in claimant's employment qualify as "extended gaps." We reason as follows.

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)[2] 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.

The court remanded *Hadley* to the Board to determine whether there was an "extended gap" in the claimant's employment. We held that 16-1/2 weeks 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. Under the circumstances of the *Hadley* case, we concluded that an unemployment period that represented approximately 63.4 percent of a 26-week period was "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.*

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[1] *Kollen* involved *former* OAR 436-60-025(5)(a), a prior version on the rule, which was contained in WCD Admin. Order 94-055. That former version of the rule provided, in relevant part:

"* * * For workers employed less than 52 weeks or where extended gaps exist and where there has been no change in the amount or method of the wage earning agreement, insurers shall use the actual weeks of employment with the employer at injury up to the previous 52 weeks * * *."

[2] *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."

Here, claimant had 3 weeks of unemployment during the 8.29 week period of his employment. Considering that claimant was unemployed for 3 weeks preceding his injury, or 36 percent of 8.29 weeks, we conclude that claimant's period of unemployment constituted an "extended gap" within the meaning of OAR 436-060-0025(5)(a). *See Pedro Frias*, 50 Van Natta at 464 (4.8 weeks of unemployment during the 31.6 week period of employment preceding the claimant's injury constituted an "extended gap" within the meaning of the current version of OAR 436-060-0025(5)(a)); *see also Ken T. Dyer*, 49 Van Natta 2086, 2087 (1997) (12 weeks of unemployment during the 52-week period preceding the claimant's injury, or 23 percent of 52 weeks, constituted "extended gaps" within the meaning of *former* OAR 436-060-0025(5)(a)). Accordingly, even assuming that only "extended gaps" may be excluded under the current version of OAR 436-025-0025(5)(a), the gap in claimant's employment constitutes an "extended gap" which is excluded from the rate calculation.

Therefore, we find that SAIF improperly calculated claimant's temporary disability rate. Instead of dividing claimant's gross earnings ($1,405)[3] during the period from January 27, 1996 to March 25, 1996 by 8.29 weeks, we conclude that claimant's gross earnings should be divided by 5.29 weeks, which results in an average weekly wage of $265.60, rather than the $168.36 calculated by SAIF.

Penalties

We adopt and affirm the ALJ's opinion on this issue, with the following comment.

The ALJ found that SAIF's calculation of claimant's TTD rate and its untimely response to claimant's discovery request for payroll records were unreasonable. In light of these findings, the ALJ assessed a 25 percent penalty based on the compensation granted by the order, to be shared equally between claimant and his counsel.

SAIF contends that its calculation of the TTD rate was reasonable because this case involved the application of an administrative rule for which there was no prior Board or court precedent. Noting that SAIF did not raise this theory until Board review, claimant contends that it may not assert such a position at this late date.

We need not resolve the question of whether SAIF's "theory" can be considered on review because, even if it could be addressed, we agree with the ALJ's conclusion that claimant is entitled to a penalty for SAIF's untimely disclosure of claimant's payroll records. In other words, even if SAIF's TTD recalculation was not unreasonable, claimant would still be entitled to the penalty assessed by the ALJ because of SAIF's discovery violation.

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 regarding the temporary disability issue is $1,200, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and claimant's counsel's statement of services), the complexity of the issue, and the value of the interest involved.[4]

ORDER

The ALJ's order dated September 10, 1997 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,200, to be paid by the SAIF Corporation.

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[3] Claimant was paid for one hour's work on February 11, 1997, that had not been reported to SAIF. (Tr. 14, 31).

[4] We note that, in requesting a $1,600 carrier-paid attorney fee, claimant's counsel's statement explains that a total of 10.6 hours has been or will be expended regarding the "right to TTD" issue. The statement further represents that these services were rendered "at hearing and before the Board." However, claimant's counsel's services at hearing have already resulted in the ALJ's "out-of-compensation" attorney fee award (25 percent of the increased compensation created by the ALJ's order, not to exceed $1,050). In light of such circumstances, our attorney fee award is confined to claimant's counsel's services on Board review in defense of that portion of the ALJ's order that addressed the "TTD rate" issue.

In the Matter of the Compensation of
MICHAEL McGOUGH, Claimant
WCB Case Nos. 97-01010 & 96-10770
ORDER ON REVIEW
Bennett, Hartman, et al, Claimant Attorneys
Wallace, Klor & Mann PC, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Tenenbaum's order which: (1) found that claimant was not an Oregon subject worker; and (2) upheld the self-insured employer's denial of claimant's occupational disease claim for a bilateral shoulder condition. On review, the issues are subjectivity and compensability. We affirm.

FINDINGS OF FACT[1]

The employer, a Pennsylvania corporation, had divisions throughout the U.S., including Oregon. The employer's Infrared Services Division, which provided a service different from the corporation's other divisions, was headquartered in Pennsylvania. This division performed infrared testing of apparatus for various utilities throughout the U.S. (Ex. 11; Tr. 5, 6). The employer entered into a four-year contract with an Oregon utility, Portland General Electric (PGE), to perform infrared testing of its transformers. As conditions of the contract, the employer was required to provide workers' compensation coverage for its workers and the workers were required to join the local union. The work was to be performed seasonally. The work began in Oregon on May 7, 1996 and ran continuously until mid-November.

In April 1996, the employer hired claimant in Pennsylvania, with the expectation that he would return to college in Pennsylvania in the fall, as he had done after working for the employer the previous summer. Claimant arrived in Oregon the first week in May and worked until mid-August. (Exs. 8, 11; Tr. 39).

The work consisted of locating and inspecting electrical transformers at many different sites in PGE's outer western and central divisions in the Portland metropolitan area. The employer's Infrared Division manager, Mr. Terrel, used the employer's local tree division office when in Oregon to supervise the PGE project, and supplies and equipment were sent to that office. (Tr. 16). The foreman for the job, Mr. Mann, was hired in Oregon out of the local union hiring hall.

Each workday, claimant's work team met at PGE's western division office in Beaverton, where they were given maps of the day's work before dispersing to their inspection sites. (Tr. 26, 34). With the assistance of the employer, claimant rented an apartment in Beaverton, close to PGE's western division office. (Tr. 43). Claimant was paid a per diem allowance seven days a week while in Oregon.

On June 14, 1996, claimant sustained a dog bite injury to his left leg while working. (Exs. AA1, AA2, AA3). On August 22, 1996, a claim was filed in Pennsylvania on behalf of claimant, which was accepted. (Exs. B, 3B).

Claimant's duties included carrying heavy equipment. Sometime in June or July 1996, claimant began feeling discomfort in his arms and shoulders, which he reported to his foreman. (Ex. 15-3, -4; Tr. 28-33). The employer provided a cart to transport claimant's equipment. (Tr. 33). On August 26, 1996, claimant sought medical treatment at an urgent care clinic in Oregon for bilateral shoulder pain. Dr. Jarmac-Miller diagnosed bilateral biceps tendinitis. (Exs. 1, 2, 3, 4). Claimant subsequently returned to Pennsylvania.

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[1] The parties submitted Exhibits 1 through 18, AA1, AA2, AA3, B, 3A, 3B, 5A, and 12A, which were admitted at hearing. (Tr. 1). Although the ALJ's order indicates that only exhibits 7, 3B, and 14-17 were admitted (Opinion and Order at 1), there is no indication in the record that the parties withdrew any of the admitted documents. Moreover, the parties refer to the admitted documents in their briefs. Under these circumstances, we conclude that Exhibits 1 through 18, AA1, AA2, AA3, B, 3A, 3B, 5A, and 12A remain a part of the record before us.

On October 21, 1996, claimant filed a workers' compensation claim in Oregon for the shoulder condition. (Ex. 5). The employer denied the claim on the grounds that claimant was not an Oregon subject worker and that his injury did not arise out of the course and scope of his employment. (Ex. 7). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Subjectivity

The ALJ found that claimant was not working at a "temporary workplace" in Oregon under former ORS 656.126(7), as he was working at multiple job sites for more than 30 days. Applying the "permanent employment relation" test, the ALJ concluded that claimant was a Pennsylvania employee temporarily working in Oregon when he experienced a bilateral shoulder condition in August 1996 and, therefore, was not an Oregon subject worker. We agree, but for different reasons.

With some exceptions not relevant here, ORS 656.027 provides that all workers are subject to the Oregon Workers' Compensation Law. However, a worker from another state doing work for the employer at a temporary workplace in Oregon may be exempted from the Oregon Workers' Compensation Law by application of the provisions of former ORS 656.126(2).[2] We conclude that the exemption is inapplicable in this case.

There is no evidence in the record regarding an interstate agreement between the states of Oregon and Pennsylvania. *See* ORS 656.126(2)(b) and (c). Consequently, even if the employer had a "temporary workplace" in Oregon, the statutory exemption under ORS 656.126(2) is inapplicable in this case. *See Bowers v. Mathis,* 280 Or 367 (1977) (conditions required by [*former*] ORS 656.126(2) (b) and (c) are provided by foreign statute and the Agreement promulgated pursuant thereto, which recognizes the extraterritorial provisions of the Oregon Workmen's Compensation Law).

Accordingly, because claimant and the employer do not qualify for exemption from Oregon's Worker's Compensation Law under the provisions of ORS 656.126(2), we apply the "permanent employment relation" test to determine whether claimant was temporarily within the state. *Northwest Greentree, Inc. v. Cervantes-Ochoa,* 113 Or App 186 (1992); *Phelan v. H.S.C. Logging, Inc.*, 84 Or App 632, *rev den* 303 Or 590 (1987). In applying that test,

> "no one factor controls; rather all of the circumstances are relevant, including the intent of the employer, the understanding of the employee, the location of the employer and its facilities, the circumstances surrounding the claimant's work assignment, the state laws and regulations that the employer otherwise is subject to and the residence of the employees." *Northwest Greentree,* 113 Or App at 189.

Moreover, where the employees are transient and work out of many locations, we consider such factors as the location of various supervisory and administrative activities and the intent of the parties in determining the permanency of the employment relation. *See Jose Gomez,* 46 Van Natta 2246, 2247 (1994).

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[2] Former ORS 656.126(2) provides:

"Any worker from another state and the employer of the worker in that other state are exempted from the provisions of ORS 656.001 to 656.794 while the employer has a temporary workplace within this state and the worker is within this state doing work for the employer:

"(a) If that employer has furnished workers' compensation insurance coverage under the workers' compensation insurance or similar laws of a state other than Oregon so as to cover that worker's employment while in this state;

"(b) If the extraterritorial provisions of ORS 656.001 to 656.794 are recognized in that other state; and

"(c) If employers and workers who are covered in this state are likewise exempted from the application of the workers' compensation insurance or similar laws of the other state. The benefits under the workers' compensation insurance Act or similar laws of the other state, or other remedies under a like Act or laws, are the exclusive remedy against the employer for any injury, whether resulting in death or not, received by the worker while working for that employer in this state."

Here, claimant was hired in Pennsylvania. (Ex. 11) He completed his employment forms in Pennsylvania and received his training in Pennsylvania. (Exs. 8, 15; Tr. 6, 21). Claimant referred to his employer as being in Pennsylvania. (Ex. 15-3). Moreover, claimant's coworkers thought claimant was a Pennsylvania employee. (Tr. 29, 33, 36).

When claimant was hired, it was understood between the employer and claimant that claimant's job would require him to go to locations in different states, based upon the type of job he performed and the nature of the employer's business. (Tr. 5-6). Claimant had worked in a different state the prior summer for the same employer. (Ex. 8; Tr. 6). Claimant was rehired in 1996 without knowing where he would be sent. He knew his job assignment would be temporary and could take him anywhere. (Tr. 6). Moreover, although claimant had a reasonable expectation of being rehired in Pennsylvania, he had no reasonable expectation of being reassigned to the employer's Oregon project. These factors weigh in favor of finding that claimant was temporarily in Oregon at the time he experienced his shoulder condition.

While in Oregon, claimant lived in rental housing which was obtained with the assistance of the Pennsylvania company. (Tr. 12, 13). The Pennsylvania division manager also helped claimant obtain rental furniture, security deposits, and sundries. (Tr. 12, 13). Claimant received per diem benefits for his lodging and meals for seven days per week. (Ex. 18, Tr. 8). These factors also support a finding that claimant was temporarily in Oregon.

The employer maintained Pennsylvania workers' compensation coverage for claimant. (Tr. 8). The Infrared Division was headquartered in Pennsylvania, and was a separate entity from the employer's Oregon division, which had no involvement (other than as an address to which supplies could be sent and the incidental use of a telephone by the project supervisor when he was in Oregon) in the Infrared Division's contract with PGE. (Tr. 4,6). Claimant's immediate supervisor was controlled by the Pennsylvania division, and that division provided all of the equipment and transportation used by the Oregon employees. All administrative functions were handled out of the Pennsylvania division and paychecks were drawn from a bank in Pennsylvania.

Applying the permanent employment relation test, and weighing each of the above factors, we conclude that, on this record, claimant has failed to establish that he was an Oregon subject worker for purposes of this claim.

ORDER

The ALJ's order dated September 18, 1997, as corrected September 30, 1997, is affirmed.

May 22, 1998 Cite as 50 Van Natta 994 (1998)

In the Matter of the Compensation of
BRUCE R. PALANUK, Claimant
WCB Case No. 97-06874
ORDER OF ABATEMENT
Cole, Cary, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

On April 22, 1998, we affirmed an Administrative Law Judge's (ALJ's) order that: (1) set aside the SAIF Corporation's partial denial of claimant's injury claim for a right knee condition; (2) awarded a $3,400 carrier-paid attorney fee under ORS 656.386(1); and (3) assessed SAIF a penalty for untimely claim processing. Contending that its conduct was not unreasonable, SAIF seeks reversal of the ALJ's penalty assessment.

In order to consider SAIF's contention, we withdraw our April 22, 1998 order. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 14 days from the date of this order. Thereafter, we will take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
LENNE A. SCOTT, Claimant
WCB Case No. 97-07410
ORDER ON REVIEW
Hollander, et al, Claimant Attorneys
Hoffman, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Menashe'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.

The employer objects to the ALJ's finding that claimant's roommate, Steve Criger, "said Thursday night claimant told him how he [claimant] was hurt." (Opinion & Order, p.1). The employer argues that, because its objection to this response (by witness Criger) was sustained by the ALJ, the finding is not based on the record and we should "strike" it. We agree that the objection was sustained and we do not rely on that portion of the witness' testimony. Nonetheless, we agree with the ALJ's finding that claimant did tell Criger on Thursday night that his back was hurt. (Tr. 14).[1]

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[1] We rely on the portion of Criger's testimony after the objection was sustained:

"Q. Did he --okay. Did [claimant] prior to Friday night ever tell you how he hurt himself? I'm not asking what he said. I'm just asking you if he ever told you.

A. Moving or lifting something at work, but I -- I mean, I had no reason to -- to specifically remark on it, but--

[Claimant's counsel]: Okay

[Employer's counsel]: I'm going to object to the answer as being unresponsive, move to strike--

ALJ: Sustained.

[Employer's counsel]: On the basis of hearsay.

[Claimant's counsel]: That's fine.

By [claimant's counsel]: (Continuing)

Q. I was just wondering if he had ever told you. I don't want to really know what you [sic] told you, but if he ever told you how he hurt himself.

A. Yes, but I can't remember what he said.

[Claimant's counsel]: Okay. Was he also living with--

ALJ: When did he--

[Claimant's counsel]: At -- on Friday night or Saturday -- over the weekend?

Witness: No, the night before.

[Claimant's counsel]: (continuing)

Q. On Thursday night?

A. Yeah. And he went to work and made it worse." (Tr. 13-14).

We agree with the ALJ that claimant has established that he injured his low back at work on Thursday, May 8, 1997 and that the work injury caused his subsequent disability and need for treatment for his low back. Consequently, we also agree that the claim is compensable. ORS 656.005(7)(a).

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

ORDER

The ALJ's order dated December 30, 1997 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the self-insured employer.

In the Matter of the Compensation of
HERMAN L. SHANKS, Claimant
WCB Case Nos. 97-04362 & 97-03236
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Moller, Bock, and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Hoguet's order that set aside its denial of claimant's right knee condition claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for dorsal muscle strain, intercostal muscle strain and pneumonia. In October 1996, Dr. Webb, claimant's treating physician, referred claimant for a physical capacities evaluation (PCE). On October 28, 1996, claimant attended the PCE. In December 1996, claimant returned to Dr. Webb with right knee complaints. Claimant eventually was diagnosed with tears in the meniscus of the knee.

The ALJ first decided that the medical evidence showed that claimant injured his right knee during the PCE. The ALJ then considered whether claimant's injury qualified as a compensable consequential condition under ORS 656.005(7)(a)(A). Relying on Barrett Business Services v. Hames, 130 Or App 190, rev den 320 Or 492 (1994), and Gary D. Hord, 48 Van Natta 2412 (1996), the ALJ concluded that the compensable injury was the major contributing cause of claimant's consequential right knee condition.

The employer challenges the ALJ's order, first asserting that the medical evidence does not prove compensability. Relying on Robinson v. Nabisco, Inc., 143 Or App 59 (1996), rev allowed 325 Or 247 (1997), and Rodney G. McAleny, 48 Van Natta 2142 (1996), the employer also contends that an injury resulting from a PCE cannot be considered a compensable consequential condition.

In Hames, the court considered compensability of an injury resulting from physical therapy for the compensable injury. The court held that where necessary and reasonable treatment of a compensable injury is the major contributing cause of a new injury, the compensable injury itself is properly deemed the "major contributing cause of the consequential condition" under ORS

656.005(7)(a)(A). 130 Or App at 197. The court reasoned that there was "a certain, almost tragic, inevitability" to the consequential condition and that "it flowed directly and inexorably " from the compensable injury. Id. at 195.

Robinson concerned compensability of a herniated disc injury that the claimant sustained during an insurer-arranged medical exam (IME) performed in relation to a compensable injury. The court noted that the legislative intent underlying adoption of ORS 656.005(7)(a)(A) was to limit what is included as part of the "natural consequences" of a compensable injury. 143 Or App at 67. The court held:

> "Admittedly, an injury that occurs during an IME is similar in some respects to an injury arising out of medical treatment. It does flow from the compensable injury. The difference, however, is a matter of degree. It simply does not flow as 'directly and inexorably' from the compensable injury as does an injury arising out of medical treatment for the compensable injury. The break in the causal connection between the original injury, and the injury incurred during the IME in this case, is not as distinct as the accident in Hicks. The events here come closer to the facts of Kephart v. Green River Lumber, 118 Or App 76, rev den 317 Or 212 (1993)], where the injury occurred during vocational rehabilitation." Id. at 66-67.

Pursuant to Robinson, we subsequently held that, based on persuasive medical evidence showing that the major contributing cause of the claimant's consequential condition was the injury sustained during a medical arbiter's examination, and not the original compensable injury, the consequential condition was not compensable. Rodney G. McAleny, 48 Van Natta 2142 (1996).

The court most recently considered whether a neck injury that resulted from abdominal "crunches" was compensable under ORS 656.005(7)(a)(A). Rogers v. Cascade Pacific Ind., 152 Or App 624 (1998). In Rogers, the court discussed its holding in Hames that injuries occurring during reasonable and necessary medical treatment are considered to be compensable consequential conditions and agreed with the Board that the claimant's activities that caused the neck injury were not reasonable and necessary medical treatment. Id. at 628-29. Specifically, the court found that the Board's conclusion was supported by the fact that the exercises performed by the claimant were done for preventative, rather than curative, reasons, as shown by evidence that the claimant's treating physician had declared the claimant medically stationary, the physical therapist previously indicated that physical therapy was not necessary, and the claimant was performing the exercises to remain conditioned in order to avoid future injuries. Id. at 630.

Here, claimant asserts that his right knee condition is compensable because it was injured during the PCE. Based on Hames, Robinson, and Rogers, claimant prevails if the PCE was "reasonable and necessary medical treatment." We first note that the record contains little evidence concerning the purpose of the PCE. Dr. Webb merely stated that claimant "is referred for a level 2 physical capacities examination" and that, following his review of the report, claimant "will then become medically stationary" and "[p]ermanent job restrictions will be outlined." (Ex. 30).

In January 1997, the claims processor sent Dr. Webb a letter stating that a "PCE was performed 10-28-96 after which you were to see [claimant] and provide a closing report." (Ex. 35). The letter also asked if Dr. Webb agreed with the PCE and whether claimant was medically stationary. (Id.) Dr. Webb indicated that he concurred. (Id.)

Based on such evidence, we find that the PCE was intended to assist Dr. Webb in closing the claim by establishing permanent disability and permanent job restrictions.[1] Thus, the PCE was for purposes of claim evaluation, which we find distinguishable from reasonable and necessary treatment of the accepted injury. That is, this record shows only that the PCE was for evaluation of claimant's physical abilities rather than to treat the accepted condition. In this regard, Dr. Webb indicated that he intended to declare claimant medically stationary following the PCE, showing that claimant's accepted

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[1] Under ORS 656.268(2)(a), the carrier may request that the Department close a claim if the worker's accepted condition is medically stationary. The carrier itself may close the claim if the worker's accepted condition is medically stationary and the worker has returned to work or the worker's attending physician has released the worker to regular or modified employment. ORS 656.268(4)(a).

condition was not expected to improve.[2] In sum, we find that claimant failed in proving that the PCE qualified as reasonable and necessary treatment. Instead, the PCE comes within the category of activities that would not have been undertaken "but for" the compensable injury. Consequently, we conclude that he also failed to establish that the compensable injury is the major contributing cause of his right knee condition. See Hames, 130 Or App at 197; Robinson, 143 Or App at 66-67; Rogers, 152 Or App at 630.

Alternatively, even if we agreed with the ALJ that the compensable injury is properly deemed the major contributing cause under ORS 656.005(7)(a)(A), we find an absence of persuasive medical opinion establishing that the PCE caused claimant's right knee condition.

Following the October 28, 1996 PCE, claimant had physical therapy on November 1 and November 14, 1996. At the first appointment, claimant complained of increased shoulder and upper back pain following the PCE; he did not mention right knee complaints until he saw Dr. Webb on December 16, 1996. (Exs. 32, 33).

Dr. Webb first indicated that claimant "had an underlying preexisting condition known as patellofemoral syndrome which was completely asymptomatic prior to * * * the physical capacities exam" and that, due to the PCE, "a preexisting underlying condition has been made materially worse as of 10-28-96[.]" (Ex. 33-2).

The record shows that claimant next sought treatment on April 15, 1997 with Dr. Morgan. (Ex. 39). Dr. Morgan concurred with a letter from the employer's attorney stating that he found "no objective evidence of knee injury" and referred claimant to Dr. Chamberlain. (Ex. 42). Claimant then underwent a MRI, which showed a tear in the lateral meniscus. (Ex. 45).

Dr. Webb then concurred with a letter from the employer's attorney stating that, based upon his finding of a preexisting patellofemoral syndrome "and a one-time exam," Dr. Webb did not consider himself qualified "to render any opinion with any degree of reasonable medical probability regarding the cause of that right knee condition[.]" (Ex. 46).

On July 21, 1997, Dr. Webb reported that he had examined claimant that morning and studied the MRI. (Ex. 48). Based on claimant's reports of no right knee pain before the PCE and the crawling, squatting, and climbing activities claimant performed at the PCE, he thought it medically probable that "the above activities required of [claimant] during the PCE caused the right knee condition[.]" (Id.)

Absent persuasive reasons to the contrary, we generally defer to the treating physician. See Weiland v. SAIF, 64 Or App 810 (1983). Here, we find persuasive reasons not to defer to Dr. Webb's opinion that activities at the PCE caused a right knee condition. First, because Dr. Webb saw claimant only twice with regard to claimant's right knee, his treatment of the right knee was limited. Furthermore, Dr. Webb's opinion is conclusory in that he does not specifically explain how the PCE activities caused claimant's meniscus to tear. Finally, Dr. Webb does not explain why he no longer believes that a preexisting condition is causing claimant's symptoms or its effect, if any, in causing the meniscus tear.

In sum, as discussed above, we conclude that, on this record, the compensable injury cannot be deemed the major contributing cause of claimant's right knee condition under ORS 656.005(7)(a)(A). Consequently, claimant failed to prove compensability.

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[2] The dissent relies on the facts that Dr. Webb had not yet declared claimant medically stationary at the time of the PCE and the continuance of physical therapy and treatment following the PCE in concluding that the PCE was "reasonable and necessary treatment." As we discussed, although Dr. Webb had not declared claimant medically stationary, he had expressed an intention to do so following the PCE. (Ex. 30). Furthermore, before the PCE, claimant's physical therapist had recommended that physical therapy be discontinued. (Ex. 29-6). Although physical therapy was continued after the PCE, it appears that the reason for doing so was because claimant had recurrence of pain after the PCE. (Ex. 32-2). Consequently, because the record shows that the PCE was ordered in the context that claimant was about to be declared medically stationary and physical therapy had been recommended to be discontinued, we find a preponderance of evidence that proves the PCE was performed for purposes of closing the claim.

ORDER

The ALJ's order dated September 4, 1997 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award also is reversed.

Board Member Hall dissenting.

I disagree with the majority's decision that claimant's right knee condition is not a compensable consequential condition under ORS 656.005(7)(a)(A). As the majority discusses, when an injury results from reasonable and necessary medical treatment, it is a compensable consequential condition. Barrett Business Services v. Hames, 130 Or App 190, rev den 320 Or 492 (1994); Rogers v. Cascade Pacific Ind., 152 Or App 624 (1998). Here, because the record shows that the PCE is "reasonable and necessary medical treatment," claimant's right knee injury is compensable.

At the time Dr. Webb ordered the PCE for claimant, he had not yet declared claimant medically stationary or provided permanent restrictions. (Ex. 30). Furthermore, following the PCE, claimant attended physical therapy and Dr. Webb requested continuation of such treatment. (Ex. 32). In fact, Dr. Webb did not declare claimant medically stationary until February 1997, almost four months after the PCE. Upon this record, it is apparent that claimant's participation in the PCE was an integral part of the medical treatment.

As the decision in Rogers shows, whether or not a claimant is declared medically stationary is indicative of whether medical treatment is curative rather than preventative. Specifically, the court discussed that, because claimant had been declared medically stationary and physical therapy was discontinued, an exercise program that resulted in a neck injury was not "reasonable and necessary medical treatment." 152 Or App at 630. Thus, based on Rogers, the fact that claimant was not yet medically stationary at the time of the PCE is strong evidence that the PCE was part of the ongoing "reasonable and necessary treatment." The fact that claimant's physical therapy and medical examinations continued after the PCE supports this conclusion.

Consequently, I would find that the PCE constituted claimant's reasonable and necessary treatment for his compensable condition. Because his right knee condition resulted from reasonable and necessary treatment, it also is compensable under ORS 656.005(7)(a)(A). Hames, 130 Or App at 197; Rogers, 152 Or App at 630.

In the Matter of the Compensation of
MARY L. SMITH, Claimant
WCB Case No. 97-08918
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Howell's order that: (1) dismissed her hearing request from the SAIF Corporation's January 26, 1998 denial of her "new injury" claim for a current low back condition; and (2) declined to award an assessed attorney fee for allegedly prevailing over the denial. On review, the issues are dismissal and attorney fees.

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

On review, claimant argues that she has prevailed over SAIF's compensability denial and that her counsel is therefore entitled to an assessed attorney fee under ORS 656.386(1). We disagree. Based on our review of SAIF's denial letters dated September 30, 1997, and January 21, 1998, we find that the denials were of a claim for a new injury allegedly occurring on July 22, 1997. Both letters expressly refer to the "July 22, 1997" date of injury and state that SAIF is not accepting a claim for injury occurring on that date. The January 21, 1998 denial letter also states that claimant's low back condition, which is the basis for the "July 22, 1997 injury" claim, "is the responsibility of another SAIF claim." (Ex. 104-1). The letter further states that claimant's current condition may be the responsibility of the accepted June 5, 1980 injury claim with SAIF, which is in "own motion" status due to the expiration of aggravation rights on the claim.

Meanwhile, claimant, through counsel, requested "own motion" reopening of the 1980 injury claim. (Ex. 99B). In accordance with the Board's rules, SAIF timely processed claimant's "own motion" request by recommending to the Board that the 1980 claim be reopened under its "own motion" authority pursuant to ORS 656.278 and OAR 438, Division 12. The Board apparently reopened the 1980 claim under its "own motion" authority and, as reflected in the ALJ's order, claimant subsequently withdrew her hearing request challenging SAIF's denials of her "July 22, 1997 injury" claim. Based on claimant's withdrawal of her hearing request, the ALJ dismissed claimant's appeal of SAIF's denials, leaving claimant's entitlement to a penalty and an assessed attorney fee as the sole issues left to be resolved.

Because the sole claim before the ALJ was for a new injury allegedly occurring on July 22, 1997[1], and claimant did not establish the compensability of that claim, we find that claimant did not prevail over a "denied claim" within the meaning of ORS 656.386(1). In fact, by withdrawing her appeal of SAIF's denials at hearing, claimant essentially agreed that her "July 22, 1997 injury" claim was not compensable and did not give rise to an entitlement to compensation. Thus, the disposition of this case differs substantially from that of the case cited by claimant, *Donald J. Boies*, 48 Van Natta 1259 (1996), where the claimant prevailed over the carrier's denial of compensability of his (occupational disease) claim. Because claimant in this case did not prevail over the denial of her (new injury) claim, she is not entitled to an assessed attorney fee under ORS 656.386(1).

ORDER

The ALJ's order dated March 3, 1998 is affirmed.

[1] The ALJ correctly noted that he lacked jurisdiction over claimant's "own motion" request for reopening of the 1980 injury claim. *See* ORS 656.278(1); *Miltenberger v. Howard's Plumbing*, 93 Or App 475 (1988).

In the Matter of the Compensation of
JANICE K. CONNELL, Claimant
Own Motion No. 98-0052M
OWN MOTION ORDER OF DISMISSAL
Hollander, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requested that the Board enforce its March 18, 1998 Own Motion Order which authorized the reopening of claimant's claim to provide temporary disability compensation beginning the date she was hospitalized for surgery. In addition, claimant requests that the Board assess a penalty for SAIF's allegedly unreasonable failure to pay compensation.

On October 9, 1979, claimant sustained a compensable injury to her back. SAIF accepted a cervical strain with fusion at C4-C7 and lumbar strain with surgery at L2-S1. Claimant's aggravation rights expired on June 22, 1986.

On November 19, 1997, claimant underwent hardware removal at L4-5 level. On March 18, 1998, the Board issued an order reopening claimant's claim for the payment of temporary disability compensation.

On April 17, 1998, our March 18, 1998 Own Motion Order became final by operation of law. Claimant's claim remains reopened. On April 20, 1998, claimant moved the Board for an order enforcing its March 18, 1998 order. Claimant contended that SAIF has not paid "time loss for the period commencing November 19, 1997 through March 24, 1998." Claimant requested that the Board issue an order directing SAIF to pay the temporary disability compensation and assess penalties for "unreasonable resistance and delay in the payment of compensation."

In response to our inquiry, SAIF submitted a May 6, 1998 wherein it asserts that it has "processed the March 18, 1998 Own Motion Order in a timely fashion," and "[Claimant] was sent the retroactive time loss owed to her before the 44th day." Claimant has not responded to SAIF's contentions.

The Board has exclusive jurisdiction to authorize the reopening of a claim under ORS 656.278 and OAR Chapter 438, Division 012. *See Miltenberger v. Howard's Plumbing*, 93 Or App 475 (1988). Moreover, the Board's authority extends to enforcing its own motion orders. *See Larry P. Karr*, 48 Van Natta 2183 (1996); *Jeffrey T. Knudson*, 48 Van Natta 1708 (1996); *Thomas L. Abel*, 45 Van Natta 1768 (1993); *David L. Waasdorp*, 38 Van Natta 81 (1986).

Inasmuch as SAIF has begun payment of and is paying temporary disability compensation in this claim, we need not "enforce" our prior order. Therefore, the penalty issue remains to be determined. However, by letter dated May 12, 1998, claimant's attorney notified the Board that claimant "withdraws her request for penalties on this issue."

Since we have found that SAIF complied with our March 18, 1998 order by providing timely temporary disability compensation, the enforcement issue is moot. Additionally, since claimant has withdrawn her request for penalties, the request is hereby dismissed, without prejudice.

IT IS SO ORDERED.

In the Matter of the Compensation of
MONTE WAKE, Claimant
WCB Case No. C8-00895
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Robert G. Dolton, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Member Bock and Haynes.

On April 17, 1998, 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 CDA.

On page 2, paragraph number 12, the CDA provides that claimant releases his rights to non-medical service workers' compensation benefits in exchange for the payment of $10,500.00 by the insurer (less a $2,625.00 attorney fee). On page 3, paragraph 13a, the CDA provides that the insurer preserves the right to recoup an overpayment in the amount of $10,627.92.

On April 24, 1998, we wrote the parties requesting clarification of the CDA. In light of the fact that the reserved overpayment was for an amount greater than the CDA proceeds, we asked the parties to address the question of whether there was consideration for the CDA.

In their response to our letter, the parties state that the CDA contains consideration in the sum of $10,500.00 for claimant's release of his non-medical benefits in the claim. The parties acknowledge that the CDA preserves the insurer's right to recoup a $10,627.92 overpayment, but note that ORS 656.268(15)(a) allows an insurer to unilaterally offset any compensation payable to the worker from a claim with the same insurer. The parties further state:

> "It is the express intent of the parties that, as additional consideration for the CDA, [the insurer] will agree to forbear its right to recover the overpaid benefits from the current claim payments. However, [the insurer] does not waive its right to recover the overpaid benefits from a future workers' compensation claim with [the insurer]. The parties also agree that those overpaid benefits remain a part of [insurer's] statutory lien. The claimant agrees that [the insurer's] forbearance constitutes additional consideration for the CDA."

We have previously held that an overpayment which had apparently been made pursuant to prior claims processing obligations could not qualify as "proceeds" of a CDA. *Timothy W. Moore*, 44 Van Natta 2060 (1992). More recently, in *Karen L. Begeal*, 49 Van Natta 231 (1997), we were asked to reconsider our holding in *Moore* in light of the enactment of ORS 656.268(15)(a).

In *Begeal*, the sole consideration for the CDA was the carrier's waiver of its right to recover a $3,599.92 overpayment. The carrier argued that ORS 656.268(15)(a) made it more likely and less speculative that overpayments would be recovered and made a carrier's waiver of an overpayment more valuable to workers. We held that although ORS 656.268(15)(a) increased the odds that a carrier would be able to recoup an overpayment, recovery of an overpayment remained an uncertain event. On the basis of this reasoning, we declined to disavow our holding in *Moore* that a carrier's waiver of an overpayment could not constitute consideration for a CDA.

Here, in contrast to *Begeal* or *Moore*, the insurer is not using a waiver of an overpayment as consideration for the CDA. Instead, the consideration for the CDA is a lump sum payment by the insurer to claimant of $10,500.00. Thus, unlike in *Begeal*, we find that there is consideration for the CDA. In this regard, we find that the lump sum payment of $10,500.00 is valid consideration for the CDA. Admittedly, the amount of the recoverable overpayment to potentially be offset against compensation payable on a future claim with the insurer is greater than the lump sum payment under the CDA. Nevertheless, considering the uncertainty that claimant will have a future claim with the insurer, and the further uncertainty that the insurer will be able to recoup all or a portion of its overpayment if a future claim involving claimant does materialize, we conclude that the insurer's $10,500 payment is consideration for the CDA.

As interpreted herein, the CDA, as amended, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the CDA is approved. An attorney fee of $2,625.00, 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
VIRGIE WEBB, Claimant
WCB Case Nos. 96-03688 & 95-09567
ORDER ON REMAND
Scott McNutt, Sr., Claimant Attorney
Brian L. Pocock, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *Bay Area Health District v. Webb*, 151 Or App 709 (1997). The court reversed our prior order, *Virgie Webb*, 49 Van Natta 479 (1997), which had affirmed that portion of the Administrative Law Judge's (ALJ's) order that set aside the insurer's denial of claimant's current low back condition. Citing *Bay Area Hospital v. Landers*, 150 Or App 154 (1997), the court has reversed and remanded for reconsideration.

FINDINGS OF FACT

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

We summarize the relevant facts as follows.

On May 3, 1988, claimant compensably injured her low back. The claim was accepted as a nondisabling lumbosacral strain. On February 8, 1990, the insurer reclassified the claim as disabling. On August 24, 1990, the insurer issued a Notice of Closure that awarded no permanent disability.

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

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

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

CONCLUSIONS OF LAW AND OPINION

Relying on *Deluxe Cabinet Works v. Messmer*, 140 Or App 548 (1996), the ALJ found that claimant's preexisting degenerative disc disease at L4-5 and L5-S1 was part of her compensable claim because the insurer had not appealed a Determination Order which had awarded permanent disability for claimant's surgery for the degenerative condition. The ALJ found that claimant's May 3, 1988 compensable injury and her compensable degenerative disc disease were the major cause of her current condition and/or her disability and need for treatment. On this basis, the ALJ set aside the employer's denial.

On review, we adopted and affirmed that portion of the ALJ's order finding that the degenerative condition was part of the compensable claim and that the compensable conditions were the major contributing cause of claimant's current condition.[1] The employer petitioned for judicial review of our order.

Subsequent to the date of our order, the 1997 legislature enacted HB 2971, which amended ORS 656.262(10). As amended, the statute now provides:

> "Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability, nor shall mere acceptance of such compensation be considered a waiver of the right to question the amount thereof. Payment of permanent disability benefits pursuant to a determination order, notice of closure, reconsideration order or litigation order or the failure to appeal or seek review of such an order or notice of closure shall not preclude an insurer or self-insured employer from subsequently contesting the compensability of the condition rated therein, unless the condition has been formally accepted." (Amendments to the statute are underlined).

Citing *Bay Area Hospital v. Landers*, (a case where the court reversed a Board decision and remanded for reconsideration in light of the amendment to ORS 656.262(10)), the court has reversed our prior decision and remanded for reconsideration. Consistent with the court's mandate, we proceed with our reconsideration.

In *Keith Topits*, 49 Van Natta 1538 (1997), we held that the 1997 amendments to ORS 656.262(10) legislatively overruled the *Messmer* decisions. In *Topits*, we concluded, based on the plain and unambiguous language of the statute, that a carrier's failure to appeal a permanent disability award does not preclude the carrier from denying a previously rated degenerative condition.

Here, as in *Topits*, the employer is not precluded from denying claimant's current condition (including her degenerative disc disease) under the amended statute (even if claimant's prior permanent disability award was based in part on that condition and the employer failed to appeal the award). *See Patricia A. Landers*, 50 Van Natta 299 (1998); *see also Leslie Mossman, Dcd.*, 49 Van Natta 1602 (1997) (amendments to ORS 656.262(10) apply retroactively to cases existing on the effective date of HB 2971). Accordingly, we proceed to the merits.

The medical evidence establishes that claimant's 1988 work injury combined with her preexisting degenerative disc disease to cause or prolong her disability and need for treatment. Therefore, claimant is subject to the major contributing cause standard of proof. *See* ORS 656.005(7)(a)(B). She must show that the May 3, 1988 work injury, when weighed against her preexisting condition, was the major contributing cause of her current disability or the major cause of her need for treatment of the combined condition. *See SAIF v. Nehl*, 148 Or App 101, *mod* 149 Or App 309, 311 (1997), *rev den* 326 Or 389 (1998).

Four medical experts address the cause of claimant's current low back condition. Dr. Bert opined that claimant's compensable May 3, 1988 injury, rather than the noncompensable June 1993 car accident, was the major cause of claimant's current low back condition. Similarly, Dr. Karasek indicated that the major cause of claimant's current pathology was the 1988 compensable injury.

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[1] We vacated that portion of the ALJ's order pertaining to the aggravation issue. We found that claimant's aggravation rights had expired and that consequently the Hearings Division lacked jurisdiction over the aggravation issue. *Webb*, 49 Van Natta at 480.

Dr. Kitchel first saw claimant in April 1992. Dr. Kitchel performed claimant's January 1996 anterior lumbar fusions at L4-5 and L5-S1. Dr. Kitchel opined that the May 1988 compensable injury was the major contributing cause of claimant's current condition and need for surgery. Dr. Kitchel indicated that claimant's degenerative disc disease and the motor vehicle accident were also contributing causes, but that the May 1988 industrial injury represented the major contributing cause. (Ex. 66A-10).

Finally, claimant's records and x-rays were reviewed by Dr. Woolpert on behalf of the employer. Dr. Woolpert opined that claimant's compensable injury should not be considered a major contributing factor to claimant's current condition and need for treatment. Based on his review of claimant's medical records and x-rays, Dr. Woolpert opined that claimant's 1988 compensable injury should probably have resolved within 30 days or less.

After reviewing the medical evidence, we are not persuaded by the opinions of Drs. Karasek and Bert. Neither of these physicians addressed the contribution from claimant's preexisting degenerative condition in determining the major contributing cause of claimant's current low back condition. Thus, we find these medical opinions to be unpersuasive. *See Dietz v. Ramuda,* 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995) (persuasive medical opinion must evaluate the relative contribution of the different causes and explain why one condition, activity or exposure contributes more to the claimed condition than all other causes or exposures combined).

Dr. Woolpert and Dr. Kitchel both addressed the contribution from claimant's degenerative disc disease. After our review of their opinions, we find Dr. Kitchel's opinion to be more persuasive. In this regard, although Dr. Kitchel first saw claimant in 1992, well after the 1988 injury, he performed claimant's recent anterior fusion surgery and has treated claimant for her current condition. As the physician who performed claimant's most recent surgery, Dr. Kitchel is in a good position to provide an opinion regarding causation. *See Argonaut Insurance Co. v. Mageske,* 93 Or App 698 (1988). In contrast, Dr. Woolpert has never examined claimant and based his opinion only on a review of medical records. Under these circumstances, we find that Dr. Kitchel is in the best position to render an opinion regarding the cause of claimant's current low back condition. Thus, we conclude that claimant has established compensability of her current condition under ORS 656.005(7)(a)(B).

Pursuant to ORS 656.388(1), 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. The employer appealed our prior order to the court. Claimant's compensation has not been disallowed or reduced. Under such circumstances, in addition to the attorney fees previously awarded by the ALJ ($3,000) and in our prior order ($1,000), we award a reasonable attorney fee under ORS 656.382(2) for claimant's counsel's services before the court.

After considering the factors set forth 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 the court level is $3,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief to the court), the complexity of the issue, and the value of the interest involved.

Accordingly, as modified and supplemented herein, we republish our April 11, 1997 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARCELLA L. BROOKS, Claimant
WCB Case No. 97-07653
ORDER ON REVIEW (REMANDING)
Mitchell & Associates, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Podnar's order[1] that: (1) denied the insurer's motion to amend its denial to include a current condition denial; (2) set aside its "back-up" denial of claimant's previously accepted claim for bilateral forearm tendinitis; and (3) awarded an assessed attorney fee of $4,000. On review, the issues are hearings procedure, propriety of the insurer's denial and attorney fees. We affirm in part, vacate in part, and remand in part.

FINDINGS OF FACT

Before working for the employer, claimant received chiropractic treatment for her neck, back and shoulders. She was treated by Dr. Setera from August 9, 1989 until approximately 1990. (Ex. A). Dr. Setera treated her for pain in her neck, low back, shoulders and upper back. On January 31, 1992, claimant began treating with Dr. Zimmerman, chiropractor. (Ex. B). She complained of headaches and neck, lower back and leg pain. (Ex. B-3). She continued occasional treatment with Dr. Zimmerman until September 30, 1992. (Ex. B-4). Claimant treated with Dr. VanHee, chiropractor, from February 15, 1993 intermittently until June 27, 1994. (Ex. C).

On July 28, 1993, claimant began treatment with Dr. Armerding. He reported that claimant had bilateral ulnar neuropathy, early carpal tunnel syndrome (CTS) and mild lateral epiphysitis, all probably caused by overuse at work. (Ex. F). Claimant was treated by Dr. Armerding, as well as Dr. Hering.

Claimant filed a claim on August 2, 1993 with the employer while a different insurer was on the risk. (Ex. I). Her "801" form indicated she had bilateral tendonitis in her hands, wrists and arms and she indicated that repetitious movement of her hands and wrists while performing dispatch duties on the keyboard caused the injury.[2] (*Id.*)

Nerve conduction studies in September 1993 were normal and there was no evidence of CTS or ulnar neuropathy. (Ex. L). Later tests in October 1993 were also normal. (Ex. N).

On November 18, 1993, Dr. Armerding reported that claimant had wrist and forearm pain while keyboarding. (Ex. Q). He said her wrist and forearm tendinitis was moderately improved, but he said it was possible claimant would continue to experience the same symptoms intermittently. (*Id.*)

Claimant's next treatment with Dr. Armerding was on April 13, 1995. He reported that she had recurrent symptoms in her left arm of burning, numbness and tingling. (Ex. S-1). He diagnosed left ulnar nerve entrapment and said her condition "does seem to be a recurrence or flare-up of her original injury which I saw her first for on July 28, 1993." (*Id.*) Dr. Armerding reported a worsening of bilateral arm pain in May 1995. (Ex. T).

On August 21, 1995, claimant filed a claim with the employer for pain, numbness, muscle spasms and stiffness in both wrists, arms, shoulders and her neck and fingers. (Ex. 1B). She had been working for the employer for three years. (*Id.*)

On claimant's portion of the "827" form for the 1995 claim, she indicated that the body part had been injured before, stating "Neck - 7 years ago couldn't turn head w/out pain - saw doctor - pain relieved had adjustment & went away." (Ex. 2). Claimant explained that her condition was caused by keyboarding "8+" hours per day. (*Id.*)

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[1] Although the ALJ's order indicated that Exhibits 1 through 18 were admitted into evidence, we note that claimant's attorney withdrew Exhibit 10 at hearing. (Tr. 8).

[2] A later report from Dr. Long indicates that claimant's 1993 wrist condition was accepted by the previous insurer. (Ex. 13-1).

Claimant was examined by Dr. Sager on September 22, 1995. (Ex. 2A). He reported that she had a past history of musculoskeletal pain, preceding her work with the employer. (Ex. 2A-2). Her previous pain included headache, chronic low back pain and neck pain. (*Id.*) He diagnosed overuse syndrome, upper extremities. (Ex. 2A-3).

On September 25, 1995, Dr. Armerding responded to the insurer's questions and indicated that claimant's symptoms since April 1995 were "quite similar to the symptoms she developed in July of 1993 which was diagnosed as a work-related overuse syndrome of tendonitis in her forearms." (Ex. 3). He diagnosed "recurrent tendonitis, both forearms, with intermittent ulnar neuropathy, probably related to muscle and tendon swelling in the forearms." (*Id.*) Dr. Armerding reported that there "may be some pre-existing effects from her previous injury of July, 1993." (*Id.*) He believed that the major contributing cause of her need for medical care was repetitive muscle forearm stress from her duties at work, primarily keyboarding. (*Id.*)

On September 28, 1995, the insurer accepted a claim for a "bilateral forearm tendonitis from repetitive motion of keyboarding which occurred April 14, 1995 as a nondisabling injury." (Ex. 3B). On October 30, 1995, the insurer reported that it was accepting a claim for "bilateral forearm tendonitis which has resulted in lost time from work commencing October 9, 1995 as a disabling injury." (Ex. 3C).

On February 27, 1996, claimant was examined by Drs. Reimer and Scheinberg on behalf of the insurer. They diagnosed "diffuse symptoms of 'pain, aching, and burning affecting the hands, wrists, forearms, and elbow areas.'" (Ex. 4-4). They were unable to comment about any preexisting pathology because they had no medical records before July 1995. (*Id.*)

Dr. Armerding continued to treat claimant. (Ex. 1). On October 28, 1996, he reported that even after several weeks off work, she required a tremendous amount of intervention to keep her symptoms under control. (Ex. 1-9).

Claimant was examined by Dr. Peterson, neurologist, on June 19, 1997 as part of a medical arbiter examination. She diagnosed bilateral carpal tunnel syndrome, bilateral ulnar neuropathy, "[p]ositive Spurling's - rule out disc herniation with left C7 radiculopathy[,] tendinitis and right lateral epicondylitis." (Ex. 11-5). Dr. Peterson recommended a further evaluation from a neurologist. (Ex. 11-7).

On July 28, 1997, claimant was examined by Dr. Long. He referred to claimant's chiropractic treatments, which began in 1987. (Ex. 13-1). Dr. Long diagnosed bilateral upper extremity pain/numbness with:

> "a) history of bilateral wrist and hand pain, 1993, etiology undefined, accepted as tendinitis.
>
> "b) progressive wrist, forearm and elbow pain, left > right, onset March 1995, treated as bilateral tendinitis, etiology undefined.
>
> "c) clinical and electrodiagnostic [sic] of median compression neuropathy in the palms, significance unclear.
>
> "d) rule out ulnar neuropathy at the elbows.
>
> "e) rule out radial neuropathy/proximal forearms.
>
> "f) suspect cervical spondylosis with cervical radiculopathy/myelopathy, etiology undetermined." (Ex. 13-5).

Dr. Long explained that there was "no convincing evidence of tendinitis in any of the usual locations." (Ex. 13-6). He felt that claimant had cervical problems and he recommended an MRI. (*Id.*) An MRI on August 1, 1997 showed a small disc herniation at C5-6. (Ex. 14A).

On August 8, 1997, claimant's attorney wrote to the insurer and requested an amendment to the Notice of Acceptance to include bilateral carpal tunnel syndrome, bilateral ulnar neuropathy, positive Spurling's and right lateral epicondylitis. (Ex. 14C).

On September 17, 1997, the insurer wrote to claimant, stating, in part:

> "We revoke the acceptances issued in this matter on September 28, 1995, October 30, 1995, and at any other time. Your previously accepted claim is hereby denied. The bases of this total denial are new medical evidence and pre-existing condition or conditions which should have been disclosed by you. Your claim is not compensable at this time. Your claim has never been compensable." (Ex. 16).

Claimant was examined by Dr. Gritzka on December 3, 1997. He diagnosed two primary conditions: repetitive stress injury, both forearms, and a centrally herniated intervertebral disc. (Ex. 17-9, -10). As part of the repetitive forearm stress injury, he also diagnosed: bilateral forearm tendinitis, left cubital tunnel syndrome (entrapment neuropathy, left cubital tunnel), bilateral carpal tunnel syndrome, bilateral medial humeral epicondylitis and ulnar neuritis at the cubital tunnel and bilateral thoracic outlet compression syndrome. (Ex. 17-9).

CONCLUSIONS OF LAW AND OPINION

At hearing, the insurer's attorney moved to amend its denial to include a denial of claimant's current condition. The ALJ denied the motion on the basis that the amendment was not actually an amendment, but rather an issuance of a new and distinct denial. Furthermore, the ALJ reasoned that the proposed amendment would have been a prospective denial because no conditions were currently in accepted status.

The ALJ found that, with regard to the accusations of fraud, misrepresentation or other illegal activity, the insurer had failed to establish a scintilla of evidence to support its claim. The ALJ concluded that claimant had provided the insurer with sufficient information for a reasonable and prudent claims examiner to make further inquiry. The ALJ also rejected the insurer's argument that there was new medical evidence that the previously accepted claim was not compensable.

"Back-up" Denial

On review, the insurer contends that claimant significantly misrepresented her prior history of neck and arm problems, which entitled it to issue a "back-up" denial. For the following reasons, we disagree with the insurer's contention.

ORS 656.262(6)(a) provides, in part:

> "The insurer or self-insured employer may revoke acceptance and issue a denial at any time when the denial is for fraud, misrepresentation or other illegal activity by the worker. If the worker requests a hearing on any revocation of acceptance and denial alleging fraud, misrepresentation or other illegal activity, the insurer or self-insured employer has the burden of proving, by a preponderance of the evidence, such fraud, misrepresentation or other illegal activity. Upon such proof, the worker then has the burden of proving, by a preponderance of the evidence, the compensability of the claim."

Under this provision, the carrier first must prove fraud, misrepresentation or other illegal activity by claimant. *See Bauman v. SAIF*, 295 Or 788 (1983). The carrier then must show that such fraud, misrepresentation or other illegal activity "could have reasonably affected" its decision to accept the claim. *See Ebbtide Enterprises v. Tucker*, 303 Or 459, 464 (1987); *David F. Lemus*, 49 Van Natta 815 (1997).

Here, claimant signed an "801" form on August 21, 1995. (Ex. 1B). On September 28, 1995, the insurer accepted a nondisabling claim for a bilateral forearm tendonitis. (Ex. 3B). On October 30, 1995, the insurer accepted a disabling claim for bilateral forearm tendonitis. (Ex. 3C).

The insurer contends that claimant made clear and material misstatements in the "827" form. On the "827" form for the 1995 claim, claimant indicated that the body part had been injured before, stating "Neck - 7 years ago couldn't turn head w/out pain - saw doctor - pain relieved had adjustment & went away." (Ex. 2). The insurer's claims adjuster who issued the acceptance testified that she had

relied on the August 1995 document (Ex. 2) in which claimant reported that she had received chiropractic care seven years ago and had treatment and her symptoms had resolved. (Tr. 56). The adjuster testified that if she had known the true nature and extent of claimant's chiropractic care from 1987 though 1993, she would not have accepted the claim. (Ex. 57).

Later in the hearing, however, the adjuster said that she did not receive the "827" form (Ex. 2) until October 12, 1995, which was after the initial September 28, 1995 acceptance. (Tr. 70). Under these circumstances, we are not persuaded that claimant's "827" form, no matter what information it contained, "could have reasonably affected" the insurer's decision to accept the claim. *See Ebbtide Enterprises v. Tucker*, 303 Or at 464.

The adjuster testified that the only medical record she had at the time of the first acceptance was Dr. Armerding's September 25, 1995 report. (Tr. 70). She also had claimant's "801" form. (Ex. 1B). We examine those documents to determine whether claimant made any misrepresentations that "could have reasonably affected" the insurer's decision to accept the claim.

In the "801" form signed on August 21, 1995, claimant explained:

> "I use the keyboard 8+ hours a day at work - In April I started having pain - different from my original tendonitis injury - sharp pain in elbow, shoulder, neck - worse on left side, migraines, more recently - dull pain on top of wrist & arms - worse on left." (Ex. 1B).

Claimant indicated that the body part had not been previously injured. (*Id.*)

On September 25, 1995, Dr. Armerding responded to the insurer's questions:

> "[Claimant] presented to me on 4/13/95 stating that for the past one to two weeks she had been putting in some overtime hours and increased time on the keyboard and was beginning to have burning, numbness, and tingling in her forearms, especially the left, primarily radiating over the lateral aspect of the forearms into her 5th fingers. This was quite similar to the symptoms she developed in July of 1993 which was diagnosed as a work-related overuse syndrome of tendonitis in her forearms. After my examination of 4/13/95 and reassessments on 5/19/95, 7/10/95, and 8/24/95, and 9/23/95, my diagnosis of this condition is recurrent tendonitis, both forearms, with intermittent ulnar neuropathy, probably related to muscle and tendon swelling in the forearms. My impression is that this diagnosis arises from repetitive motion stresses from her duties at work." (Ex. 3).

Dr. Armerding reported that there "may be some pre-existing effects from her previous injury of July, 1993." (*Id.*) He believed that the major contributing cause of her need for medical care was repetitive muscle forearm stress from her duties at work, primarily keyboarding. (*Id.*)

Although claimant's "801" form indicated the "body part" had not been previously injured, she expressly referred to her "original tendonitis injury" and said her current symptoms were different. (Ex. 1B). Dr. Armerding's September 25, 1995 report clearly indicated that claimant had a similar condition in 1993, which was probably having an effect on her current condition. He reported that claimant's current condition was "quite similar to the symptoms she developed in July of 1993 which was diagnosed as a work-related overuse syndrome of tendonitis in her forearms." (Ex. 3). He diagnosed "*recurrent* tendonitis" in the forearms and intermittent ulnar neuropathy. (*Id.*; emphasis added). He further stated that there "may be some pre-existing effects from her previous injury of July, 1993." (*Id.*)

Based on the information the insurer had at the time of the original acceptance, we are not persuaded that claimant made any material misrepresentations. Claimant disclosed her previous tendonitis injury and both her "801" form and Dr. Armerding's report indicated that some of her symptoms were similar. Thus, the insurer knew about the previous 1993 tendonitis claim and that it was similar to claimant's current condition. Moreover, the insurer's adjuster testified that in August 1995, she was aware that claimant had previously had some sort of cervical problems. (Tr. 75-77). The insurer had received a form completed by the claimant that asked, among other things, "other treatment received but not described above." (Tr. 76). The response was "[c]ervical traction, manual manipulation tense [sic] unit." (*Id.*)

An insurer has a duty to fully investigate the claim in order to determine a claimant's right to compensation. *Charles A. Tureaud*, 47 Van Natta 306, 307 (1995). Here, the insurer's failure to further investigate the claim before acceptance is not sufficient to support a "back-up" denial based on fraud, misrepresentation or other illegal activity. At the time of the original acceptance, the insurer had information that claimant had a previous 1993 tendonitis claim that had some similarities with her current condition and she previously received treatment for cervical problems. The insurer chose not to investigate that information before acceptance, although it had nearly two months left before it was required to accept or deny the claim. *See* ORS 656.262(6)(a).

In sum, we conclude that the insurer has not met its burden of proving fraud, misrepresentation or other illegal activity by claimant or that any such activity could have reasonably affected its decision to accept the claim.

Alternatively, the insurer contends that its denial was based on medical evidence that was newly discovered after the acceptance. The insurer asserts that Dr. Long's July 28, 1997 report, as well as Dr. Gritzka's report, constitute newly discovered evidence. The insurer also contends that the chiropractic records dating back seven years constitute newly discovered evidence.

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

The requirement of "later obtained evidence" in ORS 656.262(6)(a) refers to new material, *i.e.*, something other than the evidence that the carrier had at the time of the initial acceptance. *CNA Ins. Co. v. Magnuson*, 119 Or App 282, 286 (1993). A reevaluation of known evidence, for whatever reason, is not "later obtained evidence" under ORS 656.262(6)(a). *Id.*

On July 28, 1997, almost two years after claim acceptance, Dr. Long diagnosed bilateral upper extremity pain/numbness with, among other things: "history of bilateral wrist and hand pain, 1993, etiology undefined, accepted as tendinitis" and "progressive wrist, forearm and elbow pain, left > right, onset March 1995, treated as bilateral tendinitis, etiology undefined." (Ex. 13-5). He reported there was "no convincing evidence of tendinitis in any of the usual locations." (Ex. 13-6). He felt there was a high probability that claimant probably had disease in the cervical spine and he felt that assessment for cervical disease was mandatory. (*Id.*)

Dr. Long's July 28, 1997 report indicated that claimant had "no convincing evidence of tendinitis in any of the usual locations" and he was concerned that claimant had cervical disease. We construe his report to mean that, with the passage of time almost two years after acceptance, claimant's cervical problems could be causing her current symptoms, rather than tendinitis. Although Dr. Long indicated that etiology of the bilateral tendinitis was undefined, his report does not establish that claimant never had bilateral forearm tendinitis. We are not persuaded by his report that claimant did not experience the bilateral forearm tendinitis condition that was accepted by the insurer. Even if we assume that the tendinitis condition has now resolved, claimant's cervical condition is not the same as the accepted bilateral forearm tendinitis condition. Under these circumstances, we conclude that the employer's "back-up" denial related to a different condition than the one accepted. *See Gordon K. Yeater*, 49 Van Natta 1790 (1997) (the claimant's current condition was bilateral ulnar nerve subluxation; because that condition was not the same as the accepted strains, the carrier's "back-up" denial related to a different condition than the one accepted).

The insurer relies on Dr. Gritzka's report to support its denial on the basis of "new medical evidence." However, Dr. Gritzka's December 3, 1997 report was dated more than two months *after* the insurer's September 17, 1997 denial. (Exs. 16, 17). Inasmuch as the insurer did not have Dr. Gritzka's report when it issued its denial, we are not persuaded that its denial was based on any "new medical evidence" from Dr. Gritzka.

In any event, for the reasons discussed above, we are not persuaded by the insurer's argument. Dr. Gritzka reported claimant's bilateral forearm tendinitis had "resolved." (Ex. 17-12). However, he included "bilateral forearm tendinitis" in his list of diagnosable conditions related to the repetitive stress injury of both forearms. (Ex. 17-9). Dr. Gritzka explained that claimant had a repetitive stress injury,

which was "characterized by diffuse activity-related aching and is often described as a 'forearm tendinitis.'" (Ex. 17-10). Although Dr. Gritzka also diagnosed a cervical condition, the etiology of which was "problematic," as we discussed above, the cervical condition is not the same as the accepted bilateral forearm tendinitis condition. Dr. Gritzka's report does not support the insurer's "new medical evidence" argument.

The insurer also contends that the chiropractic records dating back seven years constitute newly discovered evidence. The insurer asserts that the chiropractic records noted neck, shoulder and arm problems.

As we discussed earlier, claimant's "801" form expressly referred to her "original tendonitis injury" and Dr. Armerding's September 25, 1995 report clearly indicated that claimant had a similar condition in 1993, which was probably having an effect on her current condition. The insurer had that information at the time it issued its acceptance. Furthermore, the insurer's claims adjuster testified that in August 1995 (before the initial acceptance), she was aware that claimant had previously had some sort of cervical problems. (Tr. 75-77). The insurer had received a form completed by the claimant that asked, among other things, "other treatment received but not described above." (Tr. 76). The response was "[c]ervical traction, manual manipulation tense [sic] unit." (*Id.*)

We conclude that the additional medical evidence in the form of previous chiropractic records is based on the same information the insurer knew, or should have known, at the time of claim acceptance. A reevaluation of known evidence, for whatever reason, is not "later obtained evidence" under ORS 656.262(6)(a). *Magnuson*, 119 Or App at 286. Because the insurer's "back-up" denial was not based on "later obtained evidence" and the insurer has not met its burden of proving fraud, misrepresentation or other illegal activity by claimant, we conclude that its denial was invalid under ORS 656.262(6)(a).

Motion to Amend Denial

The insurer argues that its denial clearly denied a current condition, although it moved as a precautionary measure to amend the denial to include a current condition denial. The insurer contends that the ALJ erred by not allowing it to amend the denial.

The ALJ denied the insurer's motion on the basis that the amendment was not actually an amendment, but rather an issuance of a new and distinct denial. Furthermore, the ALJ reasoned that the proposed amendment would have been a prospective denial because no conditions were currently in accepted status.

We first address the insurer's argument that its denial expressly denied a current condition. A carrier is bound by the express language of its denial. *Tattoo v. Barrett Business Services*, 118 Or App 348, 351 (1993). In *Tattoo*, the court reasoned that, to hold to the contrary, would allow an employer to change what it had expressly said in a denial to the detriment of all parties who have relied on the language. *Id.* at 352.

The insurer's denial stated, in part:

> "We revoke the acceptances issued in this matter on September 28, 1995, October 30, 1995, and at any other time. Your previously accepted claim is hereby denied. The bases of this total denial are new medical evidence and pre-existing condition or conditions which should have been disclosed by you. Your claim is not compensable at this time. Your claim has never been compensable." (Ex. 16).

The insurer's denial revoked claimant's acceptances and stated that the previously accepted claim was denied. The insurer characterized the denial as a "total denial" and said that the claim had never been compensable. Although the insurer said that the "claim is not compensable at this time[,]" we are not persuaded that, in light of the other statements in the denial, the insurer was also denying claimant's current condition. Moreover, a denial of claimant's current condition and need for treatment is irreconcilably inconsistent with the insurer's assertion that the claim has never been compensable. Although it is conceivable that the insurer's denial could include such alternative arguments, we are not persuaded that this denial expressly included a "current condition" denial.

In *SAIF v. Ledin*, 149 Or App 94 (1997), the court clarified that none of its previous cases had addressed the ability of a carrier to amend its denial at hearing. In *Gregg Muldrow*, 49 Van Natta 1866, 1867 (1997), we relied on *SAIF v. Ledin* and determined that the carrier was not precluded from amending its denial at hearing. However, we further reasoned that extrinsic evidence (*i.e.*, the carrier's response to the claimant's hearing request) may not be used to interpret the express language of the denial. Consequently, although the carrier was allowed to amend its denial at hearing under OAR 438-006-0031 and 438-006-0036, we concluded that, to afford due process, the claimant must be given an opportunity to respond to the newly raised issue. We held that the claimant was surprised by the carrier's amended denial at hearing and his request for a continuance to respond to the newly raised issue should have been granted. 49 Van Natta at 1868. *See also Larry L. Ledin*, 50 Van Natta 115 (1998).

In the present case, we conclude that the insurer was not precluded from amending its denial at hearing. 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. As in *Ledin* and *Muldrow*, we conclude that, where such an amendment is permitted, the responding party must be given an opportunity to respond to the new issues raised to afford due process. OAR 438- 006-0091(3); *Muldrow*, 49 Van Natta at 1868. 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, claimant objected to the insurer's request to amend its denial at hearing (Tr. 12). If the denial was amended, claimant, in effect, requested a continuance of the hearing. (Tr. 13-14). Inasmuch as original authority to consider such procedural motions rests with the ALJ, we find it appropriate to remand this case to the ALJ for consideration of claimant's motion to continue the hearing based on the insurer's amended denial. *See Larry L. Ledin*, 50 Van Natta at 117.

Accordingly, we vacate the portion of the ALJ's order that denied the insurer's motion to amend its denial, and remand this portion of the case to ALJ Podnar for further proceedings consistent with this order. The ALJ may conduct these further proceedings in any manner that he finds will achieve substantial justice. ORS 656.283(7). The ALJ shall then issue a final appealable order.

Attorney Fee

The insurer argues that the ALJ's attorney fee award of $4,000 is excessive. The insurer asserts that most of the work done by claimant's attorney's concerned a vocational rehabilitation issue and new efforts directed at the insurer's denial were "minimal."

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

Our review of the record reveals the following information. The primary issue in dispute was the insurer's "back-up" denial. Fifty-one exhibits were received into evidence, 18 of which were generated or submitted by claimant's counsel. There were no depositions taken. The hearing transcript consists of 93 pages. Claimant and her mother testified on claimant's behalf and two witnesses testified for the insurer. Claimant's counsel did not submit a statement of services.

As compared to typical compensability cases, the issue here was more complex than a typical workers' compensation case because it involved complex medical and legal issues. The issues were whether the insurer had met its burden of proving fraud, misrepresentation or other illegal activity by claimant and whether the insurer had obtained new medical evidence that established that the claim was not compensable. The value of the interest and the result obtained for claimant is considerable. The attorneys involved in this case were skilled and experienced. There were no frivolous issues or defenses. In addition, there was a real risk in the "back-up" denial issue that claimant's counsel might go uncompensated. After considering these factors, we agree with the ALJ that $4,000 is a reasonable assessed fee for claimant's counsel's services regarding the "back-up" denial.

Claimant's attorney is also entitled to an assessed fee for services on review regarding the "back-up" denial. 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 amended denial issue or the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated December 30, 1997 is affirmed in part and vacated in part. That portion of the ALJ's order that denied the insurer's motion to amend the denial is vacated. We remand this portion of the ALJ's order concerning the insurer's "current condition" denial to ALJ Podnar for further proceedings. Those proceeding shall be conducted in any manner that the ALJ deems achieves substantial justice. Thereafter, the ALJ shall issue a final appealable order on the "current condition" denial issue. The remainder of the ALJ's order is affirmed. For services on review regarding the "back-up" denial, claimant's attorney is awarded $1,500, payable by the insurer.

In the Matter of the Compensation of
RICHARD V. FRENCH, Claimant
WCB Case No. 97-06043
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Mongrain's order that: (1) found that claimant timely filed his occupational disease claim for hearing loss; and (2) set aside SAIF's denial of the condition. On review, the issues are timeliness of claim filing and compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant has worked for SAIF's insured since 1972. In April 1997, claimant filed a claim for hearing loss, which SAIF denied on the basis that a prior employer was potentially responsible for the claim. After first finding that claimant timely filed his claim, the ALJ concluded that SAIF was responsible for the claim under the last injurious exposure rule. SAIF challenges the ALJ's order, asserting that claimant's filing of his claim was not timely and that it carried its burden of proof to shift responsibility to a prior employer.

It is undisputed that claimant first sought medical treatment for his hearing loss while he was working for SAIF's insured. Thus, for purposes of the last injurious exposure rule, the "onset of disability" (*i.e.*, the triggering date for determining which employment is the last potentially causal employment) occurred during claimant's employment with SAIF. *Bracke v. Baza'r*, 293 Or 239, 248 (1982); *Timm v. Maley*, 125 Or App 396 (1993). Consequently, initial responsibility rests with SAIF.

Roseburg Forest Products v. Long, 325 Or 305 (1997), addressed the imposition of responsibility for a claim under the last injurious exposure rule. 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.

The record in this case contains one opinion concerning the cause of claimant's hearing loss. Examining otologist, Dr. Hodgson, found that, based on a 1972 audiogram, claimant had a "moderate high frequency hearing loss" when he began work with the employer. (Ex. 5-4). Dr. Hodgson further found that hearing loss was stable until the mid-1980's, when each ear sustained a change at one frequency, but at different periods. (*Id.*) According to Dr. Hodgson, such changes were "not the result of occupational noise exposure" but, instead, due to "a minor degenerative change in the ear[.]" (*Id.*) Dr. Hodgson explained:

> "If occupational noise was worsening [claimant's] pre-existing hearing loss, then one would have expected a gradual change over time, particularly in his early years of employment when hearing protection was not used except in occasional situations. We would expect it more often in the higher frequencies at 3000 to 6000 Hz where no change has occurred and then we would expect if the change occurred at 2000 Hz it would occur during the same interval." (*Id.*)

Based on these circumstances, Dr. Hodgson concluded that "the sole cause of any occupational hearing loss in this case is due to noise exposure prior to 1972 and therefore prior to employment with [SAIF's employer]." (*Id.* at 5). Dr. Hodgson also found "no evidence * * * that work exposure at [SAIF's employer] has independently contributed to [claimant's] hearing loss, or contributed independently to a pathological worsening of his pre-existing hearing loss." (*Id.*)

Dr. Hodgson was subsequently deposed, where he reiterated his opinion concerning the course of claimant's hearing loss. (Ex. 8).

The ALJ found that Dr. Hodgson's opinion was not sufficient for SAIF to shift responsibility to the prior employer. In particular, the ALJ held that, if noise exposure had not caused claimant's hearing loss after 1972, then the 1972 and 1997 audiograms for presbycusis-adjusted hearing impairment should be the same; because they were not, the ALJ concluded that Dr. Hodgson's opinion conflicted with his findings and, thus, was not reliable.

There is no dispute that this case is complex and, thus, requires expert medical evidence. *See Uris v. Compensation Department*, 247 Or 420 (1967). Here, the only medical opinion provides that the sole cause of claimant's hearing loss is from prior employment. We find Dr. Hodgson's opinion to be based on an accurate history and provides a well-reasoned explanation in support of his conclusion. In particular, Dr. Hodgson explained why the course of claimant's hearing loss after 1972, including the type and timing of the hearing loss, showed that occupational exposure did not contribute to claimant's condition.

Dr. Hodgson also explained that, when there are a series of audiograms, "you look for overall trends" and, because hearing tests fluctuate, "you can't just simply pick out one or two hearing tests." (Ex. 8-10). For this reason, Dr. Hodgson based his opinion on all of the audiogram tests, including those performed between 1972 and 1997. (*Id.* at 13, 15, 17). Based on this explanation, we disagree with the ALJ that differences between the 1972 and 1997 audiograms shows that Dr. Hodgson's findings are inconsistent with his opinion. Rather, we find more persuasive Dr. Hodgson's opinion, who has medical expertise and reviewed all the audiograms, than any findings we may make based on our own comparison of two hearing tests.

Consequently, having found Dr. Hodgson's opinion persuasive, we conclude that SAIF showed that it was impossible for workplace conditions at its employer to have contributed to claimant's hearing loss. Therefore, it is not responsible for the claim. *See Long*, 325 Or at 308. Finally, having found that SAIF is not responsible, we need not address whether claimant timely filed his claim.

ORDER

The ALJ's order dated January 7, 1998 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

In the Matter of the Compensation of
RAYMOND A. HARTLEY, Claimant
Own Motion No. 66-0017M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

On May 20, 1998, the SAIF Corporation submitted a request for additional medical benefits relating to claimant's compensable May 16, 1946 industrial injury which resulted in an above-the-knee amputation of the left leg. Claimant was awarded permanent total disability benefits in 1955. SAIF recommends the reopening of this claim to provide for medical treatment for intractable phantom limb pain (left leg amputation), prosthesis for the left leg, upkeep of prosthesis, a psychological evaluation and a spinal cord stimulator.

Inasmuch as claimant sustained a compensable injury prior to January 1, 1966, he does not have a lifetime right to medical benefits pursuant to ORS 656.245. William A. Newell, 35 Van Natta 629 (1983). However, for conditions resulting from a compensable injury occurring before January 1, 1966, the Board may authorize the payment of medical benefits. ORS 656.278(1)(b).

In a operative report dated April 9, 1998, Dr. Kosek, claimant's treating physician observed that if the increase of the dosage of claimant's morphine through his intrathecal morphine pump should not be effective, a dorsal column stimulator be provided for his intractable pain syndrome. SAIF also asserts that Dr. Kosek has recommended a psychological evaluation prior to the implantation of the spinal cord stimulator.

Based on these opinions, we are persuaded that the requested medical treatment for intractable phantom limb pain (left leg amputation), prosthesis for the left leg, upkeep of prosthesis, a psychological evaluation and a spinal cord stimulator are reasonable and necessary for the compensable May 16, 1946 injury. Accordingly, claimant's claim is reopened to provide for medical treatment for intractable phantom limb pain (left leg amputation), prosthesis for the left leg, upkeep of prosthesis, a psychological evaluation and a spinal cord stimulator. This order shall supplement our June 3, 1992 and June 20, 1994 orders that previously reopened claimant's 1946 claim for the payment of medications, office visits, tests, prescriptions, and implantation of an intrathecal morphine pump.

This authorization for compensable medical services shall continue on an ongoing basis for an indefinite period of time, until there is a material change in treatment or other circumstances. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
TERRY L. VANYI, Claimant
WCB Case Nos. 97-03852, 97-03851 & 97-03623
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys
Reinisch, 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) Baker's order that awarded claimant's counsel an extraordinary attorney fee under ORS 656.308(2)(d) of $3,800 for prevailing over the employer's responsibility denial. On review, the issue is attorney fees. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant requested a hearing from another carrier's denial and from the employer's "de facto" denial. A hearing was scheduled and claimant prepared to litigate the issues of compensability, claim processing (claimant's position was that the employer's 90 day claim processing period had run and that the employer had "de facto" denied the claim), penalties and attorney fees and responsibility. The day prior to hearing, the employer agreed to waive the claim processing/compensability issues and litigate responsibility. Claimant, in turn, agreed to withdraw the issue of penalties and attorney fees for allegedly improper claim processing. The ALJ found the employer responsible and awarded an "extraordinary" attorney fee under ORS 656.308(2)(d).

The employer argues that the ALJ erred in awarding an "extraordinary" fee under ORS 656.308(2)(d). Specifically, the employer argues that claimant did not file a claim until shortly before the hearing and that the employer "elected for purposes of judicial economy to waive the 90 day acceptance or denial issues relating to compensability and to simply go forward on the issue of responsibility."[1] On this basis, the employer asserts that the record contains no extraordinary circumstances justifying a fee in excess of $1,000. Claimant asserts that the case required more effort than the typical responsibility case and argues that an attorney fee under ORS 656.386(1) for obtaining a pre-hearing rescission of the employer's denial and/or ORS 656.308(2)(d) is appropriate. The employer contends that an attorney fee under ORS 656.386(1) is inappropriate because claimant did not file a claim, there was no "de facto" denial to be rescinded.

The record does not establish that there was a "denied claim" for purposes of awarding a fee under ORS 656.386(1). In this regard, there is no evidence concerning when a claim was made or whether the employer "refused to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation." *See* ORS 656.386(1)(b)(A). Accordingly, we do not award an attorney fee under ORS 656.386(1).

Pursuant to ORS 656.308(2)(d), an attorney fee shall not exceed $1,000 at hearing and on review, absent a showing of extraordinary circumstances. *See Liberty Northwest Ins. Corp. v. Gordineer*, 150 Or App 136, 141-42 (1997).

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[1] In its reply brief, the employer objects to the documents attached to claimant's respondent's brief. The documents consist of requests for hearing and Board hearing notices in this matter. In addition, one of the documents is a statement of time spent on the case which was submitted to the ALJ at hearing. Because all of these documents and pleadings are already present in the record, they do not constitute extra-record evidence. Thus, we deny the employer's motion to strike the documents.

After reviewing this record, we are unable to find that extraordinary circumstances exist which justify a fee greater than $1,000. In this regard, the record reveals the following information. The hearing lasted one hour and fifteen minutes and the hearing transcript was 41 pages long. One witness testified and there were 53 exhibits, 47 of which were submitted by claimant's attorney. On review, claimant submitted a three page respondent's brief.

Under similar facts, we have found that there were no "extraordinary circumstances" under ORS 656.308(2)(d). For instance, *Steve H. Salazar*, 48 Van Natta 2389 (1996), involved 33 exhibits, including a 16-page deposition transcript, and two carriers were joined at hearing. One witness testified at hearing and the hearing transcript was 32 pages. The claimant's attorney submitted a two page legal memorandum. On review, the claimant's attorney submitted a two page respondent's brief and a three page cross-respondent's brief. In *Tammy Locke*, 48 Van Natta 250, 251 (1996), there were two carriers, a 40 page hearing transcript with one witness and a record consisting of 26 exhibits, including a 50 minute deposition transcript.

Based on *Salazar* and *Locke*, we conclude that there were no "extraordinary circumstances" under ORS 656.308(2)(d).[2] Consequently, claimant's attorney is awarded $1,000 for services at hearing regarding the responsibility issue, payable by the employer.

ORDER

The ALJ's order dated December 30, 1997 is modified in part and affirmed in part. That portion of the order awarding a $3,800 attorney fee is modified. In lieu of the ALJ's award, claimant is awarded an attorney fee of $1,000 for services at hearing regarding the employer's responsibility denial, to be paid by the employer. The remainder of the ALJ's order is affirmed.

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[2] We find this case to be distinguishable from *Janice K. Gonzalez*, 49 Van Natta 638 (1997) where the Board found an extraordinary fee award was justified under ORS 656.308(2)(d) where the claimant had to be prepared to litigate complex issues beyond that of the ordinary case. In *Gonzalez*, the claimant was required to litigate issues involving timeliness, the retroactive application of the responsibility statute, the constitutionality of the statute, and to defend against the insurer's "back-up responsibility denial defense." Here, in contrast with *Gonzalez*, the issues claimant prepared to litigate were compensability and claim processing issues which were not of the complexity involved in *Gonzalez*.

In the Matter of the Compensation of
ROBERT N. CLARK, Claimant
WCB Case No. 96-10350
ORDER OF ABATEMENT
Cole, Cary, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Claimant requests reconsideration of our April 30, 1998 order that set aside the insurer's denial of claim for an L4-5 disc herniation and awarded a $4,000 assessed attorney fee. Specifically, claimant requests that we increase the $4,000 attorney fee to $6,500.

In order to further consider claimant's request, we withdraw our April 30, 1998 order. The insurer is granted an opportunity to respond to claimant's motion. To be considered, the insurer's response must be received within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
DALE F. CECIL, Claimant
WCB Case No. 97-06967
ORDER ON REVIEW (REMANDING)
Max Rae, Claimant Attorney
Mannix, Nielsen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that: (1) found that claimant's bilateral carpal tunnel syndrome claim was not prematurely closed; and (2) reinstated a Determination Order which awarded temporary disability from January 9, 1995 through June 19, 1995, but no permanent disability. Claimant has submitted a medical arbiters' report and requests that this matter be remanded to the Hearings Division for admission of that evidence and consideration of his other challenges to the Determination Order. On review, the issue is remand. We vacate, in part, the ALJ's order and remand.[1]

FINDINGS OF FACT

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

Claimant, age 51 at the time of hearing, has an accepted claim for bilateral carpal tunnel syndrome. On March 25, 1997, the Department of Consumer and Business Services issued a Determination Order closing claimant's claim. The Determination Order set forth a medically stationary date of January 8, 1996, and awarded temporary disability, less time worked, from January 9, 1995 to June 19, 1995.

Claimant requested reconsideration, raising the issues of premature closure, temporary disability dates, impairment findings and the rating of scheduled permanent disability. On August 5, 1997, an Order on Reconsideration set aside the March 25, 1997 Determination Order as premature.

The self-insured employer requested a hearing, asserting that the claim was not prematurely closed. The ALJ agreed, and on December 16, 1997, issued an Opinion and Order reinstating the March 25, 1997 Determination Order. Claimant requested review.

In the meantime, the parties stipulate that the Department agreed to schedule claimant for a medical arbiter examination, which was conducted on March 14, 1998.

CONCLUSIONS OF LAW AND OPINION

Although claimant does not specifically challenge the ALJ's determination that he was medically stationary on March 25, 1997 when his claim was closed, claimant does request remand, either to the Hearings Division or the Department, for the taking of additional evidence and for consideration of the other issues raised in his May 1997 request for reconsideration. In response, the employer argues that remand is unnecessary and asks the Board to consider the medical arbiters' report and conduct a de novo review of claimant's other challenges to the Determination Order.

The Board's review is limited to the record created at hearing. ORS 656.295(3) and (5). The only exception to this rule is that, under limited circumstances, we may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." See Groshong v. Montgomery Ward Co., 73 Or App 403 (1985). The medical arbiters' report at issue in this case is not the type of material which is the proper subject of administrative notice, as its content is subject to dispute.[2] Consequently, we decline to take administrative notice of the March 14, 1998 medical arbiters' report as a form of evidence.

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[1] As set forth above, the ALJ determined that claimant failed to prove that his claim was prematurely closed. Claimant does not challenge that finding on review. Consequently, we do not vacate the ALJ's order in its entirety. Rather, we vacate the ALJ's order only insofar as it reinstated and affirmed other aspects of the March 25, 1997 Determination Order.

[2] Generally, the Board will take official notice of agency orders and stipulations by the parties that are relevant to the issue in dispute. *See, e.g. Dewey W. Kennedy*, 47 Van Natta 399 (1995). The arbiter's report is not issued by the Department and is not an agency decision.

While we lack the authority to remand this matter to the Department for further proceedings, see Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993), claimant is entitled to a medical arbiter report and a hearing on his other challenges to the Determination Order. See ORS 656.268(7)(a); see also Nancy L. Sabin, 50 Van Natta 508 (1998) (In fashioning a remedy that accommodated both the Pacheco-Gonzalez decision and the claimant's statutory right to a medical arbiter's evaluation, Board remanded the case to the ALJ for deferral pending receipt of the medical arbiter's report).

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

Here, we find a compelling basis to remand. The proffered evidence (i.e., the March 14, 1998 medical arbiters' report) clearly concerns claimant's disability. Because the Department set aside the Determination Order as premature and did not appoint a medical arbiter prior to completion of the reconsideration proceeding, the proffered medical arbiters' report was not obtainable at the time of hearing. Finally, because the proffered evidence evaluates the extent of claimant's injury-related permanent impairment (an issue not previously considered during the reconsideration proceeding or at hearing), we conclude that it is reasonably likely to affect the outcome of this case.

Accordingly, that portion of the ALJ's order which reinstated the Determination Order in its entirety is vacated and the matter is remanded to ALJ Howell to reopen the record for admission of the medical arbiters' report.[3] The ALJ may proceed in any manner that will achieve substantial justice. ORS 656.283(7). The ALJ shall then issue a final, appealable order concerning claimant's other challenges, namely his entitlement to additional temporary disability and scheduled permanent disability.

IT IS SO ORDERED.

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[3] The arbiters' report is admissible at hearing pursuant to ORS 656.268(6)(e), notwithstanding the general limitation on "post-reconsideration" evidence set forth in ORS 656.283(7). See Larry A. Thorpe, 48 Van Natta 2608, 2610 (1996) (ORS 656.268(6)(e) constitutes an exception to the general limitation on "post-reconsideration" evidence in ORS 656.283(7)).

In the Matter of the Compensation of
CORRINA M. JOHANSEN, Claimant
Own Motion No. 97-0354M
OWN MOTION ORDER
Black, Chapman, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

On September 30, 1997, we consolidated claimant's request for temporary disability compensation for her compensable bilateral wrist flexor tendonitis and bilateral carpal tunnel with litigation concerning the compensability of her current chronic myofascial left neck, shoulder, periscapular and upper extremity pain syndrome which was pending before the Hearings Division. (WCB Case No. 97-06326). We took this action because the insurer had also raised work force issues.

On April 29, 1998, Administrative Law Judge (ALJ) Brown approved a "Disputed Claim Settlement," which resolved the parties' dispute concerning the compensability of claimant's current left carpal tunnel syndrome, bilateral de Quervain's tenosynovitis, bilateral wrist flexor tendonitis, chronic myofascial neck, shoulder, periscapular and upper extremity pain syndrome which was pending before the Hearings Division. Pursuant to that settlement, claimant agreed that the insurer's July 30, 1997 denial would remain in full force and effect. In addition, claimant stipulated that her request for hearing "shall be dismissed with prejudice," and that the settlement resolved "all issues raised or which could have been raised on or before the date this settlement is approved by an Administrative Law Judge."

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 light of the parties' settlement, the current condition for which claimant requests own motion relief remains in denied status. Consequently, we are not authorized to reopen claimant's 1988 injury claim with the insurer as she is not entitled to temporary disability compensation.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
KENNETH G. CULP, Claimant
Own Motion No. 66-0066M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

On May 20, 1998, the SAIF Corporation submitted a request for additional medical benefits relating to claimant's compensable spinal cord injury. Claimant was awarded permanent total disability benefits in 1958. SAIF recommends the reopening of this claim to provide for medical treatment for claimant's right elbow condition which it contends is a consequential condition to his 1951 compensable claim.

Inasmuch as claimant sustained a compensable injury prior to January 1, 1966, he does not have a lifetime right to medical benefits pursuant to ORS 656.245. William A. Newell, 35 Van Natta 629 (1983). However, for conditions resulting from a compensable injury occurring before January 1, 1966, the Board may authorize the payment of medical benefits. ORS 656.278(1)(b).

In a letter dated May 11, 1998, Dr. Wenner, claimant's treating physician opined that claimant's right olecranon bursitis with some soft tissue injury is directly related to claimant's accepted condition and recommended medical treatment including anti-inflammatories and padding. He further opined that it may be necessary to excise some soft tissue nodules found in claimant's right elbow.

Based on Dr. Wenner's unrebutted opinion, we are persuaded that the injury to claimant's right elbow represents a compensable component of his accepted condition and that the requested medical treatment for claimant's right olecranon bursitis with some soft tissue injury is reasonable and necessary. Accordingly, claimant's claim is reopened to provide for medical treatment for claimant's right elbow condition including anti-inflammatories, padding and possible excision of soft tissue nodules. This order shall supplement our June 26, 1992 order that previously reopened claimant's 1951 claim for the payment of medications, office visits, tests, medical supplies, prescriptions and prosthetic supplies.

This authorization for compensable medical services shall continue on an ongoing basis for an indefinite period of time, until there is a material change in treatment or other circumstances. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
SCOTTLAND FOWLER, Claimant
WCB Case Nos. 97-05071, 97-04980 & 97-03869
ORDER ON RECONSIDERATION
Rasmussen, et al, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys
H. Thomas Andersen (Saif), Defense Attorney

On April 27, 1998, we abated our April 9, 1998 Order on Review that: (1) set aside Twin City Fire Insurance Company's (Twin City's) denial insofar as it denied claimant's current condition; (2) awarded claimant's attorney an assessed attorney fee of $1,750 pursuant to ORS 656.386(1) for services at hearing concerning compensability of claimant's current condition; (3) awarded claimant's attorney an assessed fee of $1,000 pursuant to ORS 656.308(2)(d) for services at hearing and on review regarding the responsibility issue; and (4) awarded claimant's attorney an assessed fee of $1,000 pursuant to ORS 656.382(2) for services on review concerning Twin City's current condition compensability denial. In its request for reconsideration, Twin City contends that neither its request for review nor its briefs addressed any current condition denial. Twin City also argues that it raised an issue at hearing concerning the SAIF Corporation's obligation to share in any assessed fee. Twin City further contends that the attorney fees are excessive. Having received responses from SAIF and claimant, we proceed with our reconsideration.

On reconsideration, Twin City contends that neither its request for review nor its briefs addressed any current condition denial. For the reasons stated in our previous order, we continue to adhere to our conclusion that Twin City's June 9, 1997 letter denied an aggravation claim *and* claimant's current condition.

Twin City also argues that it raised an issue concerning SAIF's obligation to share in any assessed fee in its September 22, 1997 letter to the ALJ. In our previous order, we declined to address Twin City's argument on review that SAIF may be responsible for paying the assessed attorney fee because we found that Twin City had not contended at hearing that SAIF's denial included a denial of compensability. In any event, we found that based on the parties' positions at hearing, the record did not support a conclusion that SAIF's denial extended to the compensability of claimant's current condition. We referred to the parties' discussion at hearing in which they agreed that SAIF's denial was a denial of responsibility only.

On reconsideration, SAIF contends that it has no responsibility for paying any part of claimant's attorney fees. For the following reasons, we agree with SAIF's position.

After considering the parties' arguments, even if we assume that Twin City initially raised an issue concerning SAIF's obligation to share in any assessed fee, we conclude that the parties subsequently agreed that SAIF's denial was a denial of responsibility only. We adhere to our conclusion that the record does not support a conclusion that SAIF's denial extended to the compensability of claimant's current condition. Although Twin City had an opportunity at hearing to contend that SAIF had denied compensability as well as responsibility, we conclude that Twin City waived this argument when its attorney expressly agreed with the ALJ's statement of the issues. At hearing, the ALJ questioned the attorneys about the issues, as follows:

> "ALJ: And SAIF's Denial is a Denial of responsibility of a new injury -- responsibility only of a new injury?
>
> "[Claimant's attorney]: Correct. Yes.
>
> "ALJ: And the [Twin City] Denial is aggravation of current condition?
>
> "[Claimant's attorney]: Correct.
>
> "ALJ: "[Twin City's attorney], would you agree with that statement of the issues?
>
> "[Twin City's attorney]: Yes.

"ALJ: For the record, any cross-issues?

"[Twin City's attorney]: No.

"[SAIF's attorney]: I agree for SAIF Corporation and Langeliers, and there are no cross-issues." (Tr. 3).

On reconsideration, we adhere to our conclusion that based on the parties' positions at hearing, SAIF is not responsible for any portion of claimant's attorney fees.

Twin City also contends that the assessed fees are excessive. After reviewing Twin City's arguments, we continue to find that the assessed fees awarded in our previous order are reasonable. *See* OAR 438-015-0010(4). For the reasons expressed in our previous order, we adhere to our conclusion that claimant's attorney is awarded an assessed attorney fee of $1,750 pursuant to ORS 656.386(1) for services at hearing concerning claimant's current condition compensability denial and an assessed fee of $1,000 pursuant to ORS 656.308(2)(d) for services at hearing and on review regarding the responsibility issue.

Twin City argues that claimant is not entitled to a $1,000 attorney fee for services on review because "no one" argued the issue of compensability of the current condition. To the contrary, claimant's attorney argued on review that Twin City had issued a denial of an aggravation *and* his current condition. Claimant's attorney relied on Dr. Butters' opinion to establish compensability. Furthermore, the ALJ's order addressed compensability of claimant's current condition and 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).

On reconsideration, we adhere to our conclusion that a reasonable fee for claimant's attorney's services on review regarding the current condition compensability denial is $1,000, payable by Twin City. 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 unsuccessful aggravation issue or the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

On reconsideration, as supplemented and modified herein, we adhere to and republish our April 9, 1998 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
DEBBI R. MARX, Claimant
WCB Case No. 96-10762
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the SAIF Corporation's denial of claimant's current lumbar condition. On review, the issue is compensability.[1]

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[1] We acknowledge claimant's contention that the denial in this case is an invalid preclosure denial, which is not authorized by ORS 656.262(7)(b). We decline to address this argument because it was not raised at hearing. *See Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991); *Dixie L. Stanton*, 49 Van Natta 295, 296 (1997).

We adopt and affirm the ALJ's order. *See Cindy L. Keen*, 49 Van Natta 1055, 1056 (1997) ("Notwithstanding claimant's characterization of disc degeneration as part of the normal aging process, the medical evidence in this case persuasively establishes that, prior to [the compensable injury], claimant had degenerative disc disease which not only *predisposed* her to low back injury but also contributed to her current condition and need for treatment.").

ORDER

The ALJ's order dated January 2, 1998 is affirmed.

May 28, 1998 Cite as 50 Van Natta 1023 (1998)

In the Matter of the Compensation of
RONALD D. FULLER, Claimant
WCB Case No. 95-04992
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Biehl, Bock, and Haynes.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Crumme's order that: (1) found a Determination Order procedurally invalid based on allegedly inadequate notice; (2) alternatively found claimant permanently and totally disabled; and (3) assessed a penalty for allegedly unreasonable claims processing. Claimant cross-requests review of those portions that: (1) found that the Determination Order was not procedurally invalid based on allegedly incorrect notice of appeal rights; and (2) declined to award an assessed attorney fee under ORS 656.382(2). On review, the issues are procedural validity of the Determination Order, permanent total disability, potentially, extent of unscheduled and scheduled permanent disability, and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Procedural Validity of Determination Order

We adopt that portion of the ALJ's order finding the Determination Order procedurally invalid based on SAIF's lack of notice to claimant and claimant's attorney when it submitted the results of its examination to the Department. Having reached this conclusion, we need not address whether the Determination Order is procedurally invalid because, according to claimant, it contained an incorrect notice of appeal rights, or address the merits of permanent total disability. Consequently, we do not adopt those portions of the ALJ's order.

Penalties and Attorney Fees

The ALJ assessed a penalty based on his conclusion that SAIF unreasonably resisted the payment of compensation by failing to give notice to claimant's attorney about the February 1994 examination and failing to notify claimant and claimant's attorney when it requested that the Department reexamine claimant's permanent total disability. Claimant argues that the ALJ should also have assessed an attorney fee under ORS 656.382(1).

We have agreed with the ALJ that the Determination Order is invalid because SAIF did not comply with *former* OAR 436-30-065(2) when it failed to notify claimant and claimant's attorney that it

had submitted the results of its reexamination to the Department.[1] SAIF also did not comply with ORS 656.331(1)(a) when it failed to notify claimant's attorney about the February 1994 examination.

We do not find that such conduct, however, constitutes an unreasonable delay or refusal to pay compensation, as required by ORS 656.262(11)(a). The February 1994 examination and SAIF's submission to the Department did not, by themselves, result in the reduction of claimant's permanent total disability benefits. Rather, it was the Department's Determination Order that reduced claimant's permanent total disability award. Consequently, we find that SAIF did not unreasonably delay or refuse to pay compensation and, thus, no penalty is warranted. For the same reason, we find that claimant is not entitled to an attorney fee under ORS 656.382(1).

Because SAIF requested review and we found that claimant's compensation should not be disallowed or reduced, 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 procedural validity of the Determination Order issue is $1,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated August 4, 1997 is affirmed in part and reversed in part. That portion of the order awarding a penalty is reversed. That part of the order finding the Determination Order procedurally invalid is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the SAIF Corporation.

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[1] We disagree with the dissent that *former* OAR 436-30-065(2) is an improper enlargement of the Department's statutory authority concerning its redetermination of permanent total disability benefits. ORS 656.726(3) charges the Director "with duties of administration, regulation and enforcement of [ORS Chapter 656]." In the discharge of his duties, ORS 656.726(3)(g) authorizes the Director to "[p]rescribe procedural rules for and conduct hearings, investigations and other proceedings pursuant to [ORS Chapter 656] regarding all matters other than those specifically allocated to the board or the Hearings Division." Because the Director is expressly authorized to redetermine permanent total disability under ORS 656.206(5), the Director is likewise authorized under ORS 656.726(3)(g) to prescribe "procedural rules" for the redetermination proceeding. In our view, such rules encompass the requirement of prior notification to the other party in the proceeding, *i.e.*, the worker and his attorney, if represented. Accordingly, the Director's promulgation of OAR 436-30-065(2) and its requirement of prior notification did not exceed his statutory authority.

Board Member Haynes dissenting in part.

I disagree with the majority's decision to adopt and affirm that portion of the ALJ's order setting aside a Determination Order because SAIF failed to notify claimant when it asked the Department to redetermine claimant's permanent total disability award. Because the majority adopts and affirms, I first provide the relevant facts before explaining my disagreement with the majority's order.

In August 1982, claimant injured his low back while working. He subsequently underwent surgery. In September 1983, claimant injured both knees and back while working for the same employer. He underwent surgery on both knees and a second surgery on the low back. In 1987, claimant was awarded permanent total disability.

In December 1993, SAIF notified claimant that he was scheduled for an "independent medical examination." After claimant underwent the examination in February 1994, SAIF requested the Department to reconsider claimant's permanent total disability award. The Department issued a Determination Order finding claimant no longer was permanently and totally disabled and awarding unscheduled and scheduled permanent disability. Claimant requested a hearing.

The ALJ found that the Determination Order was not procedurally valid and set it aside. The ALJ did so on the basis that SAIF did not notify claimant and his attorney when it submitted its request to the Department for redetermination of the permanent and total disability award. In deciding that the Determination Order was invalid, the ALJ relied on the ORS 656.331(1), which provides:

"(1) Notwithstanding any other provision of this chapter, if an injured worker is represented by an attorney and the attorney has given written notice of such representation:

"(a) The director, the insurer or self-insured employer shall not request the worker to submit to an independent medical examination without giving prior or simultaneous written notice to the worker's attorney.

"(b) An insurer or self-insured employer shall not contact the worker without giving prior or simultaneous written notice to the worker's attorney if the contact affects the denial, reduction or termination of the worker's benefits."

The ALJ also relied on *former* OAR 436-30-065(2) (WCD Admin. Order 5-1992), which states that, when requesting the Department to reduce permanent total disability, the carrier must "notify the worker, and the worker's attorney, if represented," as well as *former* OAR 436-60-015 (WCD Admin. Order 29-1990).[1] The ALJ reasoned that, because SAIF did not "notify the worker and the worker's attorney" when it requested that the Department reduce claimant's permanent total disability, "the request for reduction was invalid"; furthermore, because the request was not valid, "the director did not have authority to issue the Determination Order reducing claimant's permanent total disability."[2]

I disagree that SAIF's request for redetermination was "invalid." First, under ORS 656.206(5), each carrier must "reexamine periodically" each permanent total disability claim for which it is responsible. Reexamination must be conducted every two years or "such other frequent interval as the director may prescribe." The carrier must "forward to the director the results of each reexamination." Thus, although *former* OAR 436-30-065(2) speaks in terms of the carrier "requesting" the Department to redetermine permanent total disability, SAIF was statutorily required to submit to the Department the results of its reexamination.

There is no requirement in ORS 656.206(5) that the carrier notify or otherwise provide any material to claimant, or claimant's attorney, when forwarding results of its reexamination to the Department. There also is no such requirement in ORS 656.331. Subsection (a) relates to a carrier's notice to the worker to submit to an independent medical examination; thus, this portion of the statute does not concern SAIF's "request" to the Department. Subsection (b) prohibits the carrier against "contact" with the worker "without giving prior or simultaneous written notice to the worker's attorney if the contact affects the denial, reduction or termination of the worker's benefits." Here, in sending to the Department the results of its reexamination, SAIF did not "contact" claimant because its correspondence was directed to the Department for reexamination of claimant's permanent total disability. Consequently, subsection (b) also does not apply.[3]

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[1] *Former* OAR 436-60-015 provides:

"(1) When an injured worker's attorney has given written notice of representation prior or simultaneous written notice shall be given to the worker's attorney pursuant to ORS 656.331;

"(a) When the Director or insurer request the worker to submit to a medical examination; or

"(b) When the insurer contacts the worker regarding any matter relating which may result in denial, reduction or termination of the worker's benefits; or

"(c) When the insurer contacts the worker regarding any matter relating to disposition of a claim pursuant to ORS 656.236.

"(2) The Director shall assess a civil penalty against an insurer who intentionally or repeatedly fails to give notice as required by this rule."

[2] The ALJ also discussed SAIF's failure to notify claimant's attorney when it scheduled claimant for a February 1994 "independent medical examination." Because his conclusion relied on SAIF's failure to notify claimant and his attorney of its submission to the Department, however, I limit my analysis to this issue.

[3] For the same reason, I consider *former* OAR 436-60-015 as being inapplicable to this case. That is, because SAIF's submission to the Department does not constitute a request that claimant submit to a medical examination or qualify as a "contact" with claimant, the rule has no relevance to whether SAIF's "request" was invalid because it filed to provide a copy to claimant's attorney.

Thus, SAIF did not transgress any statutory requirements when it submitted its materials to the Department. As explained above, however, *former* OAR 436-30-065(2) does require the carrier to "notify the worker, and the worker's attorney, if represented, when requesting a reduction in permanent total disability benefits." SAIF does not dispute the ALJ's finding that it failed to satisfy this rule when it submitted its materials to the Department following its reexamination. Administrative rules, however, must be consistent with an agency's statutory authority. An agency may not alter, amend, enlarge or limit the terms of a statute by rule. *Cook v. Workers' Compensation Department*, 306 Or 134, 138 (1988).

Here, in the absence of any statutory requirement that the carrier provide "notice" to the worker and the worker's attorney when submitting materials pursuant to ORS 656.206(5), I find *former* OAR 436-30-065(2) to be an enlargement of the statute. As such, it should be given no effect. *See Welliver Welding Works v. Farnen*, 133 Or App 203, 211 (1995) (affirming the Board's holding that the director's rule conflicted with the statute and was invalid).

In sum, I strongly disagree with the majority's adoption of that portion of the ALJ's order finding the Determination Order procedurally invalid. There simply is an absence of statutory authority supporting the ALJ's decision that SAIF was required to notify claimant and his attorney when it requested that the Department redetermine claimant's permanent total disability award. Thus, the Department's rule requiring notification is an enlargement of its statutory authority and should be given no effect.

Thus, because the Determination Order is not procedurally invalid, the majority should address the merits of whether or not claimant continues to be permanently and totally disabled. As part of its burden in showing that claimant is no longer entitled to permanent total disability, SAIF must provide evidence concerning whether, "but for the compensable injury," claimant is willing to seek work. *See* 656.206(3); *SAIF v. Stephen*, 308 Or 41, 43 (1989). Here, claimant testified at hearing that he was "not interested" in returning to work. (Tr. 163). Claimant expressed the same sentiment during the February 1994 examination, when he stated that he was "not interested in return-to-work." (Ex. 27-4).

Based on such evidence, I agree with the ALJ that claimant is not willing to seek work. The ALJ nevertheless found that claimant "has been in the work force sufficiently to qualify for permanent total disability benefits" because his compensable conditions were the "major cause" of "the realistic and reasonable belief that he has not been able to regularly perform gainful and suitable work."

Under *SAIF v. Stephen*, there must be findings "concerning whether, but for the compensable injury, the claimant would have returned to work" and it is not sufficient "to show only she is prevented from returning by other, nonjob-related disabilities." 308 Or at 48 (emphasis in original). Under this test, we do not look to whether claimant's compensable conditions are the "major cause" of a "realistic and reasonable belief that he has not been able to regularly perform gainful and suitable work." Rather, if the record shows that claimant would be willing to work "but for the compensable conditions," then SAIF does not prevail in establishing that claimant's permanent total disability should be reduced.

The "compensable conditions" in this case are the low back and both knees. Claimant also has been treated for right rotator cuff tear or impingement syndrome; right upper back pain; neck pain; and right hand symptoms. As the ALJ noted, these conditions have not been accepted and, thus, they are not part of claimant's "compensable conditions."

According to Dr. Bert, claimant's "multiple chronic complaints including his back and neck" prevent him from being able to "show up with any predictability for work[.]" (Ex. 35). Claimant indicated at the February 1994 examination that he had "no vocational goals due to his numerous limitations and pain complaints[.]" (Ex. 29-2). Claimant also indicated that he did not need any vocational rehabilitation services "due to his pain complaints[.]" (Id.)

Such evidence shows that claimant would not be willing to work "but for" the compensable conditions. Rather, the record shows that claimant's unwillingness is due to his compensable and noncompensable conditions. In other words, SAIF established that claimant is not willing to work "but for" the compensable conditions. Thus, SAIF carried its burden of proving that claimant is not entitled to permanent total disability.

I come to a similar conclusion concerning claimant's ability to perform a gainful and suitable occupation. Under the "odd lot" doctrine, a worker is permanently totally disabled if he is permanently incapacitated from performing gainful and suitable employment due to a combination of his physical condition and nonmedical factors, such as age, education, work experience, adaptability to nonphysical labor, mental capacity and emotional conditions, as well as the condition of the labor market. *Clark v. Boise Cascade Co.*, 72 Or App 397 (1985). A claimant's noncompensable conditions, however, are not included in determining whether a claimant is permanently totally disabled unless any disability from such condition preexisted the claimant's compensable injury. *Searles v. Johnston Cement*, 101 Or App 589, 592-93 (1990), *rev den* 310 Or 393 (1990).

Here, although there is evidence that claimant sustained an injury to his neck in 1978 (Ex. 25), the record up to the date of the 1987 hearing (when claimant was awarded permanent total disability) documents only impairment from claimant's compensable conditions in the low back and knees. (Exs. 6, 7, 8, 10, 11, 12, 19). Given the absence of proof that claimant's noncompensable conditions were disabling at the time of the injuries, those conditions are not considered in determining permanent total disability status.

As explained above, Dr. Bert based his assessment that claimant continues to be permanently totally disabled on compensable and noncompensable conditions. Because he included noncompensable conditions in his opinion, it is not persuasive. *See Weiland v. SAIF*, 64 Or App 810 (1983) (deference is not given to the treating physician's opinion when there are persuasive reasons not to do so).

Richard Ross, vocational consultant, testified on behalf of claimant. Mr. Ross conceded that claimant could perform some sedentary work, including hotel/motel desk clerk. (Tr. 46, 49, 56 (Day 2)). According to Mr. Ross, however, because claimant experienced a variation in his symptoms, claimant was not capable of performing even sedentary work on a dependable or sustained basis; in other words, Mr. Ross felt that claimant could work for only brief periods of time. (*Id.* at 46-47).

Mr. Ross further testified that he relied on Dr. Bert's opinion concerning claimant's abilities in deciding that claimant was limited to working only brief periods of time. (*Id.*) Because Mr. Ross relied on Dr. Bert's opinion, I find Mr. Ross' opinion flawed for the same reasons we discounted Dr. Bert's opinion; that is, because Mr. Ross included claimant's noncompensable conditions in rendering his opinion, it does not constitute persuasive evidence that claimant is permanent totally disabled due to his compensable conditions.

The remaining evidence shows that claimant is physically capable of sedentary or sedentary-light employment. (Exs. 31-3, 34-5). The record also shows the availability of jobs in claimant's area, including that of hotel/motel desk clerk, cashier, and collection clerk, which claimant is capable of performing. (Ex. 41-11, 41-12). Based on such evidence, I conclude that SAIF established that claimant is capable of regularly performing at a gainful and suitable occupation. *See* ORS 656.206(1).

Based on the foregoing analysis, I dissent from the majority's order.

In the Matter of the Compensation of
MARK A. MIDDLETON, Claimant
WCB Case Nos. 97-05979 & 97-04936
ORDER ON RECONSIDERATION
Callahan & Stevens, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney
Randy Rice, Defense Attorney

EBI Companies requests reconsideration of our April 29, 1998 Order on Review that affirmed the Administrative Law Judge's (ALJ's) order setting aside its denial of claimant's right shoulder condition and upholding the SAIF Corporation's denial of responsibility for the same condition. In moving for reconsideration, EBI asserts numerous allegations concerning our order, including the argument that we did not sufficiently explain why we found most persuasive the opinion of the treating surgeon, Dr. Weiner; that Dr. Weiner's opinion constituted merely a "but-for" analysis; and we did not explain why we did not find more persuasive the opinion of examining physicians Drs. Strum and Wilson. EBI also continues to allege that SAIF is responsible for the right shoulder condition.

After again reviewing the parties' arguments, the record, the ALJ's order, and our Order on Review, we continue to adhere to the reasoning and conclusion in the order. In particular, we find sufficient our analysis of the persuasiveness of the medical opinions, as well as our legal reasoning and conclusion that EBI is responsible. Thus, we decline to provide further reasoning.

Accordingly, we withdraw our April 29, 1998 order. On reconsideration, as supplemented, we republish our April 29, 1998 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
SANDY K. PREUSS, Claimant
WCB Case No. 97-03107
ORDER DENYING MOTION TO DISMISS
Doblie & Associates, Claimant Attorneys
Sather, et al, Defense Attorneys

Claimant has requested Board review of Administrative Law Judge (ALJ) Podnar's order. Asserting that claimant's request for review is untimely, the self-insured employer moves for dismissal of her appeal. The motion is denied.

FINDINGS OF FACT

On March 5, 1998, ALJ Podnar issued an Opinion and Order that upheld the employer's partial denial of claimant's claim for fibromyalgia. The order included notice to the parties that they had 30 days to request Board review.

On Monday, April 6, 1998, claimant, through counsel, mailed to the Board by certified mail, return receipt requested, a request for Board review. The request included a certificate of service indicating that copies of the request were mailed to all parties on April 6, 1998.

CONCLUSIONS OF LAW AND OPINION

An ALJ's order is final unless, within 30 days after the date that copies of the order are 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).

Filing means the physical delivery of a thing to any permanently staffed office of the Board, or the date of mailing. OAR 438-005-0046(1)(a). If filing of a request for Board review of an ALJ's order is accomplished by mailing, it shall be presumed that the request was mailed on the date shown on a receipt for registered or certified mail bearing the stamp of the United States Postal Service showing the date of mailing. OAR 438-005-0046(1)(b).

The 30th day after the date of mailing of the ALJ's order was April 4, 1998, a Saturday. We have previously held that, when the last day of the 30-day appeal period falls on a Saturday or a legal holiday, including Sunday, the appeal period runs until the end of the next day that is not a Saturday or legal holiday. *E.g., James D. Hill*, 49 Van Natta 308 (1997); *Anita L. Clifton*, 43 Van Natta 1921 (1991); *Sharon D. Stephens*, 40 Van Natta 105 (1988). *See also* ORS 174.120; ORCP 10A. Inasmuch as the 30th day in this case fell on a Saturday and the following day (Sunday) was a legal holiday, *see* ORS 187.010(1)(a), claimant's appeal period ran until the end of Monday, April 6, 1998.

The employer argues that our rulings in *Hill* and *Clifton* have been implicitly overruled by *Corrie M. Harp*, 50 Van Natta 211 (1998), where we granted a motion to strike an appellate brief that was due on Columbus Day, a federal holiday, but was not filed until the next day. We disagree. As the employer acknowledges, Columbus Day is not a legal state holiday. (Employer's motion, p. 2 fn 1). *See*

ORS 187.010, 187.020. Therefore, when the due date for the appellate brief in *Harp* fell on Columbus Day, the filing period was not extended to the next business day, as it was in *Hill* and *Clifton*. Thus, our holding in *Harp* is entirely consistent with our rulings in *Hill* and *Clifton*.[1]

Inasmuch as claimant's request for review was mailed, by certified mail, to the Board on April 6, 1998, it was timely filed. *See* ORS 656.289(3), 656.295(2); OAR 438-005-0046(1)(a); *Harold E. Smith*, 47 Van Natta 703 (1995). Because claimant's request for review was timely filed, and all parties were timely served with copies of her request, we conclude that we have appellate jurisdiction over this matter. Accordingly, the employer's motion is denied.

In light of these circumstances, the briefing schedule shall be revised as follows.[2] Claimant's appellant's brief shall be due 21 days from the date of this order. The employer's respondent's brief shall be due 21 days from the date of mailing of claimant's brief. Claimant's reply brief shall be due 14 days from the date of mailing of the employer's brief. Thereafter, this case will be docketed for Board review.

IT IS SO ORDERED.

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[1] The employer also cites to a 1994 Board decision, *Wing K. Chan* (WL 63561), arguing that our holding in *Harp* also constituted a rejection of the Board's ruling in *Chan*. In *Chan*, the Board held that, when the 30th day for appealing an ALJ's order fell on a Saturday, and the following Monday (October 11, 1993) was a federal holiday (presumably Columbus Day), the final day to timely request review was the next business day, Tuesday. Thus, the Board in *Chan* incorrectly treated Columbus Day as a legal state holiday and extended the appeal period to the next business day. As we indicated in *Harp*, a federal holiday does not extend the filing period unless the holiday qualifies as a legal state holiday under ORS 187.010 and 187.020. Therefore, to the extent that our holding in *Chan* was inconsistent with our reasoning in *Harp*, that holding was implicitly disavowed.

[2] The employer contends that the time for filing claimant's appellant's brief has expired. We disagree. The filing of the employer's motion to dismiss tolls the time for filing of claimant's appellant's brief. OAR 438-011-0025.

May 28, 1998 Cite as 50 Van Natta 1029 (1998)

In the Matter of the Compensation of
JACK B. ROY, Claimant
WCB Case No. 97-06218
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Moller.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Thye's order that: (1) affirmed an Order on Reconsideration award of 21 percent (31.5 degrees) scheduled permanent partial disability (PPD) for the loss of use or function of the left leg (knee); and (2) awarded claimant a $2,000 assessed attorney fee. On review, the issues are extent of scheduled PPD and attorney fees.

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

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[1] As a preliminary matter, we note that, following completion of the briefing schedule and without submitting further argument, SAIF submitted a copy of an April 16, 1998 Opinion and Order issued by ALJ Podnar in which the ALJ upheld SAIF's January 9, 1997 denial of claimant's new consequential injury claim and current condition relating to his left knee. As a policy matter, unless authorized, we will not consider supplemental argument presented after completion of the briefing schedule. The parties may, however, bring to the Board's attention recent decisions issued after completion of the briefing schedule. *Betty L. Juneau*, 38 Van Natta 553 (1986), *aff'd mem* 85 Or App 219, *rev den* 303 Or 590 (1987).

Consistent with the *Juneau* rationale, SAIF has brought ALJ Podnar's "post-briefing schedule" decision to our attention. Nevertheless, given our decision that ALJ Thye correctly rated the extent of scheduled PPD based only on impairment related to the compensable left knee injury, without awarding PPD for the denied consequential condition or determining the compensability of that condition, we find the Podnar decision on the compensability of the consequential condition does not change the result regarding the extent issue currently before us.

Scheduled PPD

Claimant injured his left knee while working for SAIF's insured on August 14, 1996, and SAIF accepted a left medial meniscus tear and ACL strain. Dr. Witczak performed a partial medial meniscectomy and femoral chondroplasty on October 1, 1996. Claimant then reinjured his left knee while leaving a physical therapy treatment on October 25, 1996. A December 20, 1996 MRI revealed a retear of the meniscus, which was treated conservatively.

On January 9, 1997, SAIF issued a denial of claimant's "new consequential injury and current condition."[2] On January 13, 1997, SAIF issued a Notice of Closure which awarded claimant 5 percent scheduled PPD for the left knee based on the partial medial meniscectomy. Claimant requested reconsideration of the closure, a medical arbiter examination was performed, and a July 16, 1997 Order on Reconsideration awarded 21 percent scheduled PPD for the left knee. This award was based on the surgery and the arbiter's examination findings of reduced range of motion and loss of repetitive use of the left knee.

In determining claimant's scheduled PPD, the ALJ deferred to the opinion of the medical arbiter that claimant's reduced range of motion and chronic condition were entirely attributable to the initial accepted injury. Based on that opinion, the ALJ affirmed the Order on Reconsideration award of 21 percent scheduled PPD for the left knee.

On review, SAIF argues that the ALJ should have deferred to Dr. Witczak's opinion that claimant would not have had reduced range of motion or a chronic condition if he had not reinjured his knee. SAIF further contends that, in affirming the reconsideration order, the ALJ awarded scheduled PPD for a denied consequential condition and made a finding that the consequential condition is compensable which is outside the proper scope of this litigation. Finally, SAIF contends that the ALJ incorrectly apportioned disability under OAR 436-035-0007(2)(a) and (4)(b). In response, claimant contends that SAIF's argument cannot be considered because it is being raised for the first time on review.

We need not consider claimant's "scope of review" challenge because, after reviewing the medical record and applicable rules, we conclude that the ALJ acted correctly in affirming the reconsideration order award of 21 percent scheduled PPD. We base our conclusion on the following analysis.

First, we agree with the ALJ's deference to the arbiter's opinion that claimant's reduced motion and chronic condition are entirely attributable to the initial knee injury. We defer to the arbiter for the reasons given by the ALJ, and because the attending physician's opinion became somewhat equivocal once he was given a correct history.

Because we accept the arbiter's opinion, we reject SAIF's argument that the ALJ awarded PPD for a denied consequential condition and ruled on the compensability of that condition. We, instead, conclude that the ALJ's analysis is limited to the rating of impairment for the initial compensable injury.

We further conclude that the ALJ's ultimate ruling is consistent with the applicable version of OAR 436-035-0007. In this regard, we note that the ALJ applied the current version of this rule, which applies to claims closed on or after the February 15, 1997 effective date of WCD Admin. Order 96-072. However, the claim at issue in this case was closed on January 6, 1997. Accordingly, we apply former OAR 436-035-0007 (WCD Admin Order 96-051), which provides in pertinent part:

> "(1) 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 compensable injury or disease including the compensable condition, a consequential condition and direct medical sequela. Unrelated or noncompensable impairment findings shall be excluded and shall not be valued under these rules[.]

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[2] As discussed above, this denial was subsequently upheld.

"(2) Where a worker has a *superimposed condition*, only disability due to the compensable condition shall be rated as long as the compensable condition is medically stationary and remains the major contributing cause of the *superimposed condition*. Then, apportionment is appropriate. Disability shall be determined as follows:

"(a) The physician shall describe the current total overall findings of impairment. The physician shall describe the percentage of those findings that are due to the compensable condition. Only the portion of those impairment findings that are due to the compensable condition shall receive a value.

"* * * * *

"(3) Where a worker has a preexisting condition, the following applies:

"* * * * *

"(4) If the compensable condition is no longer the major contributing cause of the * * * *superimposed condition*, and a major contributing cause denial has been issued, the following applies:

"* * * * *

"(b) When the worker's compensable condition is medically stationary, even though the worker's overall condition is not, and findings of impairment from the compensable condition do not overlap with findings of impairment from the * * * *superimposed conditions*, impairment shall be determined pursuant to the method in section (1) of this rule." (Italics added).

As used in this rule, the term "superimposed condition" means "a condition that arises after the compensable injury or disease which contributes to the worker's overall disability or need for treatment but is not the result of the original injury or disease[.]" Former OAR 436-035-0005(14).

When we analyze the present claim under former OAR 436-035-0007, we conclude that section (3) is not applicable because this claim does not involve a preexisting condition. However, the claim does involve a "superimposed condition" within the meaning of sections (2) and (4). Claimant's condition after the reinjury is in denied status and is, thus, "a condition that arises after the compensable injury or disease which contributes to claimant's overall disability or need for treatment but is not the result of the original injury or disease." Id. We further conclude that, while section (2) addresses superimposed conditions, it is otherwise not applicable because of SAIF's current condition denial. In light of that denial, claimant has not established that the initial accepted knee injury remains the major contributing cause of any superimposed condition.

We next consider the language of section (4)(b) of the rule and conclude that it is applicable to the present claim. While claimant's initial knee injury is medically stationary, the record does not establish that the current superimposed condition is also stationary. Furthermore, the medical arbiter's opinion establishes that the findings of impairment from the compensable condition do not overlap with findings of impairment from the superimposed condition. Accordingly, we analyze this claim under section (4)(b) of the rule which, in turn, provides that impairment shall be determined pursuant to the method in section (1). That section authorizes a value for "findings of impairment that are permanent and were caused by the compensable injury." This includes claimant's loss of range of motion and chronic condition, which the arbiter persuasively opined were entirely attributable to the initial compensable injury.[3]

In summary, we conclude that the ALJ's ultimate ruling on the extent issue is consistent with the applicable version of OAR 436-035-0007 and does not award PPD for a denied consequential condition or determine the compensability of that condition. Consequently, we affirm the ALJ's ultimate decision to affirm the reconsideration award of 21 percent scheduled PPD for the left knee.

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[3] We would reach the same result if this claim did not involve a "superimposed condition." In that event, section (4) of the rule would not apply, but impairment would still be determined under section (1). See OAR 436-035-0007(1).

Attorney Fee

The ALJ awarded claimant a $2,000 assessed fee for his attorney's efforts in successfully defending against SAIF's request for reduction of claimant's scheduled PPD award. See ORS 656.382(2). On review, SAIF challenges that attorney fee on the ground that the ALJ did not discuss the factors enumerated in Schoch v. Leupold & Stevens, 325 Or 112 (1997). In response, claimant contends that the attorney fee challenge is beyond the proper scope of the Board's review. Alternatively, claimant argues that SAIF is not contesting the amount of the fee -- just the lack of discussion of the factors.

We conclude that SAIF's challenge to the amount of the fee is implicit in its argument on review. However, for the reasons discussed below, we also find that the ALJ's $2,000 attorney fee award is reasonable under ORS 656.382(2) and OAR 438-015-0010(4). Accordingly, we need not address claimant's scope of review argument.

Under ORS 656.382(2), claimant is entitled to a reasonable attorney fee, to be paid by SAIF, if the ALJ finds that the compensation awarded to claimant should not be disallowed or reduced. In determining whether an attorney fee is reasonable, the following factors listed in OAR 438-015-0010(4) are considered:

"(a) The time devoted to the case;

"(b) The complexity of the issue(s) involved;

"(c) The value of the interest involved;

"(d) The skill of the attorneys;

"(e) The nature of the proceedings;

"(f) The benefit secured for the represented party;

"(g) The risk in a particular case that an attorney's efforts may go uncompensated; and

"(h) The assertion of frivolous issues or defenses."

Here, claimant's attorney did not generate any of the admitted exhibits, the hearing before the ALJ was brief and did not involve testimony, and the record contained less than twenty exhibits. On the other hand, the case did involve a legal issue of above-average complexity, and the value of the interest involved is $10,080. Both attorneys are skilled litigators with substantial experience in workers' compensation law, and no frivolous issues or defenses were raised. Finally, there was a risk that claimant's attorney may go uncompensated. After considering these factors, we find that $2,000 is a reasonable fee for claimant's attorney's services at hearing in defending the Order on Reconsideration award.

Claimant's attorney is also entitled to an assessed fee for services on review concerning the extent of permanent disability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, to be paid 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. We further note that claimant is not entitled to an attorney fee on review for his counsel's services regarding the ALJ's attorney fee award. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated December 31, 1997 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,000, payable by the SAIF Corporation.

In the Matter of the Compensation of
RICHARD L. ULMEN, Claimant
WCB Case No. 96-07764
ORDER ON REVIEW
Michael A. Bliven, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that upheld the SAIF Corporation's denial of his claim for a cervical strain, left shoulder strain, left trapezius strain and left C4-5 disc protrusion.[1] On review, the issue is compensability.

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

The ALJ analyzed the claim as an occupational disease and concluded that claimant had degenerative changes in the cervical spine that preexisted the occupational exposure in May 1996. The ALJ found that claimant's work activities combined with the preexisting degenerative condition and, therefore, claimant was required to prove that the work activities were the major contributing cause of a worsening of his preexisting condition and of the combined condition.

Claimant argues that the claim should be analyzed as an injury, not an occupational disease, and he contends that the material contributing cause standard applies to this case. Claimant argues that his C4-5 disc protrusion occurred during a short, identifiable, discrete period of time.

For the following reasons, we agree with claimant that the claim should be analyzed as an injury, rather than an occupational disease. However, we find that ORS 656.005(7)(a)(B) applies to this case, not a material contributing cause standard. Notwithstanding the different analysis, we agree with the ALJ's analysis of the medical opinions and conclude that claimant has failed to establish compensability of his claim. On page 4 of the ALJ's Opinion and Order, we replace the last two paragraphs with the following analysis.

In determining the appropriate standard for analyzing compensability, the focus is on whether claimant's C4-5 disk condition was an "event," as distinct from an ongoing condition or state of the body, and whether the onset was sudden or gradual. *Mathel v. Josephine County*, 319 Or 235, 240 (1994); *James v. SAIF*, 290 Or 343, 348 (1981); *Valtinson v. SAIF*, 56 Or App 184, 187 (1982).

Claimant has worked for the employer for over nine years as a laborer. His main job is to drive a Hyster, although he also engages in other labor involving the loading of trucks and pallets. Claimant testified that he normally drives a Hyster for two to three hours a day. (Tr. 29). However, for approximately two weeks before May 13, 1996, claimant was driving a Hyster for eight to ten hours per day. (Tr. 29, 32). Claimant testified that he went to work on May 13, 1996 and, as the day went on, he started getting a pain in his shoulder and reported it to his supervisor. (Tr. 15, 19). His supervisor testified that claimant said his shoulder was hurting but he did not know what had happened. (Tr. 6). Although some later medical reports referred to the onset of immediate pain after hitting a bump with the Hyster (Exs. 23, 25A-2, 26-5), claimant testified that he did not remember hitting a particular chuckhole and having an immediate onset of pain. (Tr. 35).

We conclude that the record supports the occurrence of an injury. The injury was unexpected, as claimant had not had similar pain or symptoms before May 1996. (Tr. 17-18). Although we conclude that the medical reports that referred to claimant hitting a chuckhole and having an immediate onset of pain are not accurate, claimant's symptoms were "sudden in onset" in that they occurred over a discrete, identifiable period of time when he was driving the Hyster eight to ten hours per day. The fact that claimant's pain grew progressively worse over a short period of time does not make it "gradual in

[1] Although SAIF's denial referred to a cervical strain, left shoulder strain, left trapezius strain and left C4-5 disc protrusion, the ALJ pointed out that the only condition that is really in dispute is the C4-5 disc herniation. On review, claimant focuses on establishing compensability of the C4-5 disc condition.

onset." *Donald Drake Co. v. Lundmark*, 63 Or App 261, 266 (1983), *rev den* 296 Or 350 (1984) (the claimant's back trouble coincided precisely with jolting of the faulty loader; the fact that the claimant's back pain grew worse over his six-week employment did not make it "gradual in onset"); *Rickey C. Amburgy*, 48 Van Natta 106 (1996). Therefore, we analyze the claim as an accidental injury, rather than an occupational disease.

Claimant acknowledges that the insurer's evidence showed he had some osteophytes and degenerative changes in his neck that predated the industrial injury. However, he argues that they are not "preexisting conditions" because they are not a "congenital abnormality, personality disorder or similar condition." We disagree.

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[.]"

For the following reasons, we conclude that the medical evidence establishes that claimant had degenerative disc disease in his cervical spine that contributed or predisposed him to disability or need for treatment and, therefore, constitutes a "preexisting condition" pursuant to ORS 656.005(24). Moreover, the medical evidence establishes that claimant's preexisting condition "combined" with his work activities to cause disability or a need for medical treatment.

A June 7, 1996 MRI of claimant's neck showed large posterior osteophytes at C4-5 with a central and left lateral disk protrusion at that level. (Ex. 11). Dr. Gritzka reported that claimant's strain and herniation combined with some preexisting C4-5 disc disease. (Ex. 26-6). In a concurrence letter from claimant's attorney, he agreed that claimant had a preexisting C4-5 disc disease/degeneration, including degenerative disease and possibly spondylosis, which combined with claimant's work incident. (Ex. 25-3). Dr. Dickerman reported that claimant had a preexisting ongoing degenerative disease at C4-5, which was the major contributing cause of his combined condition. (Ex. 21-3). Drs. Strum and Wilson identified claimant's degenerative disk disease at C4-5 as a preexisting condition and indicated it combined with his work activities. (Ex. 25A-6). Dr. Ordonez agreed that claimant's cervical disc herniation combined with a preexisting cervical disc "spondylosis/disease/degeneration/osteophytes[.]" (Ex. 31-3).

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

After reviewing the record and applying ORS 656.005(7)(a)(B), we adopt and affirm the ALJ's reasoning and conclusions that the opinions of Drs. Weller, Gritzka and Ordonez are not persuasive. We conclude that claimant has not sustained his burden of proving compensability, even under a different standard of proof.

ORDER

The ALJ's order dated December 9, 1997 is affirmed.

In the Matter of the Compensation of
JAMES T. CARNES, Claimant
WCB Case No. C8-01122
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Ernest M. Jenks, Claimant Attorney
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Member Bock and Moller.

On May 18, 1998, 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 CDA.

The proposed agreement provides on page 2, paragraph 7:

> "This claim has not been closed. A Determination Order dated April 24, 1998 issued during settlement negotiations, and both parties agree that said order should be considered moot, with no permanent disability to be paid before or after this settlement is finalized."

In addition, paragraph 8, on the same page provides:

> "The total amount (percent) of unscheduled/scheduled permanent disability benefits awarded on the claim is: A Determination Order issued on April 24, 1998 (subsequent to the settlement reached in this case), which awarded claimant 33 percent unscheduled permanent partial disability, equal to 105.60 degrees, and 37 percent scheduled permanent partial disability, equal to 55.50 degrees. As this Determination Order issued subsequent to settlement, and the validity of same is contested by the insurer, both parties hereby agree that the April 24, 1998 Determination Order is moot, and that the permanent disability awarded in that order will not be paid before or after this Claim Disposition Agreement is finalized."

OAR 438-009-0022(4)(b) and OAR 438-009-0022(4)(c) require that the CDA give the date of first claim closure, if any, and the amount of any permanent disability award(s). Here, despite the issuance of the Determination Order, the CDA indicates that the claim has not been closed and that the parties consider the Determination Order "moot." It is not the function of a CDA to accomplish claim processing functions. See Debbie K. Ziebert, 44 Van Natta 51 (1992). In addition, we do not have authority to review the Determination Order and we are not aware of any authority allowing parties to agree in a CDA that the claim has not been closed when a Determination Order has issued or to agree that an unappealed Determination Order award is "moot." Under such circumstances, we interpret the CDA as providing that the claim was first closed on April 24, 1998 and that claimant has been granted an award of 33 percent unscheduled permanent disability and 37 percent scheduled permanent disability.[1]

As interpreted herein, the CDA is in accordance with the terms and conditions prescribed by the Board. See ORS 656.236(1). Accordingly, the parties' CDA is approved. An attorney fee of $6,145, payable to claimant's counsel, is also approved.

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[1] Although the CDA provides that the carrier will not pay the April 24, 1998 Determination Order award of permanent disability benefits, we do not find that the carrier was or is legally obligated to pay these benefits prior to or after submission of the CDA. Payment of temporary and permanent disability benefits must continue until the CDA is submitted to the Board. *See* ORS 656.236(1)(a) (submission of a CDA stays all other proceedings and payment obligations, except for medical services); *see also Robert Derderian*, 45 Van Natta 1042 (1993) (Board disapproved a CDA that treated temporary and permanent disability benefits legally due and payable prior to submission of the CDA as an "advancement" of the CDA proceeds). Here, the carrier had until the 30th day after the April 24, 1998 Determination Order to pay the permanent disability award. *See* OAR 436-060-0150(7)(c). The CDA was submitted to the Board on May 18, 1998, less than 30 days after the Determination Order issued. Thus, it appears that no benefits were legally due and payable prior to the submission of the CDA. After the CDA was submitted to the Board, the carrier's obligation to pay the permanent disability benefits awarded by the Determination Order was stayed under ORS 656.236(1). In addition, upon approval of the CDA, claimant has released his rights to permanent disability benefits in the CDA.

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
BETTY J. CLARK, Claimant
WCB Case Nos. 97-06118 & 96-04140
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Menashe's order that set aside its denial of claimant's aggravation claim for her current left shoulder condition under her June 5, 1995 injury claim. Claimant has cross-requested review asserting that, in the alternative, her current left shoulder condition constitutes an aggravation of her October 27, 1992 compensable injury. On review, the issues are compensability and aggravation. We reverse in part and affirm in part.

FINDINGS OF FACT

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

Claimant, age 49 at the time of hearing, worked at all pertinent times as a bus driver for the employer. On October 27, 1992, she was assaulted by a man who boarded the bus. The assailant attempted to push her out of the driver's seat and her left shoulder struck the side of the bus. The employer accepted a left shoulder contusion-strain and a situational stress condition. The claim was closed on February 25, 1993 with an award of temporary disability through December 19, 1992, but no permanent disability.

On August 3, 1993, claimant returned for treatment complaining of neck and left shoulder pain. She was diagnosed with a chronic cervical and trapezius strain. The claim was reopened.

A September 12, 1993 MRI of the left shoulder found no evidence of a rotator cuff tear, but mild indentation on the supraspinatus musculotendinous junction by a bulbous acromioclavicular joint. On October 26, 1993, Dr. Jacobs reported that claimant had two sources of chronic pain: chronic myofascial pain involving the left trapezius and chronic impingement syndrome. In November 1993, Drs. Laycoe and Brown diagnosed chronic left trapezius pain secondary to strain, related by history to her October 27, 1992 injury. They found no objective evidence of permanent impairment. Dr. Jacobs concurred with the report of Drs. Laycoe and Brown, and the claim was reclosed by a February 4, 1994 Notice of Closure which awarded temporary disability only. An October 7, 1994 Order on Reconsideration affirmed the Notice of Closure.

On June 5, 1995, the bus claimant was driving was involved in a head-on collision. She had on her lap belt and did not strike her head or lose consciousness in the accident. Claimant was taken for emergency treatment and diagnosed with a neck and back strain. She also complained of mild left knee and shoulder pain. The employer accepted cervical, thoracic and lumbar strain conditions.

On July 5, 1995, claimant began treating with Dr. Davis. He noted that claimant had increased tone at the trapezius muscle on the right, but her primary complaint was of left hip and low back pain. He diagnosed left hip strain with mild left low back strain and prescribed physical therapy.

In July 1995, claimant was evaluated by Dr. Marble at the employer's request. At that time, claimant had no complaints regarding her neck and upper extremities, her symptoms were limited to midline lumbosacral discomfort radiating into the left buttock and leg.

Claimant continued to treat with Dr. Davis through October 16, 1995, at which time he declared her medically stationary without permanent impairment. The claim was closed pursuant to a November 7, 1995 Notice of Closure, which awarded temporary disability only.

On February 13, 1996, claimant saw Dr. Mosqueda complaining of neck and left shoulder pain. On February 15, 1996, claimant saw Dr. Baertlein, who found complaints of chronic back pain without objective findings. On February 16, 1996, Dr. Mosqueda released claimant to work with restrictions of no lifting more than 10 pounds and no repetitive bending. On March 8, 1996, Dr. Mosqueda released claimant from work for one week and prescribed physical therapy.

On March 15, 1996, claimant complained of left shoulder pain, which she related to her July 1995 accident. A March 19, 1996 MRI of the left shoulder was interpreted as showing a partial full thickness tear of the supraspinatus tendon, probable tear or considerable inflammation in the subscapularis tendinous attachment. Dr. Mosqueda suspected a torn rotator cuff, and referred claimant to Dr. Butler.

On April 11, 1996, claimant was again examined by Dr. Marble at the employer's request. His examination was basically limited to her upper extremity complaints. He reported shoulder discomfort of uncertain etiology, possible related to rotator cuff tendinitis. In a supplemental report, he opined that claimant's left shoulder condition was unrelated to her June 1995 industrial injury. Drs. Davis, Mosqueda and Butler concurred.

On July 22, 1996, claimant began treating with Dr. Grewe, who diagnosed left shoulder impingement with possible rotator cuff tear. An arthrogram did not show a full thickness tear. On August 23, 1996, Dr. Grewe performed surgery on claimant's left shoulder. The post-operative diagnosis was left shoulder impingement.

On April 16, 1997, claimant was examined by Dr. Jones, orthopedic surgeon, who diagnosed rotator cuff tear or impingement syndrome related to degenerative processes and probably not either injury. Drs. Davis and Grewe concurred.

On October 1, 1997, claimant was referred to Dr. Gritzka. He opined that claimant's July 1995 accident was the major contributing cause of her left shoulder impingement.

CONCLUSIONS OF LAW AND OPINION

Relying primarily on the opinion of Dr. Gritzka, the ALJ found that claimant's June 5, 1995 injury worsened her preexisting low grade shoulder impingement and was the major contributing cause of her need for treatment in 1996. In so finding, the ALJ set aside the employer's aggravation denial of the June 5, 1995 injury and upheld the aggravation denial of the October 1992 injury. On review, the employer argues that claimant has failed to prove by a preponderance of the evidence that her left shoulder impingement is compensably related to either her June 1995 injury or her October 1992 injury.[1] We agree with the employer.

To establish a compensable aggravation, claimant must show an actual worsening resulting from the original injury. ORS 656.273(1); Gloria T. Olson, 47 Van Natta 2348 (1995). An aggravation has two components: causation and actual worsening. If the allegedly worsened condition is not already a compensable condition, compensability must first be established under ORS 656.005(7)(a). Id.; see also Dennis P. Adams, 49 Van Natta 842 (1997)

Here, the employer accepted a left shoulder contusion-strain following claimant's October 1992 assault and cervical, thoracic and lumbar strains following her June 1995 injury. Claimant's current condition has been diagnosed as left shoulder impingement syndrome. Because claimant's left shoulder impingement is not an accepted condition, in order to establish a worsened condition resulting from the original injury, she must first establish that the impingement syndrome is a compensable condition.

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[1] The employer also raises procedural challenges to claimant's aggravation claim arising from the June 1995 injury, asserting that, because there was no accepted condition involving the left shoulder, claimant was required to request acceptance of her impingement syndrome under ORS 656.262(6)(d) or assert a "new medical condition" claim pursuant to ORS 656.262(7)(a). Because employer denied claimant's aggravation claims on their merits and did not raise any procedural challenges at hearing, we decline to consider the issue for the first time on review. See, e.g., Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991); Kenneth L. Devi, 49 Van Natta 108 (1997).

Although the medical evidence concerning the cause of claimant's left shoulder condition is divided, there is agreement among the experts that claimant has an anatomical impingement (a Type II acromion) that preexisted her injuries and predisposed or contributed to her impingement syndrome in 1996. (See, e.g. Exs. 139-33, 140-15, 141-12) Therefore, claimant's left shoulder condition must be evaluated as "combined condition" under ORS 656.005(7)(a)(B), and claimant must establish that her compensable injury is the major contributing cause of the disability of her combined condition or the major contributing cause of her need for treatment of the combined condition.

After considering the expert medical opinions, particularly the opinions of Drs. Davis, Mosqueda, Butler, Grewe, Marble and Jones, we conclude that claimant has failed to prove that either her 1992 injury or her 1995 injury is the major contributing cause of her left shoulder impingement or need for treatment of that condition.

Dr. Davis, who treated claimant in the months following her 1995 injury, opined that claimant's impingement syndrome was probably unrelated to her October 1992 injury or her June 1995 injury. Dr. Davis explained that although claimant complained of left shoulder pain following her 1992 and 1995 injuries, her complaints were directed to the trapezius area rather than the rotator cuff area.[2] He reported that claimant probably had a chronic trapezius strain as a result of her 1992 injury, but that the impingement-type symptoms she reported (to Dr. Jacobs) in late 1993 were unrelated to the 1992 incident. Dr. Davis also explained that, when he treated her following her 1995 injury, claimant complained of trapezius pain (which she related to her 1992 injury) and, primarily, low back and left hip pain related to her 1995 injury. (Ex. 140). Dr. Davis concurred with the assessment of Drs. Jones and Marble that claimant's impingement condition in 1996 was probably degenerative in nature. (Exs. 122, 140).

Drs. Mosqueda and Butler, who treated claimant's left shoulder symptoms in 1996, also concurred with Dr. Marble's determination that claimant's impingement syndrome was probably related to degenerative changes rather than her 1992 or 1995 industrial injuries, because her pain complaints following these injuries were not consistent with a shoulder girdle problem.[3] (Exs. 121, 123, 124).

Dr. Grewe, who began treating claimant's left shoulder in July 1996, opined that the major contributing cause of claimant's current (1996) disability was the impingement symptoms she had "dating back to 1992."[4] Dr. Grewe concluded that claimant's impingement syndrome preexisted her June 1995 injury, but that the June 1995 injury aggravated her condition. (Ex. 130). Following this report, Dr. Grewe concurred with Dr. Jones' April 16, 1997 report, in which Dr. Jones indicated that claimant's left shoulder impingement symptoms (in 1993 and 1996) were related to degenerative processes and not the October 1992 incident or the June 1995 accident. (Exs. 133, 137). Because Dr. Grewe does not identify either of claimant's compensable injuries as the major contributing cause of her impingement syndrome or its worsening in 1996, his opinion does not support compensability.

The only medical assessment that arguably supports the compensability of claimant's current left shoulder condition is that of Dr. Gritzka and, unlike the ALJ, we find his causation opinion to be based on an incomplete history and too conclusory to be persuasive. See Miller v. Granite Construction, 28 Or App 473, 476 (1977) (medical opinions that are not based on a complete and accurate history are not persuasive); Moe v. Ceiling Systems, 44 Or App 429 (1980) (rejecting conclusory medical opinion). Dr.

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[2] Dr. Davis explained that the trapezius muscle and the rotator cuff involve two distinct areas of the shoulder. As an example, he noted that "the trapezius is about as closely related to the rotator cuff as the biceps muscle in your arm -- upper arm is to your wrist. It's about that -- mechanically about that far removed." (Ex. 140-18).

[3] The medical records document that claimant complained of left trapezius symptoms in the months following her October 1992 assault, but did not complain of left shoulder girdle pain and impingement-type symptoms until at least August 1993. (See Exs. 2, 3, 18, 24). The records further document that claimant experienced left trapezius symptoms in July 1995, following her June 1995 accident, but that she did not specifically complain of left shoulder girdle pain until March 1996, when she was treating with Drs. Mosqueda and Butler. (Exs. 54, 55, 72, 99, 100, 102). At hearing, claimant testified that although she experienced pain in her neck and left shoulder areas following both of her compensable injuries, her left shoulder had not "frozen up" prior to the incident in February or March 1996. (Tr. 26-27).

[4] Actually, as noted above, claimant first complained of impingement-type symptoms in mid-to-late 1993, rather than 1992. (Exs. 18 - 24).

Gritzka concluded, based on claimant's history that her left shoulder continued to bother her after her 1992 injury and that it worsened after her 1995 injury, that her June 1995 injury was the major contributing cause of her worsened condition and need for treatment. (Ex. 141). Dr. Gritzka further opined that although claimant had a predisposition for rotator cuff tendinitis (because of her Type II acromion), she sustained a superimposed injury on June 5, 1995 which aggravated, and was the major cause of, her left shoulder condition.

Considering the contrary opinions of claimant's treating doctors, we are unpersuaded by Dr. Gritzka's opinion because he does not distinguish between claimant's ongoing complaints of pain consistent with her chronic trapezius strain and her other symptoms consistent with an impingement syndrome. Furthermore, Dr. Gritzka does not explain why claimant's June 5, 1995 injury would be more of a cause of her disability and need for treatment than her preexisting condition, nor does he address how claimant's 1995 injury would have involved her left rotator cuff tendon. Consequently, we find Dr. Gritzka's report insufficient to sustain claimant's burden of proof on compensability.

Because we conclude that claimant failed to prove by a preponderance of the evidence that her allegedly worsened condition is causally related to either of her accepted injuries, claimant has not established a compensable aggravation.

ORDER

The ALJ's order dated November 18, 1997 is reversed in part and affirmed in part. That part of the order that set aside the aggravation denial of the June 5, 1995 injury is reversed, and the employer's denial is reinstated and upheld. The assessed attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
JON M. CLARKE, Claimant
WCB Case No. 97-07680
ORDER ON REVIEW
Sara L. Gabin, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) upheld the insurer's denial of claimant's low back injury claim; and (2) declined to award interim compensation. On review, the issues are compensability and interim compensation.[1] We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability

The ALJ stated, "According to Dr. Karty, there are no objective findings." (Opinion and Order, p. # 2). Instead, we find that claimant has not established a compensable injury by medical evidence "supported by objective findings," as required by ORS 656.005(7)(a) and 656.005(19).

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[1] Claimant also requests that we remand the case to the ALJ for a finding concerning claimant's credibility. We deny the request because we find that claimant did not carry his burden of proof even if he is a credible witness. *See Samantha L. Spencer*, 49 Van Natta 280, 281 (1997); *see also Lynn M. Elliott*, 41 Van Natta 2063, 2064 (1989) (an ALJ need not always make a credibility assessment to avoid remand).

In addition, we acknowledge the insurer's objection to claimant's reliance on a document referencing a numerical code for a lumbosacral sprain/strain diagnosis. We do not address this objection, because the result would be the same even if we were to consider the disputed document.

We reach this conclusion based on Dr. Karty's comment that claimant's initial examination appeared "benign" and his later opinion that claimant's "examination was inconclusive and/or compromised due to pain complaints/possible pain behavior." (Exs. 9, 16).

Interim Compensation

The ALJ found that claimant failed to prove entitlement to interim compensation because time loss was not authorized by Dr. Karty, attending physician. We reach the same result, based on the following facts and reasoning.

On August 14, 1997, claimant left work and sought treatment for low back pain. Dr. Karty examined claimant and recommended work restrictions. (Ex. 10). Claimant returned to modified work at his regular wage on August 15, 1997. (Ex. 9).

On August 19, 1997, claimant returned to Dr. Karty. Dr. Karty recommended additional work restrictions and suggested that claimant work only half-days.[2] (Ex. 12). Claimant testified that he then worked a couple half-days (two or three), before he quit because he was not getting along with his boss. (Tr. 11; *see* Ex. 15-16-18; Tr. 7, 12).

On this record, we cannot say that claimant lost wages or work time for more than three days. Consequently, he has not established entitlement to temporary disability (in the form of interim compensation). *See* ORS 656.210(3);[3] 656.212(1).[4] *See Tennant v. Lyman Slack Chevrolet*, 102 Or App 470, *rev den* 310 Or 547 (1990); *Kathleen A. Wilfong*, 48 Van Natta 165, 166 (1996) (because the claimant did not miss more than three days of work as a result of her claim, she was not entitled to any time loss benefits); *Melton J. Jackson*, 42 Van Natta 264, 266 (1990) (because the claimant did not miss work for more than three days as a result of the injury by the fourteenth day, no interim compensation was due under ORS 656.210(3))

ORDER

The ALJ's order dated January 22, 1998 is affirmed.

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[2] The insurer apparently received Dr. Karty's work restrictions on August 22 and 28, 1997. (*See* Exs. 11, 12).

[3] ORS 656.210(3) provides:

"No disability payment is recoverable for temporary total or partial disability suffered during the first three calendar days after the worker leaves work or loses wages as a result of the compensable injury unless the worker is totally disabled after the injury and the total disability continues for a period of 14 consecutive days or unless the worker is admitted as an inpatient to a hospital within 14 days of the first onset of total disability. If the worker leaves work or loses wages on the day of the injury due to the injury, that day shall be considered the first day of the three-day period."

[4] ORS 656.212 provides in relevant part:

"When the disability is or becomes partial only and is temporary in character:

"(1) No disability payment is recoverable for temporary disability suffered during the first three calendar days after the worker leaves work or loses wages as a result of the compensable injury. If the worker leaves work or loses wages on the day of the injury due to the injury, that day shall be considered the first day of the three-day period."

In the Matter of the Compensation of
ADAM J. DELFEL, Claimant
WCB Case No. 97-07883
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Lane, Powell, et al, Defense Attorneys

Reviewed by the Board en banc.

The insurer requests review of Administrative Law Judge (ALJ) Mills' order that: (1) awarded 9 percent (13.5 degrees) and 20 percent (30 degrees) scheduled permanent disability for loss of use or function of the right and left legs, respectively, whereas an Order on Reconsideration awarded no permanent disability; and (2) denied the insurer's request for an overpayment offset. On review, the issues are extent of scheduled permanent disability and offset. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following correction, supplementation, and summary. Claimant last saw Dr. Bachhuber on April 14, 1992. (Ex. 8).

On January 20, 1991, claimant sustained a compensable crush injury to his right and left legs. Claimant treated with Dr. Bachhuber, who last saw claimant on April 14, 1992.

On June 26, 1992, claimant's claim was closed with no award of permanent disability. Claimant requested reconsideration and asked for appointment of a medical arbiter. Claimant raised, among other issues, premature closure. Following claimant's examination by a medical arbiter, an Order on Reconsideration was issued on February 17, 1993. That order found claimant medically stationary and awarded 11 percent (16.5 degrees) scheduled permanent disability for loss of use or function of the left leg, for a total award of $5,032.50. (Ex. 13). The insurer paid this award to claimant.

Claimant requested a hearing and raised, among other issues, premature closure. By Opinion and Order dated April 19, 1994, which was affirmed on Board review on November 23, 1994, claimant's claim was found prematurely closed and the prior Determination Order and Order on Reconsideration were set aside. (Exs. 14, 19). In addition, the insurer's "de facto" denial of claimant's right leg claim was set aside and the claim remanded to the insurer for processing.

Claimant's claim was reopened. Dr. Bachhuber had since retired and claimant did not seek medical treatment or obtain a new attending physician following the reopening of his claim. In June 1994, claimant was examined by a panel of physicians on behalf of the insurer. (Ex. 16). Their report was not concurred in by any attending physician. In March 1997, claimant was examined by Dr. Duff, orthopedist, on behalf of the insurer. (Ex. 22). His report was also not concurred in by any attending physician.

In May 1997, claimant's claim was again closed, this time with an award of 5 percent scheduled permanent disability bilaterally for the left and right ankles. (Ex. 25). Claimant requested reconsideration and asked for appointment of a medical arbiter. Dr. Neumann served as medical arbiter and examined claimant on July 29, 1997. (Ex. 27). Dr. Neumann's findings revealed both valid and invalid permanent impairment findings.

On August 29, 1997, an Order on Reconsideration issued that rejected the report from Dr. Neumann and instead relied upon the findings from a prior examining physician's (Dr. Duff's) report and reduced claimant's permanent disability award to zero. (Ex. 29).

CONCLUSIONS OF LAW AND OPINION

Extent of Scheduled Permanent Disability

The ALJ rejected the insurer's argument that OAR 436-035-0007(12)[1] and (13)[2] apply under the circumstances of this case and allow the Director to rely on an examining physician's report to determine impairment. The ALJ found that, to the extent that OAR 436-035-0007(12) and (13) suggest that impairment evidence from an examining physician (which has not been concurred with by an attending physician) can be used to satisfy a preponderance of the evidence standard and therefore outweigh other evidence from an attending physician or medical arbiter, the rules are inconsistent with the statutory framework and are not enforceable. We agree.

Disability standards adopted by the Director pursuant to ORS 656.726 are used to evaluate disability. ORS 656.283(7), 656.295(5). The standards adopted by the Director that are in effect at the time of claim closure are used in determining claimant's permanent disability. ORS 656.283(7), ORS 656.726(3)(f)(A). Claimant's claim was closed by Determination Order dated May 16, 1997. (Ex. 25). Therefore, the standards at Workers' Compensation Department Administrative Order 96-072, effective February 15, 1997, apply to determine claimant's disability. OAR 436-035-0003(2) and (3).

However, administrative rules must be consistent with an agency's statutory authority. An agency may not alter, amend, enlarge or limit the terms of a statute by rule. *Cook v. Workers' Compensation Department*, 306 Or 134, 138 (1988). ORS 656.726(3)(f) gives authority to the Director to define standards for evaluating disabilities. On the other hand, ORS 656.245(2)(b)(B) and 656.268(7) explicitly limit the evidence that may be used to rate impairment. In this regard, ORS 656.245(2)(b)(B) provides, in relevant part:

> "(b) A medical service provider who is not a member of a managed care organization is subject to the following provisions:
>
> "* * * * *
>
> "(B) * * * Except as otherwise provided in this chapter, *only the attending physician at the time of claim closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability.*" (Emphasis added).

The only exception that ORS Chapter 656 provides to the requirement that impairment findings be provided by the attending physician relates to impairment findings made by a medical arbiter appointed by the Director pursuant to ORS 656.268(7), which provides, in relevant part:

> "(a) If the basis for objection to a notice of closure or determination order issued under this section is disagreement with the impairment used in rating of the worker's disability, * * * the director shall refer the claim to a medical arbiter appointed by the director.

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[1] OAR 436-035-0007(12) provides:

"Impairment findings made by a consulting physician or other medical providers (e.g. occupational or physical therapists) at the time of closure may be used to determine impairment if the worker's attending physician concurs with the findings as prescribed in OAR 436-010-0280. If an attending physician's findings or comments are unavailable or incomplete, impairment may be established by the preponderance of medical evidence." WCD Admin. Order 96-072 (eff. 2/15/97).

[2] OAR 436-035-0007(13) provides:

"Impairment is established by the attending physician in accordance with ORS 656.245(2)(b)(B) and OAR 436-010-0280 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 established a different level of impairment. Where a preponderance establishes a different level of impairment, the impairment is established by the preponderance of evidence." WCD Admin. Order 96-072.

"* * * * *

"(f) The findings of the medical arbiter or panel of medical arbiters shall be submitted to the department for reconsideration of the determination order or notice of closure.

"(g) After reconsideration, no subsequent medical evidence of the worker's impairment is admissible before the department, the Workers' Compensation Board or the courts for purposes of making findings of impairment on the claim closure."

The court has interpreted ORS 656.245(2)(b)(B) and 656.268(7) to mean that, with the exception of a medical arbiter appointed pursuant to ORS 656.268(7), only the attending physician at the time of claim closure or other physicians with whom the attending physician concurs may make findings concerning a worker's impairment. *See Tektronix, Inc. v. Watson*, 132 Or App 483 (1995); *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666 (1994).[3] Thus, reports from examining physicians are not probative for the purposes of rating impairment unless those findings are ratified by the claimant's attending physician. *Watson*, 132 Or App at 486.

In addition, although the court in *Koitzsch* recognized the difference between offering an examining physician's impairment findings for impeachment, rather than as proof of the employer's factual contentions regarding a worker's impairment, it found that ORS 656.245(2)(b)(B) made no such distinction. 125 Or App at 670. After examining the legislative history behind ORS 656.245(3)(b)(B), the court determined that "the legislature intended to eliminate Board reliance on independent medical examinations as a basis for its evaluation of a worker's disability" and concluded that reports from examining physicians are not admissible for the purpose of impeaching a medical arbiter's opinion. *Id.* at 669-70.

Authoritative court interpretations of a statute become a part of that statute as if written into it at the time of enactment. *SAIF v. Allen*, 320 Or 192, 204 (1994); *Walther v. SAIF*, 312 Or 147, 149 (1991); *Jay A. Nero*, 47 Van Natta 163 (1995). Thus, to the extent that OAR 436-035-0007(12) and (13) allow consideration of impairment evidence from an examining physician, whose opinion has not been ratified by the attending physician, those rules are inconsistent with ORS 656.245(2)(b)(B) and 656.268(7) and the court's interpretation of those statutory requirements.

Nevertheless, OAR 436-035-0007(12) and (13) may be interpreted in a way that gives effect to all the applicable statutes, without altering or limiting by rule the terms of ORS 656.245(2)(b)(B) and 656.268(7). *Cook v. Workers' Compensation Department*, 306 Or at 138. Specifically, to be consistent with the controlling statutes, we conclude that, as used in OAR 436-035-0007(12) and (13), the determination of the "preponderance of medical evidence" is limited to the findings of the attending physician (or other physicians with whom the attending physician concurs), or findings of the medical arbiter. ORS 656.245(2)(b)(B) and 656.268(7); *Tektronix, Inc. v. Watson*, 132 Or App at 486; *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App at 669-70.

Applying that definition of "preponderance of the evidence" to the facts of the present case, the findings of Dr. Duff, examining physician, are not probative for determination of claimant's impairment because Dr. Duff is not claimant's attending physician and his findings are not concurred with by an attending physician. Nor may Dr. Duff's findings be used to impeach the opinion of the medical arbiter, Dr. Neumann. *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App at 669-70. Thus, under the facts of this case, the only probative impairment evidence that may be considered is provided by Dr. Neumann.

The insurer argues that Dr. Neumann's findings are not persuasive because they indicate invalid impairment findings. Therefore, the insurer argues, Dr. Neumann's findings, although unrebutted, do not establish a "preponderance of the evidence." We disagree.

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[3] We note that *Koitzsch* and *Watson* interpreted an earlier version of ORS 656.268(7). However, although renumbered, the relevant provisions of ORS 656.268(7) were not substantively changed.

As found by the ALJ, and contrary to the insurer's argument, Dr. Neumann measured both invalid and valid impairment findings. Moreover, the ALJ rated claimant's permanent disability based only on the valid impairment findings. We adopt the ALJ's reasoning and conclusions regarding this issue.[4]

Offset

At hearing, the insurer raised the issue of entitlement to an offset for an overpayment of permanent partial disability in the amount of $5,032.50. The ALJ declined to authorize an offset. We disagree.

Claimant does not dispute the amount of this overpayment or the fact that it arose when the insurer paid $5,032.50 permanent partial disability compensation awarded by the February 17, 1993 Order on Reconsideration, which was subsequently set aside when it was determined that claimant's claim had been prematurely closed. (Exs. 13, 14, 19, 25A, 30). Instead, claimant's sole argument is that the insurer is precluded from raising the offset issue at hearing because it failed to raise that issue during the reconsideration process.

ORS 656.283(7) provides, in relevant part:

> "Evidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing, and issues that were not raised by a party to the reconsideration may not be raised at hearing unless the issue arises out of the reconsideration order itself."

In *Blaine P. Hosey*, 50 Van Natta 360 (1998), a decision issued subsequent to the ALJ's order, we applied ORS 656.283(7) and determined that, where an issue was not manifest in the closure order, a party's failure to raise that issue during the reconsideration process did not preclude that party from raising the issue at hearing. In *Hosey*, we considered whether we had jurisdiction over a temporary disability rate issue when that issue had not been raised during the reconsideration process. The closure order had awarded certain dates of temporary disability and indicated that deduction of overpaid disability benefits was allowed. However, the closure order itself did not specify the rate of the claimant's temporary disability benefits. On these facts, we determined that the disability rate issue was not manifest in the closure document itself. Under those circumstances, we found that the claimant's failure to raise the rate issue during the reconsideration proceeding did not prohibit him from raising the temporary disability rate issue at hearing under ORS 656.283(7). *Id.* at 361,[5] *Bryan M. Fitzsimmons*, 50 Van Natta 433 (1998).

Here, the May 16, 1997 Determination Order, the closure order in question, did not address the issue of offset of overpaid *permanent* disability in any manner, including listing the amount of any previously overpaid permanent disability. Because the issue of offset of overpaid permanent disability is not manifest in the closure order itself, the insurer is not precluded from raising that issue at hearing under ORS 656.283(7). *Hosey*, 50 Van Natta at 361.

Claimant also contends that the issue of offset of overpaid permanent disability did not arise out of the August 29, 1997 Order on Reconsideration itself. Instead, claimant contends, that issue arose out of the April 19, 1994 Opinion and Order that set aside the prior reconsideration order and created an overpayment of the $5,032.50 the insurer had already paid pursuant to that prior reconsideration order. Claimant's contentions do not promote his position. As explained above, pursuant to our reasoning in *Hosey* and under the facts of this case, the insurer may raise the offset issue at hearing.

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[4] However, we make the following correction of a clerical error in the last paragraph on page four of the ALJ's opinion. In that paragraph, the ALJ discussed Dr. Neumann's questioning of the validity of claimant's "flexion" findings in his knees. This should read "extension." Dr. Neumann questioned claimant's "extension" findings, not his "flexion" findings. (Ex. 27-3, -4, -5). This clerical error does not affect claimant's permanent disability award because, in calculating claimant's disability, the ALJ correctly excluded claimant's "extension" findings and included his "flexion" findings.

[5] In *Hosey*, we disavowed the *William T. Masters*, 48 Van Natta 1788 (1996), decision to the extent that it was inconsistent with our holding.

Nevertheless, it is apparent that the parties are proceeding from a mistaken belief that prior case law holding that a carrier may not unilaterally recoup an overpayment without prior authorization still applies. *See Travis v. Liberty Mutual Ins.*, 79 Or App 126 (1986); *Forney v. Western States Plywood*, 66 Or App 155 (1983). However, the 1995 legislature enacted ORS 656.268(15)(a) that provides as follows:

> "An insurer or self- insured employer may offset any compensation payable to the worker to recover an overpayment from a claim with the same insurer or self-insured employer. When overpayments are recovered from temporary disability or permanent total disability benefits, the amount recovered from each payment shall not exceed 25 percent of the payment, without prior authorization from the worker."

We recently examined the effect of ORS 656.268(15)(a) in *Jerald J. Cooper*, 50 Van Natta 146, *on recon* 50 Van Natta 914 (1998). We determined that, by enacting ORS 656.268(15)(a), the legislature apparently overturned prior case law that required a carrier to obtain *prior* authorization by the Department, an ALJ or the Board before offsetting compensation to recover an overpayment. We found that, under current law, a carrier may unilaterally offset compensation to recover an overpayment in the manner set forth in ORS 656.268(15), and if the worker disagrees with the carrier's offset, the worker may request a hearing under ORS 656.283(1). However, we determined that nothing prevents a carrier from requesting prior authorization for an offset in a specific amount. 50 Van Natta at 147, n.1.

In *Cooper*, the Department issued a reconsideration order that expressly authorized offset of overpaid temporary disability against any unpaid disability. The claimant did not contest the Department's authorization or any other portion of its reconsideration order. However, the insurer requested a hearing requesting offset of a specific amount of an alleged overpayment. We determined that the insurer's entitlement to an offset for overpaid temporary disability benefits against future disability awards was established by ORS 656.268(15) and the Department's reconsideration order. 50 Van Natta at 147. Therefore, the insurer's entitlement to an offset was not before the ALJ. Instead, the sole offset issue before the ALJ was whether the insurer had proven the specific *amount* of its alleged overpayment. On that issue, we agreed with the ALJ that the insurer had failed to meet its burden of proof. *Id.*

Applying the reasoning in *Cooper* to the present case, we find that, although the insurer was not required to request prior authorization for an offset of the overpayment of permanent disability under ORS 656.268(15)(a), it may raise the issue of the specific amount of its overpayment and we have authority to determine the amount of overpayment.

Here, the parties do not dispute the amount of overpayment of $5,032.50. Instead, claimant argues only that the Hearings Division and the Board do not have jurisdiction over the offset issue because the insurer did not first raise the issue on reconsideration. However, pursuant to *Hosey* and *Cooper*, we have concluded that the Hearings Division and the Board have both jurisdiction over this offset issue and authority to approve or disapprove the amount of the overpayment. Because we have rejected the only basis for claimant's objection to the insurer's claimed overpayment, it follows that the insurer's overpayment has been established. *Norma J. Johnson*, 50 Van Natta 197 (1998). Therefore, we authorize the insurer's offset in the amount of $5,032.50.

Attorney Fees

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

ORDER

The ALJ's order dated January 27, 1998 is reversed in part and affirmed in part. That portion of the order that declined to authorize the insurer's requested offset of $5,032.50 is reversed. The insurer is authorized to offset this amount against current and future disability benefits in the manner prescribed by ORS 656.268(15)(a). The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,200, payable by the insurer.

In the Matter of the Compensation of
KELLY S. GILGAN, Claimant
WCB Case No. 97-07923
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Sather Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that upheld the self-insured employer's denial of her occupational disease claim for bilateral carpal tunnel syndrome. On review, the issue is compensability.

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

The ALJ upheld the employer's denial of claimant's bilateral carpal tunnel condition. The ALJ concluded that the medical evidence failed to establish that employment conditions were the major contributing cause of a pathological worsening of claimant's preexisting carpal tunnel condition and of the "combined" condition pursuant to ORS 656.802(2)(b).[1]

On review, citing *Diane L. Zachary*, 49 Van Natta 2055 (1997), claimant contends that, in order to establish the compensability of her carpal tunnel condition, she must prove that work activities were the major contributing cause of the disability or need for medical treatment of the "combined" condition. *See* ORS 656.802(2)(c);[2] *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). Asserting that the medical opinion of an examining physician, Dr. Gill, satisfies her burden of proof under this standard, claimant argues that the employer's denial should be set aside. We disagree.

Dr. Gill opined that, while claimant's work activities played a part in claimant's need for treatment, including recommended surgery, the primary cause of her need for treatment was underlying "constitutional" factors which he descibed as "a significant underlying abnormality." (Ex. 13-17). Therefore, even assuming that claimant's proposed standard of proof were applicable, we would still conclude that her bilateral carpal tunnel condition is not compensable. Accordingly, we affirm.

ORDER

The ALJ's order dated January 27, 1998 is affirmed.

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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."

[2] ORS 656.802(2)(c) provides that occupational diseases shall be subject to all of the same limitations and exclusions as accidental injuries under ORS 656.005(7).

In the Matter of the Compensation of
JERI L. HANSON, Claimant
WCB Case No. 97-05773
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
Employers Defense Counsel, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Myzak's order that affirmed an Order on Reconsideration award of 8 percent (25.6 degrees) unscheduled permanent disability for the neck and right shoulder. On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

Claimant began working for the employer as a school custodian in about 1988. This job required repetitive use of claimant's right upper extremity. While performing her custodial duties on August 30, 1994, claimant compensably injured her neck and right shoulder. She was diagnosed with a cervical strain and right shoulder impingement syndrome, and the insurer accepted a claim for these conditions. In May 1996, claimant underwent an arthroscopy and arthroscopic subacromial decompression of the right shoulder.

The treating physician, Dr. Macha, released claimant to her regular work duties on September 3, 1996. As of January 16, 1997, claimant was performing all of her regular work duties, but was experiencing severe numbness and pain in her right fingers with heavy mopping. On January 21, 1997, Dr. Macha reported that the numbness and tingling in claimant's right fingers was associated with mopping more than four hours at a time. Dr. Macha continued claimant's release to regular work with the caveat that she not perform mopping for more than four hours in a shift.

Thereafter, claimant was terminated from her employment for reasons unrelated to the compensable injury. On February 19, 1997, Dr. Macha declared claimant medically stationary and opined that she was permanently restricted from "repetitious use of the right upper extremity". Claimant subsequently returned to housecleaning work, which she performed 20 hours per week. This housecleaning activity involved lighter cleaning equipment and smaller areas to clean than the custodial job with the employer.

Claimant's injury claim was closed by a March 17, 1997 Determination Order, amended March 25, 1997, that awarded 16 percent (51.2 degrees) unscheduled permanent disability. That award was based on a +1 age value, a +3 skills value, a +2 adaptability value, and a +8 impairment value. Both the insurer and claimant requested reconsideration, with the insurer seeking a decrease in the award and claimant seeking an increase. A June 16, 1997 Order on Reconsideration reduced that award to 8 percent, based on +8 impairment and no value for social and educational factors.

The highest Specific Vocational Preparation (SVP) time of any job that claimant has met in the five years prior to claim closure is SVP 2. The parties stipulate that claimant's permanent impairment value for her compensable injury is +8.

CONCLUSIONS OF LAW AND OPINION

Under ORS 656.726(3)(f)(D), only impairment is considered in determining unscheduled disability when the attending physician releases the worker to regular work at the job at injury, but the worker is terminated for cause unrelated to the injury. Here, claimant contends that the ALJ erred in finding that claimant had been released to "regular work" and, thus, was not entitled to a value for social and vocational factors. "Regular work" means "the job the worker held at the time of injury, or employment substantially similar in nature, duties, responsibilities, knowledge, skills and abilities." OAR 436-035-0005(17)(c).

Here, the ALJ relied on the fact that Dr. Macha released claimant to her regular work duties with the caveat of no continuous mopping for more than four hours. The ALJ reasoned that claimant had returned to her regular work because her post-injury duties were not modified, as distinct from the manner in which she performed those duties. The ALJ thus concluded that claimant had been released to regular work because, while she had to perform her job duties in such a way that she did not mop for more than four hours in a shift, the actual job duties had not been modified.

The ALJ relied on Margaret M. Morgan, 49 Van Natta 1934 (1997). In Morgan, we agreed with a Department determination that the claimant was not entitled to social/vocational values for age, education and adaptability because she had returned to "regular work." OAR 436-035-0270(3)(a). While acknowledging that the claimant's work site had been substantially modified, we concluded that the claimant had returned to "regular work" because the record established that she had been released for regular full-time work, and did not establish that there had been any change in the job duties that the claimant performed prior to her injury.

Claimant relies on Vincent D. Drennen, 48 Van Natta 819 (1996). The treating physician in Drennen released the claimant to regular work because no light duty was available and the claimant requested the release. The claimant then managed to perform his regular job as a steel fabricator's helper by avoiding bending, stooping, twisting and heavy lifting as much as he could. We concluded that the claimant did not actually return to his at-injury job.

Here, the ALJ's analysis assumes that claimant's only restriction was mopping for more than four hours in a shift, per Dr. Macha's January 21, 1997 work release. However, when claimant was subsequently found to be medically stationary by Dr. Macha on February 19, 1997, he opined that claimant was permanently restricted from "repetitious use of the right upper extremity." Dr. Macha's opinion is unrebutted in the record. Moreover, while claimant subsequently returned to housecleaning, that activity was limited to 20 hours per week and involved lighter cleaning equipment and smaller areas to clean than the custodial job with the employer. On this record, we conclude that Dr. Macha's restriction from repetitive use of the right upper extremity required a modification of claimant's job duties at the time of injury and not just a change in the way claimant performed those duties. Accordingly, we conclude that claimant was not released to her "regular work" and, therefore, is entitled to a value for social and vocational factors. Accord Drennen, 48 Van Natta at 819.

We turn to the actual calculation of that value. Claimant contends that he is entitled to a +1 age value, a + 4 skills value and a +2 adaptability factor, for a total age/education/adaptability value of +10. The insurer does not challenge these values, and the record supports them. In particular, claimant's skills value is based on claimant's job-at-injury as a custodian (DOT 381.687-014), which has an SVP value of 2. See OAR 436-035-0300(3). Accordingly, we conclude that claimant is entitled a +10 age/education/ adaptability value, which is added to the +8 impairment value, for a total award of 18 percent (57.6 degrees) unscheduled PPD.

Attorney Fees

Claimant requests an assessed fee under ORS 656.382(2) for finally prevailing over the insurer's request for reconsideration seeking reduction of the Determination Order award of PPD. Additionally, claimant requests an out-of-compensation fee under ORS 656.386(2) for any additional PPD awarded by the Board.

ORS 656.382(2) provides as follows:

> "If a request for hearing * * * is initiated by an employer or insurer, and the Administrative Law Judge * * * finds that the compensation awarded to a claimant should not be disallowed or reduced, the * * * insurer shall be required to pay to the claimant or the attorney of the claimant a reasonable attorney fee in an amount set by the Administrative Law Judge * * * for legal representation by an attorney for the claimant at and prior to the hearing[.]"

Here, claimant argues that the reconsideration process is part of the hearing process so that the insurer's request for reconsideration is a "request for hearing" within the meaning of ORS 656.382(2). Accordingly, claimant contends that he is entitled to an assessed fee for finally prevailing against the insurer's request for reconsideration. We disagree. The express terms of ORS 656.382(2) require a "request for hearing" initiated by an employer or insurer, as well as a finding by an ALJ that claimant's compensation should not be disallowed or reduced. It therefore follows that the statutory term "hearing" refers to a hearing before an ALJ. The Department's reconsideration process does not involve a hearing before an ALJ. Consequently, the insurer's request for reconsideration is not a hearing within the meaning of ORS 656.382(2), and claimant is not entitled to an assessed attorney fee under that statute. Rather, claimant is entitled to the out-of-compensation fee authorized under ORS 656.386(2).

ORDER

The ALJ's order dated January 20, 1998 is reversed. In addition to the June 16, 1997 Order on Reconsideration award of 8 percent (25.6 degrees) unscheduled permanent disability, claimant is awarded 10 percent (32 degrees) unscheduled permanent disability, giving her a total award of 18 percent (57.6 degrees) unscheduled permanent disability for the neck and right shoulder. Claimant's counsel is awarded an approved attorney fee equal to 25 percent of this increased compensation, not to exceed $3,800, payable directly to claimant's counsel.

May 29, 1998 Cite as 50 Van Natta 1049 (1998)

In the Matter of the Compensation of
ZOE A. IRVIN, Claimant
WCB Case Nos. 97-06826 & 97-06825
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Tenenbaum's orders that: (1) found that the Hearings Division lacked jurisdiction to reclassify claimant's February 15, 1994 right shoulder injury claim; (2) declined to assess a penalty for the SAIF Corporation's allegedly unreasonable failure to reclassify claimant's right shoulder injury claim; (3) found that the Hearings Division lacked jurisdiction to reclassify claimant's January 10, 1995 left shoulder injury claim; and (4) declined to assess a penalty for SAIF's allegedly unreasonable failure to reclassify claimant's left shoulder injury claim. On review, the issues are jurisdiction, reclassification, and penalties. We affirm.

FINDINGS OF FACT

Claimant worked for the employer as a clerical/counter person. On February 15, 1994, she injured her right shoulder while pulling open the front door of a commercial business. She consulted with Dr. Erickson, M.D., on March 10, 1994. Dr. Erickson submitted an 827 Form, concerning the right shoulder injury, to SAIF on March 24, 1995.

On January 10, 1995, claimant injured her left shoulder while moving a box of marble during inventory. She consulted with Dr. Erickson on February 8, 1995. Dr. Erickson submitted an 827, concerning the left shoulder, to SAIF on March 24, 1995.

By letters dated March 30, 1995, SAIF denied claimant's right and left shoulder injury claims on the basis that claimant was a non-subject worker. On May 22, 1995, SAIF issued amended denials which retracted the grounds previously listed and asserted that claimant's work activities were not the major cause of her shoulder injuries. On January 25, 1996, SAIF issued further amended denials which restated both subjectivity and compensability as grounds for the denials.

On January 29, 1996, claimant underwent right rotator cuff repair surgery which was performed by Dr. Mandiberg, M.D.

Claimant requested a hearing concerning SAIF's denials. On January 22, 1997, ALJ Podnar set aside SAIF's denials of both claimant's right and left shoulder injury claims. SAIF requested review of ALJ Podnar's order which was affirmed by the Board by Order on Review dated July 30, 1997.

On August 19, 1997, SAIF formally accepted claimant's right shoulder injury claim as a nondisabling right rotator cuff tear. On the same date, SAIF formally accepted claimant's left shoulder injury claim as a nondisabling left shoulder strain.

On August 20, 1997, claimant requested a hearing asserting that her left shoulder injury claim shoulder should be reclassified as disabling. That hearing request was assigned WCB Case Number 97-06825. Claimant also requested a hearing asserting that her right shoulder injury claim should be reclassified as disabling. That request was assigned WCB Case No. 97-06826.

CONCLUSIONS OF LAW AND OPINION

A hearing was held on November 19, 1997 regarding the issues raised in both WCB Case Numbers 97-06825 and 97-06826. The ALJ issued separate Opinion and Orders for each case number. Claimant appealed both of the ALJ's orders. Although the ALJ issued two separate orders, we consolidate the cases on review. We have taken this action because the cases were litigated together at hearing, without objection from the parties. In light of such circumstances, and because a majority of the operative facts are intertwined, the Board considers it to be in the interests of substantial justice and administrative efficiency to address and resolve these interrelated issues in one final order. *See Scottland Fowler*, 50 Van Natta 711, n 3 (1998).

Jurisdiction/Claim Reclassification

Right Shoulder Injury

We adopt the conclusions and reasoning set forth in the ALJ's order in WCB Case Number 97-06826 with the following supplementation.

Subsequent to the ALJ's order, we issued our decision in *Gerrardo Alcantar-Baca*, 50 Van Natta 199 (1998). In *Alcantar-Baca*, the claimant sustained a work injury in May 1995, but did not file a claim until April 1996. The claim was accepted in June 1996 as nondisabling. The claimant requested reclassification of the claim in August 1996. We held that because the claimant requested reclassification more than one year from the date of injury, his request was barred under ORS 656.277(1), and under ORS 656.277(2), the claimant must make his claim as a claim for aggravation. *Id.* We reasoned that the claimant's untimely request for reclassification was primarily the result of his own late filing and was not due to inactions of the carrier.

Similarly here, claimant injured her right shoulder on February 15, 1994, but did not file a claim until March 24, 1995. In August 1997, more than one year after the date of injury, claimant requested that her right shoulder injury be reclassified. Because claimant's request for reclassification was made more than one year after the date of injury, and was due to her own late filing, her request is barred under ORS 656.277(1) and, under ORS 656.277(2), claimant must make her claim as a claim for aggravation. *Alcantar-Baca*, 50 Van Natta at 199.

Left Shoulder Injury

The ALJ concluded that the Hearings Division was without jurisdiction to reclassify claimant's left shoulder injury. Alternatively, the ALJ concluded that claimant's left shoulder injury did not become disabling within one year of the date of injury and therefore the claim could not be reclassified. We agree with the ALJ's alternative conclusion.

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) and (c); *Degrauw v. Columbia Knit, Inc.*, 118 Or App 277, *rev den* 316 Or 527 (1993).

Here, although claimant injured her left shoulder on January 10, 1995 and filed her claim on March 24, 1995, the claim was not accepted by SAIF until August 19, 1997. Thus, claimant, through no fault of her own, could not challenge the claim classification within one year of the date of injury. However, as noted above, the ALJ found in the alternative that claimant's left shoulder claim did not become disabling within one year of the date of injury. We agree with and adopt the ALJ's conclusions in this regard. For this reason, we agree with the ALJ that claimant's left shoulder injury claim remains in nondisabling status.[1]

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[1] Claimant asserts that she will not receive benefits unless her claim is reclassified. However, ORS 656.277(2) provides that claims that are not eligible for reclassification may be made as an aggravation claim under ORS 656.273. Contrary to claimant's argument, we find no authority which would preclude claimant from making a claim for aggravation based on the same "worsening" alleged in support of her claim becoming disabling.

Penalties

Claimant raised the issues of penalties for SAIF's allegedly unreasonable failure to reclassify both her right and left shoulder injuries. However, claimant did not provide an argument to support her entitlement to penalties. In any event, since we have agreed with the ALJ that claimant's claims cannot be reclassified, it follows that SAIF's failure to do so was not unreasonable. Under these circumstances, penalties are not warranted.

ORDER

The ALJ's orders dated December 30, 1997 are affirmed.

In the Matter of the Compensation of
SHERRIE L. KELLEY, Claimant
WCB Case No. 96-05092
ORDER ON REVIEW
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Garaventa's order that dismissed her request for hearing. On review, the issue is the propriety of the dismissal order.

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

After neither claimant nor a legal representative appeared at the scheduled hearing, the ALJ dismissed claimant's hearing request as having been abandoned. *See* OAR 438-006-0071. On review, claimant does not provide any explanation for her failure to appear at the scheduled hearing. Instead, claimant asserts that all "physical evidence" (*i.e.*, exhibits from Dr. Morton and Dr. Yarussso) was not taken into consideration when the ALJ made her decision.

In order to argue the merits of her claim, however, claimant must have appeared at the hearing either personally or through legal counsel. Inasmuch as claimant failed to provide any explanation for non-appearance at hearing, we agree with the ALJ's decision to dismiss her hearing request. *See James C. Crook, Sr.* 49 Van Natta 65 (1997) (the ALJ properly dismissed the claimant's hearing request as having been abandoned when the claimant provided no explanation for having failed to appear at the hearing).

ORDER

The ALJ's order dated February 2, 1998 is affirmed.

In the Matter of the Compensation of
DOUGLAS W. MANSFIELD, SR., Claimant
WCB Case No. 96-04880
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Baker's order that upheld the self-insured employer's denial of claimant's consequential psychological condition claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for bilateral impingement syndrome and bilateral rotator cuff tear as a result of a June 1990 injury. In June 1995, claimant's treating internist, Dr. Hearne, referred claimant to Dr. Martin, psychiatrist.

The ALJ decided that claimant did not prove that the June 1990 injury was the major contributing cause of a psychological condition and, thus, upheld the employer's denial. Claimant contests this conclusion, asserting that he satisfied ORS 656.005(7)(a)(A) by proving that his depression condition was in major part caused by the compensable injury.

The record contains two opinions. Examining psychiatrist, Dr. Goranson, who found that the "primary diagnoses in this case would be related to [claimant's] chronic alcohol abuse and are unrelated to work." (Ex. 74-12). Dr. Goranson also noted that claimant's "wife's multiple medical problems appears to be a persuasive and significant non-work related stressor" as well as "ongoing financial problems." (*Id.* at 12-13).

Dr. Martin initially reported that claimant's psychological condition "indirectly" was a result of the original injury but that the "primary reasons" for psychiatric care was "the loss of his ability to work and loss of income[.]" (Ex. 71-2).

During a deposition, Dr. Martin explained that claimant's "ongoing concerns, fears about the future, his financial status, his wife's health, his inability to work * * * contributed greatly to his distress" and "the alcohol just worsened everything." (Ex. 79-33). Dr. Martin also stated that the "financial impact was very significant" and claimant's physical limitations from the injury "played a tremendous part" in claimant's need for psychiatrist services because they resulted in claimant being "unable to provide for his family." (*Id.* at 36, 39).

Contrary to claimant's assertions, we understand Dr. Martin as attributing claimant's psychological condition to claimant's financial status following the injury, as well as other factors, including his wife's health problems and alcohol abuse. Consequently, claimant did not show that his *compensable condition* was the major contributing cause of a consequential psychological condition. Thus, we agree with the ALJ that claimant failed to prove compensability. *See* ORS 656.005(7)(a)(A); *Baar v. Fairview Training Center*, 139 Or App 196, *rev den* 323 Or 690 (1996) (hypertension not compensable under ORS 656.005(7)(a)(A) because it was caused by the processing of the claim rather than the compensable condition itself).

ORDER

The ALJ's order dated February 24, 1998 is affirmed.

In the Matter of the Compensation of
RALPH W. MOORE, Claimant
WCB Case No. 97-09940
ORDER OF DISMISSAL
Bischoff, Strooband, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Claimant, *pro se*, has requested review of Administrative Law Judge (ALJ) Stephen Brown's April 2, 1998 order. The self-insured employer has moved to dismiss claimant's request, contending that he neglected to provide notice of his appeal to all parties to the proceeding within 30 days of the ALJ's order. *See* ORS 656.289(3); 656.295(2). Because the record does not establish that all parties received timely notice of claimant's request, we dismiss.

FINDINGS OF FACT

On April 2, 1998, the ALJ issued an order dismissing claimant's request for hearing. The order contained a statement explaining the parties' rights of appeal, including a notice that a request for review must be mailed to the Board within 30 days of the ALJ's order and that copies of the request for Board review must be mailed to the other parties within the 30-day appeal period.

On May 2, 1998, the Board received a hand-written letter from claimant. In the letter, which was undated, claimant requested review of the ALJ's order.[1] Claimant's request did not indicate that copies had been provided to the other parties to the proceeding.

On May 7, 1998, the Board mailed a computer-generated letter to the parties, acknowledging claimant's request for Board review of the ALJ's April 2, 1998 order. Thereafter, the employer moved for dismissal of claimant's appeal, contending that its first notice of claimant's request occurred when it received the Board's acknowledgment letter.

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 47, 51 (1985); *Argonaut Insurance Co. v. King, supra.* All parties to the ALJ's order must be served or receive notice. *See Kelsey v. Drushella-Klohk NCE*, 128 Or App 53, 57 (1994); *Mosley v. Sacred Heart Hospital, supra.*

Here, the 30th day after the ALJ's April 2, 1998 order was May 2, 1998. Inasmuch as claimant's request for review was received by the Board on May 2, 1998, it was timely filed. *See* ORS 656.289(3); ORS 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, the record indicates that the employer's first notice occurred when it received a copy of the Board's May 7, 1998 letter acknowledging claimant's request for review. Because May 7, 1998 is more than 30 days after the ALJ's April 2, 1998 order, such notice is untimely. *Debra A. Hergert*, 48 Van Natta 1052 (1996); *John E. Bafford*, 48 Van Natta 513 (1996).

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[1] The request also sought abatement of the ALJ's April 2, 1998 order. Because the 30-day period from the ALJ's order had expired by the time the request was brought to the ALJ's attention, the request was forwarded to the Board as an appeal of the ALJ's order.

Under such circumstances, we conclude that notice of claimant's request was not provided to the other parties within 30 days after the ALJ's April 2, 1998 order.[2] Consequently, we lack jurisdiction to review the ALJ's order, which has become final by operation of law. *See* ORS 656.289(3); 656.295(2).

Finally, we are mindful that claimant has apparently requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. However, instructions for requesting review were clearly stated in the ALJ's order. Moreover, we are not free to relax a jurisdictional requirement. *Alfred F. Puglisi*, 39 Van Natta 310 (1987); *Julio P. Lopez*, 38 Van Natta 862 (1986).

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

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[2] In the event that claimant can establish that he provided notice of his request for Board review to the employer within 30 days of the ALJ's April 2, 1998 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. Since our authority to consider this order expires within 30 days after the date of this order, claimant must file his written submission as soon as possible. Claimant is further admonished that any document he submits to the Board for its review, must be simultaneously served on all other parties to the claim.

In the Matter of the Compensation of
DARLENE E. PARKS, Claimant
WCB Case Nos. 97-00817 & 91-14716
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Mongrain's order that: (1) declined to allow claimant to testify about her June 22, 1996 knee injury and its relationship to the compensable benign paroxysmal positional vertigo (BPPV) condition; and (2) declined to set aside the employer's alleged "de facto" denial of outstanding bills for medical services from Drs. Brown and Hearns. The self-insured employer cross-requests review of those portions of the ALJ's order that: (1) directed the employer to pay outstanding bills for medical services from Dr. Grimm; and (2) awarded a $2,000 attorney fee for services concerning the employer's "de facto" denial of Dr. Grimm's outstanding bills. On review, the issues are evidence, jurisdiction, compensability and attorney fees. We affirm in part and vacate in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the last paragraph on page 2, we change the first sentence to read: "In late 1989 and early 1990, Dr. Grimm was asked by Dr. Brown to provide a second opinion regarding claimant's BPPV diagnosis. (Ex. 8A)." We do not adopt numbers 2, 3 and 4 of the ALJ's ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

Evidence

Claimant argues that the ALJ erred by not allowing her to testify about the circumstances of her knee injury.

Claimant sought to establish that her June 1996 knee injury was a consequential condition of her compensable benign paroxysmal positional vertigo (BPPV). Under ORS 656.005(7)(a)(A), claimant must establish that the compensable BPPV was the major contributing cause of her consequential knee injury.

The ALJ found there was no medical evidence that claimant's compensable BPPV was the major contributing cause of her knee injury and, therefore, claimant's testimony was irrelevant and inadmissible.

Considering the passage of time and because there are multiple potential causes for claimant's knee condition, determination of the cause of claimant's knee injury is complex and requires expert medical opinion. *Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279 (1993).

After reviewing the record, we agree with the ALJ that there are no medical opinions that establish that claimant's compensable BPPV was the major contributing cause of her knee injury. We adopt and affirm the first three paragraphs in the "Opinion" section of page 4 of the ALJ's order. We need not address whether the ALJ erred by not allowing her to testify about the circumstances of her knee injury because the outcome of the case is the same whether or not the ALJ erred by not allowing claimant's testimony. Although parties should generally be permitted to testify in compensability cases, claimant's own conclusion as to the cause in this case can be given little weight because expert medical evidence is required to determine causation. *See Moe v. Ceiling Systems*, 44 Or App 429, 433 (1980) (the claimant's lay testimony was not persuasive when the claim involves a complex medical question). In other words, even if claimant testified that her knee injury was caused by her compensable BPPV condition, we would conclude that the claim was not compensable due to the lack of supporting medical evidence.

Compensability of Medical Services

After a previous hearing in 1993 with ALJ Stephen Brown, claimant requested a hearing concerning alleged unpaid medical bills from Drs. Hearns, Brown and Park. In this case, the ALJ found that there was no persuasive evidence that Dr. Brown's billings remained unpaid or that payment was unreasonably delayed. Furthermore, the ALJ concluded that there was no evidence that Dr. Brown's services provided since October 1994 were rendered for claimant's compensable BPPV condition. Regarding Dr. Grimm's services, the ALJ found that his services were compensable diagnostic services designed to confirm and determine the extent of the BPPV. Finally, the ALJ was not persuaded that there was a compensable bill from Dr. Hearns that had been denied or unreasonably delayed.

On review, claimant contends that the employer had an opportunity to submit evidence that the medical bills had been paid and because it did not do so, the ALJ should have ruled on the compensability of medical services of Drs. Brown, Hearns and Grimm. She asserts that the medical services provided by those three physicians was reasonable, necessary and caused in material part by her January 2, 1989 injury. For the following reasons, we conclude that we do not have jurisdiction to address claimant's arguments.

In *SAIF v. Shipley*, 326 Or 557 (1998), the claimant first requested a hearing to challenge the carrier's denial of an aggravation claim. At the hearing, the claimant withdrew his aggravation claim and conceded that he had not suffered a new injury. Instead, the claimant argued that he was entitled to medical services for his accepted claim. The Supreme Court found that the Hearings Division initially had authority to conduct a hearing because the matter to be addressed concerned a claim. The Court further stated, however, that the issue ultimately presented at hearing was a claim for medical services only, which, under ORS 656.245(6), was subject to review solely by the Director. The Court held that because the Board and Hearings Division lacked authority to decide the ultimate issue, it was required to dismiss the case.

Prior to the Court's opinion in *Shipley*, 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), reasoning that such a dispute necessarily involved the denial of an "underlying claim." *Jacqueline J. Rossi*, 49 Van Natta 1844 (1997). We have continued to adhere to this holding subsequent to *Shipley* on the basis that it is consistent with the Court's opinion. *Victor G. Schunk*, 50 Van Natta 812 (1998). That is, when the worker is asserting that medical treatment for a new, unaccepted condition is compensable, we have held that the Hearings Division retains jurisdiction over the medical services/compensability dispute. *Id. Accord SAIF v. Pendergast-Long*, 152 Or App 780 (1998) (Hearings Division retains jurisdiction over dispute regarding medical benefits for aggravation or new "consequential condition").

Here, medical services for an accepted condition are the only benefits at issue. Specifically, the question for resolution is whether medical services provided by Drs. Brown, Hearns and Grimm were reasonable, necessary and caused in material part by claimant's compensable January 2, 1989 injury. In other words, the issue is one of medical services on a previously accepted claim. *See Billie I. Rumpel*, 50 Van Natta 207 (1998); *Johnny R. Johnson*, 49 Van Natta 628 (1997) (Director had jurisdiction over medical bill dispute that pertained to medical services for an accepted condition). In *Charles V. Burkhart*, 50 Van Natta 375, on recon 50 Van Natta 873 (1998), we concluded that we retained jurisdiction over the medical services dispute because such services were for a new, unaccepted condition, although they were the only benefits at issue. Unlike *Burkhart*, claimant is not asserting that she has received medical treatment for a new, unaccepted condition. Therefore, we conclude that we lack jurisdiction over this dispute. Because this matter is within the Director's jurisdiction, the ALJ likewise lacked authority to award attorney fees. *See* ORS 656.385.

ORDER

The ALJ's order dated December 8, 1997 is affirmed in part and vacated in part. That portion of the ALJ's order that addressed the employer's alleged "de facto" denial of medical services is vacated. The ALJ's attorney fee award is also vacated. The remainder of the order is affirmed.

May 29, 1998 Cite as 50 Van Natta 1056 (1998)

In the Matter of the Compensation of
STANLEY M. SHAW, Deceased, Claimant
WCB Case No. 97-08533
ORDER ON REVIEW
Susan L. Frank, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

Claimant[1] requests review of Administrative Law Judge (ALJ) Neal's order which affirmed an Order on Reconsideration that awarded no permanent disability for a bilateral foot (heel) injury. In his brief, claimant raises the issue of the ALJ's refusal to take testimony at hearing regarding the medical record. In its brief, the insurer moves to strike portions of claimant's brief as evidence that was not submitted at the reconsideration proceeding and made part of that record. On review, the issues are evidence, motion to strike and extent of scheduled permanent disability.

We grant the motion to strike, and adopt and affirm the ALJ's order, with the following supplementation.

Evidence

At hearing, claimant's counsel called claimant to testify. The ALJ refused to hear such testimonial evidence. On review, claimant asserts that the ALJ's evidentiary ruling was in error and violates his constitutional "due process" rights.

It is well-established that evidence not submitted at reconsideration, and not made a part of the reconsideration record, including testimony at hearing, is inadmissible at a subsequent hearing concerning the extent of an injured worker's permanent disability. ORS 656.283(7); *Rogue Valley Medical Center v. McClearen*, 152 Or App 239 (1998) (ORS 656.283(7) unmistakably provides that *any* evidence not submitted during the reconsideration process is inadmissible at a subsequent hearing, including the

[1] Claimant is deceased and represented in these proceedings by his beneficiary. However, for ease of reference, we shall use the word "claimant" rather than "claimant's beneficiary" in our order.

claimant's testimony); *Precision Castparts Corp. v. Plummer*, 140 Or App 227 (1996) (same);[2] *Joe R. Ray*, 48 Van Natta 325, 329 *on recon* 48 Van Natta 458 (1996). Moreover, we previously rejected the constitutional argument posed by claimant in *Joe R. Ray*, 48 Van Natta at 329-333, and decline to revisit that issue at this time. *See Dean J. Evans*, 48 Van Natta 1092 (1996).

Motion to Strike

In his appellant's brief, claimant asserted that there were errors in the medical record about which claimant would have testified in a particular way. (App. Br. at 2, 7). The insurer moves to strike those portions of claimant's brief that address testimony that was not made part of the reconsideration record.[3] We grant the insurer's motion for the same reasons provided above and have not considered those portions of claimant's brief on review.

Extent of Scheduled Permanent Disability

The insurer accepted claimant's claim for disabling bilateral calcaneous (heel) fractures. The sole issue at hearing was whether claimant, who died from causes unrelated to his compensable injury before being declared medically stationary, was entitled to an award of scheduled permanent disability relating to that condition. The ALJ concluded that claimant failed to prove permanent impairment under OAR 436-035-0007(23)(b)(A) and 436-035-0007(2)(d).

On review, claimant first argues that ORS 656.268(1)(a)[4] applies here. We do not agree, as the issue in this case is extent of permanent disability after claimant died for reasons unrelated to his injury, whereas ORS 656.268(1) applies to closures of combined or consequential condition claims when the accepted injury is no longer the major contributing cause of that condition and when the worker's condition has not become medically stationary. *See, e.g., Charles L. Wallace*, 49 Van Natta 52 (1997).

In addition, claimant contends that, where the medical evidence shows that the worker would have sustained permanent impairment regardless of his medically stationary status, the award should

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[2] The court has previously considered the application of ORS 656.283(7) where the claimant's testimony that was not submitted during reconsideration was admitted at hearing without objection but then challenged on review before the Board. The court held that, based on the Board's "well-established practice" not to consider issues that were not raised at hearing, "[b]ecause employer did not object to claimant's testimony at hearing, the Board should not have entertained employer's argument, first made to the Board, that the evidence was not admissible." *Fister v. SAIF*, 149 Or App 214 (1997). Here, unlike *Fister*, because the evidentiary issue was raised before the ALJ, we find it appropriate to address the matter.

[3] Specifically, the insurer moves to strike page two, lines 24 through 26; page three, lines 1 and 2 through the word "ambulate;" and page seven, line 10, beginning with "In illustration * * *" through line 14, through the word "* * * not."

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

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

"(a) The accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005(7) * * *. When the claim is closed because the accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions, the likely impairment and adaptability that would have been due to the current accepted condition shall be estimated."

not be limited to "irreversible findings" of impairment. Claimant also contends that OAR 436-035-0007(2)(d)[5] is exemplary and not a definition of irreversible findings. We disagree with both contentions for the following reasons.

It is well-established that the Director has broad authority to adopt disability standards pursuant to ORS 656.726(3)(f)(A). *See Schultz v. Springfield Forest Products*, 151 Or App 727 (1997) (so long as director prescribed a method within the delegation by the legislature, Board may not substitute its own judgment regarding the method of computation); *Shubert v. Blue Chips*, 151 Or App 710 (1997) (Board may not substitute its judgment for that of the Director regarding temporary rules concerning disability standards). For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the "standards" for the evaluation of disabilities adopted by the Director. We agree with the ALJ's conclusion that OAR 436-035-0007(23)(b)(A) and (d) allow a rating only for "irreversible findings" pursuant to OAR 436-035-0007(2)(d) under the circumstances of this case (*i.e.*, when a worker dies due to causes unrelated to the accepted conditions of the claim and all compensable conditions are not medically stationary at the time of death).

Moreover, we have previously held that the standards may not be applied "loosely or by analogy," because they are specific and precise. *Terry W. Prater*, 43 Van Natta 1288, 1291 (1991); *see Kelly D. Mustoe*, 46 Van Natta 285, *aff'd mem Mustoe v. Career Management Consultants*, 130 Or App 679 (1994); *Ralph A. Neeley*, 42 Van Natta 1638, 1639 (1990).[6] Thus, if the rules do not provide for a rating under particular circumstances, no rating is available under those circumstances. *Margo A. Readye, Jr.*, 50 Van Natta 177 (1998).

Turning to the facts of this case, we find that claimant's impairment cannot be measured under the standards. Although claimant contends that he suffered from "ankylosis" at the time he died, this assertion is not borne out by the record. A loss of range of motion is not the same thing as ankylosis. OAR 436-035-0190.[7]

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[5] OAR 436-035-0007(2)(d) provides in relevant part:

"Workers with *an irreversible finding of impairment as noted in this subsection*, due to the compensable condition, shall receive the full value awarded in these rules for *the irreversible finding*. * * * *For purposes of this subsection, irreversible findings are:*

"* * * * *

"LEG
Knee angulation
Length discrepancy
Meniscectomy
Patellectomy

"* * * * *

"OTHER
Amputations/resections
Ankylosed/fused joints
Displaced pelvic fracture ("healed" with displacement)
Loss of opposition
Organ transplants (heart, lung, liver, kidney)
Prosthetic joint replacements" (Emphasis supplied).

[6] As noted in footnote 5, OAR 436-035-0007(2)(d) states "for purposes of this subsection, irreversible findings are" and provides a list of specific findings. There is nothing in the language of the rule that indicates that the Director was merely giving "examples" of irreversible findings, rather than specifying a limited list of irreversible findings. Indeed, there would be little point in listing "irreversible findings" if more types of impairment could be read into this list. Thus, contrary to claimant's assertion, we conclude that the rule "defines" irreversible findings.

[7] *See* OAR 436-035-0190(2), (4), (6), and (8), in which ratings are set forth for subtalar and ankle joint range of motion findings in all planes. *Compare* OAR 436-035-0190(3), (5), (7), and (9), in which ratings are set forth for ankylosis for each of these directions of movement. *See also Robert E. Howell*, 44 Van Natta 1541 (1992) (distinguishing impairment value for subtalar ankylosis from values for subtalar ranges of motion). *Robert K. Warren*, 47 Van Natta 1471 (1995) (same).

Here, Dr. Beaman elected not to perform arthrodesis surgery, which would have resulted in an ankylosis of the joint. Instead, he performed an internal reduction, placing the fragments of bone as nearly as possible back into their normal position. As a result, claimant lost range of motion in the joint through a specific plane of movement, as described by Dr. Beaman. (Exs. 12A, 13).

Claimant did not have an immovable joint or ankylosis. Because claimant does not have ankylosis, no award for ankylosis is appropriate. Inasmuch as claimant has failed to prove a measurable impairment under OAR 436-035-0007(2)(d), he is not entitled to a rating for his heel conditions.

ORDER

The ALJ's order dated January 26, 1998 is affirmed.

May 29, 1998 Cite as 50 Van Natta 1059 (1998)

In the Matter of the Compensation of
GLEN E. WILLBUR, Claimant
WCB Case No. 97-03135
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the insurer's denial of his occupational disease claim for a left C5-6 herniated disc and C7 radiculopathy condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

Claimant has worked for the employer as a yarder operator since 1989. In January 1997, claimant sought treatment for symptoms in his right arm. Claimant eventually was diagnosed with a herniated disc at C6-7 with C7 radiculopathy and underwent surgery for the condition. (Exs. 3, 7, 12). The insurer issued a denial of claimant's cervical and radicular conditions.

We do not adopt the ALJ's second ultimate finding of fact.

CONCLUSIONS OF LAW AND OPINION

After weighing the opinions of Dr. White and Dr. Louie, the ALJ concluded that claimant failed to carry his burden to prove that his work activities were the major contributing cause of his C6-7 herniated disc and C7 radiculopathy conditions. ORS 656.266; 656.802. After our *de novo* review of the record, we adopt and affirm the ALJ's order, except as supplemented and modified below.[1]

To establish a compensable occupational disease claim, claimant must prove that employment conditions were the major contributing cause of the disease or, if the claim is based on the worsening of a preexisting disease or condition, the major contributing cause of the combined condition and a pathological worsening of the disease. ORS 656.266, 656.802(2)(a) and (b). A "preexisting condition" means any injury, disease, congenital abnormality, personality disorder or similar condition that contributes or predisposes a worker to disability or need for treatment and that precedes the onset of an

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[1] We do not adopt the ALJ's reasoning regarding "other reports he has seen or testimony that he has heard," which are not part of this record. Even though the ALJ has broad discretion with regard to the admissibility of evidence (ORS 656.283(7); *Brown v. SAIF*, 51 Or App 389, 394 (1981)), we know of no legal authority for using "other reports he has seen and medical testimony he has heard" as a basis for his ruling in this case. *Groshong v. Montgomery Ward Co.*, 73 Or App 403, 406 (1985) (acceptance of facts from source not subject to confrontation and cross-examination deprives petitioner of opportunity to challenge them); *compare Rodney J. Thurman*, 44 Van Natta 1572 (1994) (we may take official or administrative notice of any fact that is "capable of accurate and ready determination by resort to sources whose accuracy cannot readily be questioned").

initial claim for an injury or occupational disease. ORS 656.005(24). In addition, pursuant to ORS 656.802(2)(e), preexisting conditions are deemed causes in determining the major contributing cause of an occupational disease.

Resolution of the cause of claimant's occupational disease is primarily a question of medical cause and effect and, as such, must be determined on a case-by-case basis. *E.g., Cassandra J. Hansen*, 50 Van Natta 174 (1998).

Accordingly, when we consider the persuasiveness of a medical opinion addressing the contribution of an alleged "preexisting condition," we assess both whether the condition in question meets the definition of a "preexisting condition" in ORS 656.005(24)[2] and whether the opinion persuasively explains why the "preexisting condition" relates to claimant's occupational disease claim. *See Sharon D. Dan*, 49 Van Natta 1025 (1997) (Board determined that the claimant's osteoarthritis, degenerative disc disease and obesity constituted preexisting conditions as defined in ORS 656.005(24) and those conditions were the major contributing cause of her low back condition); *Muriel D. Nelson*, 48 Van Natta 1596, 1597 (1996) (Board concluded that being "slightly overweight but not a lot," without further explanation, did not fit within the definition of a preexisting condition under ORS 656.005(24)). *See also Cindy L. Reed-Keen*, 50 Van Natta 178 (1998).

Claimant's occupational disease claim is for his C6-7 herniated disc and C7 cervical radiculopathy condition. As such, the appropriate standard is whether work conditions are the major contributing cause of the disease or condition under ORS 656.802(2)(a).

Because of the multiple potential causal factors, the causation question is medically complex and requires expert medical opinion to resolve. *Barnett v. SAIF*, 122 Or App 279, 282 (1993); *Kassahn v. Publishers Paper Co.*, 76 Or App 105, 109 (1985).

Here, Dr. White explained that spondylosis, or osteoarthritis of aging, although considered a "normal" result of the aging process, is nevertheless a disease process that affects bones, ligaments and discs, and resulted in claimant's herniated disc. (Ex. 23-5, -15, -16). Similarly, Dr. Louie attributed claimant's disc herniation to an acceleration of "normal" degenerative changes in his neck. (Ex. 22A). Based on Dr. White's and Dr. Louie's opinions, we conclude that claimant's osteoarthritis preexisted and contributed to or predisposed him to disability or a need for treatment for his C6-7 herniated disc and C7 radiculopathy condition. Consequently, we conclude that the osteoarthritis constituted a preexisting condition as defined in ORS 656.005(24).

Claimant also contends that Dr. White did not have complete information regarding claimant's neck motion at work. Dr. White examined claimant and carefully questioned him about his work. Dr. White, however, did not consider repetitive rotation of the neck without axial loading, hyperextension or hyperflexion to be the major cause of claimant's herniated disc or radiculopathy (Ex. 23-13, -14, -15), and focused his analysis on claimant's age-related arthritis. We agree with the ALJ that Dr. White's opinion persuasively explained why claimant's preexisting osteoarthritic disease process was a greater contributor to claimant's herniated disc and radiculopathy condition than claimant's work exposure, in contrast to the conclusory opinion offered by Dr. Louie.[3] (*Compare* Exs. 23-15, -16, -17 with Exs. 19, 21, 22A). *Somers v. SAIF*, 77 Or App 259 (1986) (in evaluating medical evidence, we rely on those opinions that are both well-reasoned and based on accurate and complete information).

ORDER

The ALJ's order dated December 16, 1997 is affirmed.

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[2] The provisions of ORS 656.005(24) are not ambiguous regarding whether a degenerative condition (*i.e.*, disease) can be a "preexisting condition." Therefore, there is no need to resort to legislative history. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-11 (1993). Furthermore, even if a review of the legislative history were to persuade us that an age-related degenerative condition is a preexisting condition, it does not establish that the claim cannot be compensable. It would simply establish that claimant must prove that his employment conditions were the "major contributing cause of the combined condition and pathological worsening of the disease."

[3] Like the ALJ, we note that Dr. Louie based his conclusion on the assumption that claimant had a 25-year work history as a heavy equipment operator, while the record establishes that claimant worked about eight years as a yarder.

In the Matter of the Compensation of
ROBERT A. WILSON, Claimant
WCB Case No. 97-08371
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Hall and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Livesley's order that increased claimant's scheduled permanent disability award for the loss of use or function of the left leg (knee) from 5 percent (7.5 degrees), as awarded by an Order on Reconsideration, to 35 percent (52.5 degrees). On review, the issue is extent of scheduled permanent disability.

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

Relying on the findings of the medical arbiter, the ALJ concluded that claimant demonstrated scheduled permanent disability greater than the unchallenged 5 percent awarded by the Order of Reconsideration for meniscus surgery. On review, the employer argues that the ALJ erred in relying on the findings of the medical arbiter over that of Dr. Cook, claimant's treating physician.[1]

After considering the record, we find the examination report of the medical arbiter more persuasive than that of Dr. Cook.

Permanent impairment is established by a preponderance of the medical evidence, considering the arbiter's examination as well as any prior relevant impairment findings. *See Raymond L. Owen*, 45 Van Natta 1528 (1993), *aff'd Roseburg Forest Products v. Owen*, 129 Or App 442 (1995). A "preponderance of medical evidence" means "the more probative and more reliable medical opinion based upon the most accurate history, on the most objective principles and expressed with clear and concise reasoning." OAR 436-035-0005(10); *see also Carlos S. Cobian*, 45 Van Natta 1582 (1993) (in evaluating claimant's permanent disability, we rely on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment). Moreover, although we generally rely on the medical opinion of the attending physician, here we find persuasive reasons to do otherwise. *See Weiland v. SAIF*, 64 Or App 810 (1983).

When he examined claimant, Dr. Cook opined that claimant had "a full range of stable motion," and "good strength." (Ex. 3). Thus, Dr. Cook appears to support a conclusion that claimant had no impairment due to loss of range of motion. However, Dr. Cook did not make specific impairment findings which could be utilized to rate claimant's impairment, *see, e.g.*, OAR 436-035-0007(21), nor did he evaluate the other aspects of claimant's knee which are reviewed in determining whether claimant has any impairment.

In contrast, the arbiter, Dr. Scheinberg, was specifically instructed to measure impairment according to the methods described in the AMA Guides to the Evaluation of Permanent Impairment and to respond to specific questions regarding claimant's left knee. As evidenced by his report, Dr. Scheinberg conducted a thorough and comprehensive examination of claimant and reviewed all relevant medical information provided by the Department. (Ex. 10).

Because Dr. Scheinberg's report is the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment, we find it more persuasive than that of Dr. Cook, and rely on it to establish claimant's left knee impairment.

Moreover, we agree with the ALJ's analysis of Dr. Scheinberg's comment regarding the validity of his range of motion findings, with the following comment.

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[1] The insurer also objects to the ALJ's award for a chronic condition. Although the ALJ found that claimant had a chronic condition, he did not include a rating for a chronic condition in his calculation of impairment and claimant does not request a greater award than that awarded by the ALJ on review. We, therefore, do not disturb the ALJ's order regarding this issue.

Pursuant to OAR 436-035-0007(27), ratable impairment shall be rated, unless the physician determines that the findings are invalid and explains the basis for that determination. *See Justeen L. Parker*, 49 Van Natta 334 (1997).

Here, the arbiter did not determine that the left knee range of motion measurements were invalid. He also did not provide a written opinion that explained why the measurements were invalid. The arbiter stated that the left knee ranges of motion were "questionable as to validity" because he was not convinced that claimant made his best effort with actively straightening and flexing the left knee, but, at the same time, he admitted that "there was no good way to determine this." The arbiter added that there "seemed to be" a difference in claimant's ability to walk with his knee extended, compared to his ability to extend the knee when he was in the supine position. The arbiter declined to comment further on the validity of his findings. (Ex. 10-6).

In light of such circumstances, we are not persuaded that the medical arbiter determined claimant's impairment findings to be invalid. Moreover, we do not consider the arbiter's opinion to constitute an explanation for any alleged "invalid findings" determination. Accordingly, we conclude, as did the ALJ, that claimant is entitled to impairment ratings based on the left knee range of motion measurements. *See Justeen L. Parker.*

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 $900, 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 his counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated February 11, 1998 is affirmed. For services on review, claimant's counsel is awarded a fee of $900, to be paid by the insurer.

In the Matter of the Compensation of
JUDY A. TUCKER, Claimant
WCB Case No. 95-03065
ORDER ON REMAND
Susak, Dean & Powell, Claimant Attorneys
Hoffman, Hart, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. *American Protective Services v. Tucker*, 151 Or App 706 (1997). Citing *amended* ORS 656.262(10), the court has reversed and remanded our prior order for reconsideration. In our prior order, *Judy A. Tucker*, 48 Van Natta 2391 (1996), we reversed the Administrative Law Judge's (ALJ's) order and set aside the insurer's denial based on the court's holding in *Deluxe Cabinet Works v. Messmer*, 140 Or App 548 (1996).

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We briefly summarize the relevant facts. Claimant has degenerative disc disease that preexisted her compensable low back injury in 1991. Subsequent to her injury, claimant was diagnosed with "left lumbar radiculitis at L5-S1," "low back pain," "foraminal stenosis at L5-S1," and "lumbar disc disease." The insurer formally accepted a disabling "low back strain." A July 1, 1992 Determination Order closed the claim with an award of 7 percent unscheduled permanent disability, which was based on reduced ranges of motion in the low back.

Claimant sought palliative treatment from Dr. Takacs on a number of occasions from January 1994 to February 14, 1995. By letter dated February 18, 1995, as amended March 27, 1995, the insurer denied claimant's current low back condition on the basis that her low back strain had resolved and that the major contributing cause was now the preexisting lumbar disc disease.

The ALJ first concluded that claimant's accepted 1991 low back strain had combined with her preexisting degenerative disc disease. Then, relying on the opinions of Drs. Arbeene and Watson, the ALJ found that claimant's low back strain had resolved. On this basis, the ALJ concluded that the accepted low back strain was no longer the major contributing cause of claimant's current need for treatment.

In our prior order, we reversed the ALJ's order and set aside the denial. We found that the unappealed Determination Order included an award of permanent partial disability for claimant's preexisting degenerative disc disease. Relying on *Deluxe Cabinet Works v. Messmer*, 140 or App 548 (1996) *(Messmer II)*,[1] we concluded that because the insurer failed to appeal the award of permanent disability for the degenerative disc disease, it was precluded from denying that condition. On this basis, we set aside the insurer's denial.

Subsequent to the date of our prior order, the 1997 Legislature enacted HB 2971, which further amended ORS 656.262(10). As further amended, the statute now provides:

> "Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability, nor shall mere acceptance of such compensation be considered a waiver of the right to question the amount thereof. Payment of permanent disability benefits pursuant to a determination order, notice of closure, reconsideration order or litigation order or the failure to appeal or seek review of such an order or notice of closure shall not preclude an insurer or self-insured employer from subsequently contesting the compensability of the condition rated therein, unless the condition has been formally accepted." (Amendments to the statute are underlined).

The court has reversed and remanded our order for reconsideration in light of the 1997 amendments to ORS 656.262(10). Consistent with the court's directions, we proceed with our reconsideration.

In *Keith Topits*, 49 Van Natta 1538 (1997), we held that the 1997 amendments to ORS 656.262(10) legislatively overruled the *Messmer* decisions. In *Topits*, we concluded, based on the plain and unambiguous language of the statute, that a carrier's failure to appeal a permanent disability award does not preclude the carrier from denying a previously rated degenerative condition.

Here, as in *Topits*, the insurer is not precluded from denying claimant's current condition (including her degenerative disc disease) under the amended statute (even if claimant's prior permanent disability award was based in part on that condition and the insurer failed to appeal the award). *See Patricia A. Landers*, 50 Van Natta 299 (1998); *see also Leslie Mossman, Dcd.*, 49 Van Natta 1602 (amendments to ORS 656.262(10) apply retroactively to cases existing on the effective date of HB 2971). Accordingly, we proceed to the merits.

We adopt the ALJ's reasoning and conclusion regarding the scope of acceptance and compensability issues with the following supplementation.

The medical evidence establishes that claimant's work injury combined with her preexisting degenerative disc disease to cause or prolong her disability and need for treatment. Therefore, claimant is subject to the major contributing cause standard of proof. *See* ORS 656.005(7)(a)(B). She must show that the July 5, 1991 work injury, when weighed against her preexisting condition, was the major contributing cause of her current disability or the major cause of her need for treatment of the combined condition. *See SAIF v. Nehl*, 148 Or App 101, *mod* 149 Or App 309, 311 (1997), *rev den* 326 Or 389 (1998).

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[1] In *Messmer II*, the court found that the 1995 amendments to ORS 656.262(10) did not overturn its holding in *Messmer v. Deluxe Cabinet Works*, 130 Or App 254 (1994), *rev den* 320 Or 507 (1995) (*Messmer I*), that an employer's failure to challenge a permanent disability award that included an award for a noncompensable condition precluded the employer from contending that the condition was not part of the compensable claim.

Two medical opinions address the cause of claimant's current low back condition. Dr. Takacs has opined that claimant's July 1991 compensable injury is the major contributing cause of claimant's low back condition and need for treatment. Drs. Watson and Arbeene have indicated that the accepted low back strain has resolved and that the major contributing cause of claimant's current condition is her preexisting degenerative disc disease. As explained by the ALJ, Dr. Takacs' opinion is based on an incorrect history that claimant had no prior low back and left leg problems. Under such circumstances, her opinion regarding the cause of claimant's current condition is unpersuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977) (a medical opinion based on an inaccurate history is unpersuasive). Because we find no persuasive medical evidence that claimant's current condition is compensable under ORS 656.005(7)(a)(B), we conclude that the insurer's denial should be upheld.

Accordingly, on reconsideration, we affirm the ALJ's order dated February 13, 1996.

IT IS SO ORDERED.

In the Matter of the Compensation of
JENNIFER GRIFFITH, Claimant
WCB Case No. 97-01785
ORDER ON REVIEW
VanValkenburgh & Hoffman, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl and Bock.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Otto's order that set aside its denial of claimant's claim for a right breast abscess with cellulitis and diabetic ketoacidosis. On review, the issue is compensability. We affirm in part, reverse in part and modify in part.

FINDINGS OF FACT

Claimant, age 24 at the time of hearing, was diagnosed with diabetes when she was 15 years old. She gives herself insulin injections twice a day, checks her blood sugar levels once a day and watches her diet. Claimant has rather "brittle" diabetes, meaning that her condition is difficult to control. She has wide fluctuations in her blood sugar levels and often requires rather intensive control with insulin. Since she was diagnosed with diabetes nine years ago, claimant has experienced several (between six and nine) acute episodes of diabetic ketoacidosis, each of which has required hospitalization.

Since May 1995, claimant has worked as a hairstylist. During the course of her employment, slivers of cut hair have found their way through or under her clothes and have occasionally imbedded in her skin. Claimant has found hair slivers imbedded in, and irritating, the skin on her arms, her chest area, her toes and under her fingernails. At the end of each work day, claimant washes off any errant hair slivers remaining on her body and clothes.

In mid-November 1996, claimant discovered a skin irritation on her right breast, which she attributed to a hair sliver. A few days later, claimant advised her supervisor, Beth, of the infection on her breast. The supervisor suggested that claimant seek medical treatment.

Shortly thereafter, claimant sought treatment from Dr. Thompson, who noted marked cellulitis on her right breast. He prescribed antibiotics and recommended heat on the infected area. Claimant's right breast infection did not respond to this treatment and, on November 26, 1996, Dr. Thompson cleaned, drained and injected the infection with Xylocaine and removed the dead tissue.

While claimant was being treated for her skin infection, her blood sugar level remained acceptable until November 30, 1996. On that day, she awoke feeling nauseous. She vomited several times and was having difficulty breathing. A friend drove her to the hospital, where she was admitted and diagnosed with diabetic ketoacidosis.

Dr. Thompson opined that claimant's work exposure to hair slivers was the major cause of her right breast infection, and that the infection was the cause of her subsequent diabetic ketoacidosis.

Dr. Dickerman, who performed a records review at SAIF's request, concluded that it was improbable that claimant's right breast abscess was caused by a hair sliver. Dr. Dickerman further reported that even if a hair sliver had imbedded into claimant's skin, this injury combined with her underlying diabetes to cause the cellulitis and subsequent abscess. He also reported that, although the infection could lead to an imbalance of claimant's diabetes, the major cause of her combined condition and need for treatment for ketoacidosis was the underlying diabetes mellitus. Dr. Rajani, who treated claimant during her November 30, 1996 hospitalization for ketoacidosis, concurred with Dr. Dickerman.

In September 1997, Dr. Greenberg, an endocrinologist, also performed a records review at SAIF's request. Based on claimant's history of an impacted hair sliver on her breast, Dr. Greenberg opined that although claimant's diabetic condition contributed to her infection, the impacted hair would have been the major cause of the infection. Dr. Greenberg further noted that claimant's preexisting, underlying diabetes was the major cause of her need for treatment for ketoacidosis.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant was exposed to hair slivers at work, which were the major contributing cause of her right breast infection and that, although her preexisting diabetes combined with her right breast infection to cause her diabetic ketoacidosis, the right breast infection was the major contributing cause of her combined condition and need for treatment.

On review, SAIF argues that claimant has failed to prove that her work exposure caused the skin infection on her right breast. SAIF further contends that even if claimant's work exposure caused her abscess with cellulitis, she has failed to prove by a preponderance of the evidence that the hair sliver, as opposed to her preexisting, underlying diabetes condition, was the major contributing cause of her diabetic ketoacidosis.

We adopt and affirm the ALJ's determination that claimant's right breast infection is compensable. For the reasons set forth below, however, we agree with SAIF that claimant has failed to establish the compensability of her need for treatment for diabetic ketoacidosis as a combined and/or consequential condition.

Under either ORS 656.005(7)(a)(A) or 656.005(7)(a)(B), claimant must prove that her work injury was the major contributing cause of her acute ketoacidosis episode. *See, e.g., Albany General Hospital v. Gasperino*, 113 Or App 411 (1992). Determining the "major contributing cause" of a disease or injury involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause.[1] *See Dietz v. Ramuda*, 130 Or App 397 (1994) (the "precipitating" or immediate cause of an injury may or may not be the "major contributing cause"). Furthermore, "major contributing cause" means that the work activity or exposure contributes more to causation than all other causative agents combined. *McGarrah v. SAIF*, 296 Or 145, 166 (1983).

Here, Drs. Greenberg, Rajani and Dickerman all opined that claimant's underlying diabetes was the major contributing cause of her acute ketoacidosis episode. Dr. Greenberg, an endocrinologist, explained that ketoacidosis does not occur in the absence of an underlying diabetic condition, but that it can develop in the absence of underlying abscesses and infections. Drs. Dickerman and Rajani similarly opined that, although the infection threw claimant's diabetes out of balance, an individual without diabetes would not have developed ketoacidosis and required hospitalization from a hair sliver.

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[1] We reject claimant's argument that her diabetes cannot be considered a "cause" of her ketoacidosis episode for purposes of ORS 656.005(7)(a)(A) and (B). First, claimant presents no expert medical evidence to support this theory. Second, as a disease affecting the endocrine system that preceded the onset of claimant's injury claim, diabetes clearly comes within the definition of a "preexisting condition" for purposes of ORS 656.005(24). Third, despite claimant's contention, all of the medical experts in this case agree that claimant's preexisting diabetes condition combined with her right breast infection to cause her need for treatment for ketoacidosis.

Although Dr. Thompson treated claimant's infection, we find persuasive reasons not to accord special deference to his opinion that claimant's infection was the major cause of her ketoacidosis episode. First, insofar as Dr. Thompson opined that claimant's ketoacidosis was "precipitated" by her abscess and testified that infections can "stimulate" uncontrolled diabetes, we find that he is identifying the "precipitating cause," rather than the major contributing cause of claimant's need for treatment. *See, e.g., Dietz,* 130 Or App at 397 (exposure to smoke at work precipitated the claimant's heart attack, but preexisting coronary artery disease was major contributing cause of the injury); *Alec E. Snyder,* 47 Van Natta 838 (1995) (the claimant's stepping into a hole at work precipitated his low back injury, but preexisting asymptomatic lumbar spine condition was the major contributing cause).

Next, unlike Drs. Greenberg and Dickerman, Dr. Thompson does not address or explain to what extent claimant's diabetic condition predisposed her or contributed to the severity of her breast infection in the first instance. Additionally, Dr. Thompson does not address claimant's prior episodes of acute diabetic ketoacidosis, nor does he adequately explain how her infection was more of a cause for this particular episode than her preexisting, underlying diabetes. Finally, we note that, as a general practitioner, Dr. Thompson is not a specialist in endocrinology or diabetes. Consequently, on this record, we find that claimant has not established the compensability of her diabetic ketoacidosis episode in late November 1996.

Because we have determined that claimant's diabetic ketoacidosis is not compensable, we modify the ALJ's $5,000 attorney fee for claimant's counsel's services at hearing. In lieu of the ALJ's award, we find that a reasonable fee for claimant's counsel's services at hearing concerning the compensability of claimant's right breast infection is $3,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to this 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. *See* OAR 438-015-0010(4).

In addition, claimant's counsel is entitled to an assessed fee for services on review with regard to the compensability of her right breast infection. 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 with regard to the breast infection issue is $1,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated December 17, 1997 is affirmed in part, reversed in part and modified in part. SAIF's denial of claimant's diabetic ketoacidosis episode is reinstated and upheld. In lieu of the ALJ's attorney fee award, claimant's counsel is awarded $4,000, payable by SAIF, for services at hearing and on review regarding the compensable breast infection condition. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
PRISCILIANO E. LOPEZ, Claimant
WCB Case No. 97-04898
ORDER OF ABATEMENT
Willner & Associates, Claimant Attorneys
Lundeen, et al, Defense Attorneys

For the second time, claimant requests abatement and reconsideration of our March 6, 1998 Order on Review, which reversed the Administrative Law Judge's (ALJ's) order that had set aside the insurer's denial of claimant's injury claim for a "clay shoveler's" fracture. Enclosing a "post-hearing" medical report from a panel of examining physicians (Drs. Reimer and Thomas), which concludes, based on x-ray evidence, that claimant has a "clay shoveler's" fracture at C7-T1, claimant's counsel asserts that a "grave injustice" is being perpetrated against claimant.

In order to consider this matter, we withdraw our March 6, 1998 and May 12, 1998 orders. In addition, to assist us in conducting this further review, the following supplemental briefing schedule is established.

Claimant shall have 21 days from the date of this order to submit argument regarding whether this "post-hearing" medical evidence should be admitted into evidence. The insurer's response must be filed within 21 days from the date of mailing of claimant's brief. Claimant's reply must be filed within 14 days from the date of mailing of the insurer's response. Thereafter, we will take this matter under advisement. Finally, in submitting their respective positions, the parties are requested to address the affect, if any, the following holdings have on this case: *Compton v. Weyerhaeuser Co.*, 301 Or 641 (1986); *Parmer v. Plaid Pantry #54*, 76 Or App 405 (1985); *and Froilan R. Gonzalez*, 46 Van Natta 1864 (1996).

IT IS SO ORDERED.

In the Matter of the Compensation of
CHAMNITH KAO, Claimant
WCB Case Nos. 97-07241 & 97-07240
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Steven A. Wolf (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 claimant's injury or occupational disease claim for an L3-4 herniated disc condition. On review the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except we do not find that claimant experienced right-sided low back pain while playing cards at home on June 7, 1997.

CONCLUSIONS OF LAW AND OPINION

Claimant was nineteen years old when he began working for SAIF's insured in 1993. He had never experienced low back problems.

Claimant worked for the insured as a shearer operator. His job involved very heavy lifting and maneuvering of steel plates on ball fields, using a "bear claw" (a magnet with a handle) and prybars.

Claimant has suffered several compensable injuries and low back symptoms "off and on" since he began this job. His first injury occurred in August 1995. After pushing and pulling on steel plates, he had severe pain in the middle of his low back and sought emergency room treatment. His claim was accepted.

Claimant injured his low back again while bending over to band plates together in August 1996. He experienced a sudden onset of severe pain in the same place, fell to the ground, and was transported to a hospital emergency room because he was unable to move. His claim was accepted.

In October 1996, claimant injured his back again at work. SAIF denied that claimant suffered a new injury at this time, but processed the claim as related to the August 1996 injury.

After these injuries, claimant recovered enough to perform his regular heavy work activities, but his low back became sore periodically and it was never "100%." (Tr. 33).

On June 5, 1997, claimant discussed taking time off work with his supervisor, because he was having low back pain. Claimant worked a full day anyway. The next day, he informed his supervisor again that he was having low back pain, but he continued working.

On Saturday June 7, 1997, claimant felt sharp low back pain while playing cards at home. On Monday, June 9, 1997, claimant left work 3 ½ hours early because of low back pain. On Tuesday, June 10, 1997, claimant sought treatment for low back pain and allergies. He worked his regular shift that day (plus some overtime) and performed his regular work for the rest of the week, with occasional low back soreness. (See Tr. 40-41). The following Monday, June 16, 1997, claimant spent 4 ½ hours maneuvering and cutting an order of steel sheets. By the end of the day, his low back was very sore. He sought treatment on June 18, 1997 and was placed on light duty work.

Claimant's symptoms after June 16, 1997 were similar to his prior problems in that the pain was in the same place. However, his low back pain after June 16, 1997 did not wax and wane as it had previously; rather, it worsened. (See Tr. 81-82).

Dr. Rosenbaum first examined claimant in July 1997, noted his MRI indicating a disc extrusion at the L3-4 space on the right, and took claimant off work. After conservative treatment, claimant returned first to light duty, then his regular work.

SAIF denied claimant's injury and occupational disease claims. Claimant requested a hearing.

The ALJ found that claimant failed to prove compensability, primarily because of perceived inconsistencies between claimant's testimony and the record. We reverse.

Our first task is to identify the applicable law. Dibrito v. SAIF, 319 Or 244, 248 (1994); Daniel S. Field, 47 Van Natta 1457 (1995). Because there is no evidence relating claimant's low back condition to his work activities generally, ORS 656.802 does not apply. The issue is whether claimant has proven compensability under ORS 656.005(7)(a).

The only suggestion of a "preexisting condition" is Dr. Rosenbaum's opinion that claimant's herniated disc preexisted June 16, 1997 if it occurred off work on June 7, 1997. (Exs. 43, 50-2). Because we find herein that the herniation probably did not preexist June 16, 1997, there is no preexisting condition in this case and ORS 656.005(7)(a)(B) does not apply. Consequently, claimant need only prove that his work injury (i.e., his June 16, 1997 work activity) was a material cause of his disc herniation. ORS 656.005(7)(a).

The reasoned expert evidence is provided by Dr. Rosenbaum, who offered two opinions regarding causation, one finding the herniation work related and the other finding it "spontaneous" (not work related), depending on the timing of claimant's symptoms. Although Dr. Rosenbaum was apparently unable to ultimately choose between the two, we can and do, because the doctor's contingent reasoning is adequately explained and the record is otherwise completely developed.

Claimant's credibility is a central issue in this case, because medical causation depends largely on the timing of claimant's symptoms and the parties dispute the reliability of claimant's reporting in this regard.

The ALJ had "some questions about claimant's credibility," primarily based on the inconsistency between Dr. Moffet's June 10, 1997 chartnote mentioning right-sided low back pain and claimant's testimony indicating that he did not have right-sided symptoms until after June 16, 1997.

We are in as good a position as the ALJ to evaluate claimant's credibility based on an objective review of the substance of the record (especially in the absence of a demeanor-based credibility finding). See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987); Davies v. Hanel Lumber Co., 67 Or App 35 (1984).

Claimant testified that he first experienced specifically right-sided pain on June 22, 1997, while performing light duty work. He felt it again and reported it during physical therapy, the next day. (Tr. 51-53; Ex. 29). The only evidence arguably casting doubt on the timing of claimant's first right-sided symptoms is Dr. Moffet's June 10, 1997 chartnote which refers to "right lower back spasm and pains while playing cards" and "right lower back pain which has persisted." (Ex. 25). Dr. Moffett also reported that claimant "has had no radicular pain or other injury." (Id).

Claimant denies telling Dr. Moffett that he had right-sided symptoms on May 10, 1997; he also denies reporting no other injuries. Claimant clearly had other back injuries and we doubt that he would have denied having had them. (See Tr. 85). There is no evidence before or after Dr. Moffett's chart note mentioning right-sided symptoms of any kind until after June 16, 1997. We also note that claimant performed his regular work without incident between June 10 and June 16, 1997. Because Dr. Moffett's note stands out as inconsistent with the remainder of the record, we find that its inaccuracies more likely represent misunderstandings by the doctor than misrepresentations by claimant.

The ALJ also faulted claimant's credibility based on "some evidence of reporting the occurrences in a manner that might best benefit him." We do not find such evidence.

Claimant has always been reluctant to relate his low back problems to his work, because he wanted to keep his job. Although he was motivated to benefit himself in this regard, such motivation does not reflect against his credibility.[1]

We also note that claimant's low back problems have always been associated with heavy work activities, including multiple work injuries, with the single exception of the June 7, 1997 pain at home. Claimant reported that incident promptly and he has never denied its occurrence.

In addition, we specifically note that claimant told SAIF's investigator on July 11, 1997 that his pain was in the middle of his back (as usual) on June 10, 1997, and it did not become right-sided until after the June 16, 1997 injury. (Tr. 98). Claimant described his changed symptoms after June 16, 1997 to the investigator as a "kind of mile point [sic]." (Tr. 93-94). Claimant gave this history before Dr. Rosenbaum identified the onset of specific symptoms as pivotal to the causation question. Because claimant could not have anticipated the eventual significance of his reporting at this time, we conclude that his responses were probably truthful rather than motivated by secondary gain. Considering claimant's repeated return to work after his prior work injuries (despite ongoing back problems regularly associated with work activities), his willingness to report the single occurrence of off-work symptoms, and the otherwise consistent medical record, we find no persuasive reason to doubt claimant's testimony concerning his symptoms. Because we also find no persuasive reason to discount Dr. Rosenbaum's unrebutted alternative conclusions, we proceed to consider the import of his opinion.

Dr. Rosenbaum stated it would be "impossible to state with any certainty whether an individual has developed a lumbar disk herniation secondary to a physically active occupation as opposed to a spontaneous event." (Ex. 50-1). He "would not specifically assess [claimant's] work to be the cause of a lumbar disc herniation unless the onset of his symptoms were [sic] associated with his work activity in either the form of lumbar discomfort or his radiating leg pain." (Ex. 50-1-2). Applying Dr. Rosenbaum's reasoning to the facts of this case, and particularly considering claimant's continued performance of heavy work through June 16, 1997, we find that the herniation probably did not precede that date.

Ultimately, Dr. Rosenbaum indicated that it was difficult for him to attribute claimant's herniated disc to his work injuries if claimant had had right low back symptoms before June 16, 1997. Considering claimant's history that he had not had such symptoms and that his right radicular symptoms also began after June 16, 1997, Dr. Rosenbaum stated that the herniation would be related to one of claimant's injuries, if: (1) claimant had continuing low back pain after his August 1996 injury; (2) his increased low back pain after playing cards on June 7, 1997 was not right-sided; and (3) he did suffer another low back injury at work on June 16, 1997. (Ex. 54-2).

On this record, we find that claimant did have ongoing low back problems since the August 1996 injury, but he did not have right-sided low back pain or right radicular symptoms until after June 16, 1997. (Tr. 33; Exs. 12-17, 21, 23). Because we further find that claimant's low back condition changed significantly with his heavy work on June 16, 1997, we also conclude that he suffered an injury at work on that date. (See Ex. 42-1). In reaching these conclusions, we reiterate that we find no persuasive reason to discount claimant's reporting that his changed symptoms after June 16, 1997 were a "mile point" in his long history of low back problems. Accordingly, based on Dr. Rosenbaum's reasoning, we further conclude that it is more likely than not that claimant's June 16, 1997 work injury was a material contributing cause of his L3-4 disc herniation. Consequently, the claim is compensable.

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[1] Moreover, claimant is not charged with accurately identifying the cause of his medical condition.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $6,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record, claimant's appellate briefs, and his attorney's statement of services), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated December 11, 1997 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on review, claimant is awarded a $6,000 attorney fee, payable by SAIF.

In the Matter of the Compensation of
LONNIE TRAVIS, Claimant
WCB Case No. 97-08466
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order that: (1) set aside its denial of claimant's "combined" low back condition; and (2) assessed a 20 percent penalty for the employer's allegedly unreasonable denial. On review, the issues are compensability and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the exception of his finding that claimant's fall from a truck in 1995 resulted in low back pain. Instead, we find that claimant's symptoms were confined to the buttocks. (Tr. 13).

CONCLUSIONS OF LAW AND OPINION

On March 27, 1997, claimant, a housekeeper, injured his low back making a "murphy bed." A chiropractor, Dr. Salmons, provided claimant's initial treatment and diagnosed a "lumbosacral sprain." (Ex. 4). Dr. Salmons later referred claimant to Dr. Fox, a medical doctor, who diagnosed an "acute lumbar strain" and "probable intervertebral ligament tear strain." (Ex. 9). The employer accepted a disabling claim for lumbar strain on July 10, 1997.

The employer subsequently amended its acceptance on October 6, 1997 to include a "combined" condition, consisting of the previously accepted lumbar strain and several other conditions: a prior noncompensable lumbar laminectomy at L4-5; a L4-5 disc herniation; scoliosis and degenerative disc disease of the lumbar spine; and degenerative arthritis of the right hip. (Ex. 37). The next day, on October 7, 1997, the employer issued a denial of the "combined" condition on the ground that the compensable March 31, 1997 injury was no longer the major contributing cause of his low back condition and need for treatment. (Ex. 38). The employer issued an "amended" denial on December 18, 1997, reciting the same grounds. (Ex. 44). Claimant requested a hearing, seeking reversal of the denials and an award of penalties and attorney fees for an allegedly unreasonable denial of his current low back condition.

The ALJ set aside the employer's denial of claimant's "combined" condition. Citing *Harry L. Lyda*, 48 Van Natta 1300 (1996), *aff'd State Farm Insurance Company v. Lyda*, 150 Or App 554 (1997), the ALJ reasoned that the employer's denial was improperly based on ORS 656.262(6)(c) because there had been no change in circumstances in the 24 hours separating the acceptance of the "combined" condition

and the subsequent denial such that the original compensable injury "ceased" to be the major contributing cause of the combined condition.[1] Moreover, the ALJ assessed a 20 percent penalty, finding that the employer's denial was unreasonably issued. Citing *CNA Insurance Companies v. Magnuson*, 119 Or App 282 (1993), the ALJ reasoned that no new evidence had come into the insurer's possession since its acceptance of the combined condition to support issuance of a denial. In addition, the ALJ noted that the Court of Appeals' decision in *Lyda* had issued well before the amended denial issued in December 1997.

On review, the employer contends that its "combined condition" denial was procedurally valid under *Lyda* and that claimant's current combined low back condition is not compensable on the merits.[2] Also, the employer asserts that the ALJ's penalty assessment was incorrect.

We need not determine the procedural validity of the employer's denial under ORS 656.262(6)(c). That is, even if the "combined condition" denial was properly issued under that statute, we would still find that claimant's current "combined condition" is compensable. However, we disagree with the ALJ's determination that the employer's denial was unreasonably issued. We reach these conclusions for the following reasons.

Under ORS 656.005(7)(a)(B), to establish the compensability of a "combined condition," claimant must prove that the March 21, 1997 injury was the major contributing cause of the need for treatment his low back condition. *SAIF v. Nehl*, 148 Or App 101, *mod* 149 Or App 309 (1997); *Tektronix, Inc. v. Nazari*, 117 Or App 409 (1992), *mod* 120 Or App 590, *rev den* 318 Or 27 (1993). In satisfying the "major contributing cause" standard, claimant must show that the compensable injury contributed more to his low back condition or need for treatment than all other factors combined. *See McGarrah v. SAIF*, 296 Or 145, 146 (1983); *Dethlefs v. Hyster Co.*, 295 Or 298, 309-310 (1983). In evaluating the medical evidence concerning causation, we consider all potential contributors to claimant's current condition, not just the precipitating cause. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 321 Or 416 (1995) (Persuasive medical opinion must evaluate the relative contribution of different causes and explain why work exposure or injury contributes more to the claimed condition than all other causes or exposures combined).

Claimant has the burden of proving that his low back condition is compensable by a preponderance of the medical evidence. ORS 656.266. Because of the multiple potential causal factors, the causation issue is a complex medical question which must be resolved on the basis of expert medical evidence. *Uris v. Compensation Department*, 247 Or 420, 426 (1967); *Kassahn v. Publishers Paper Co.*, 76 Or App 105, 109 (1985), *rev den* 300 Or 546 (1986).

Claimant's attending physician, Dr. Fox, opined that the March 21, 1997 injury was the major contributing cause of claimant's current back condition. While acknowledging that claimant has a preexisting low back condition, Dr. Fox noted that claimant was performing unrestricted work at the time of injury and was pain free. (Ex. 34). Dr. Fox later reiterated that claimant's March 21, 1997 injury was "work related." (Ex. 38b).

We generally defer to the attending physician's opinion, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983). We find no such reasons to do otherwise here. Claimant testified that he did have prior back surgery in the early 1970's and received chiropractic treatment in 1988 and 1989. (Tr. 12). However, claimant stated that he did not have any problems with

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[1] The statute provides:

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

[2] The ALJ did not address the merits of the compensability of claimant's current combined condition in light of his finding that the employer's denial was improperly issued under ORS 656.262(6)(c).

his back since that time. (Tr. 13).[3] Claimant further testified that the pain he experienced on March 21, 1997 was different from anything that he had previously experienced and that he had never before suffered leg pain. (Trs. 9, 14). We find that this history is generally consistent with that related to Dr. Fox and other physicians. (Exs. 9, 17, 21). Because it is well reasoned and based on an accurate history, Dr. Fox's opinion is persuasive. *Somers v. SAIF*, 77 Or App 259 (1986).

Moreover, Dr. Fox's opinion is supported by that of a consulting neurologist, Dr. Karasek, who opined that the March 21, 1997 injury was the "cause" of claimant's current need for treatment. (Ex. 38a). Although Dr. Karasek also stated that the opinion of a consulting neurosurgeon, Dr. Chestnut, would carry more weight, Dr. Chestnut could not render a definitive opinion regarding the causation issue. Dr. Chestnut was unable to say which factor, claimant's preexisting back condition or his "work activities," was the major contributing cause of claimant's current condition. Dr. Chestnut opined that both "share the culpability in an unquantified and probably unquantifiable ratio." (Ex. 40).

Dr. Farris, an examining physician, provided the remaining opinion addressing the causation issue. Dr. Farris initially opined that, if claimant never had radicular symptoms prior to the incident of March 21, 1997, then that injury would be the major contributing cause of a disc herniation at L4-5. (Ex. 20-8). There is no evidence to contradict claimant's testimony that he never previously experienced leg symptoms. Thus, we conclude that Dr. Farris' initial report supports compensability of claimant's current low back condition.

Dr. Farris subsequently reviewed Dr. Karasek's medical records which contained a history that claimant had intermittent low back problems since 1970 and that claimant had chiropractic adjustments over the years. (Ex. 36-1). Dr. Farris then opined that, if claimant had "significant" problems with his low back over the years, he would be "inclined" to state that the preexisting back condition would be the major contributing cause of claimant's current low back symptoms. (Ex. 36-2). Dr. Farris emphasized that the causation issue depended on whether claimant had symptoms to a "significant" degree between 1970 and 1997. *Id.*

We do not find Dr. Farris' second report to be helpful in deciding the causation issue because he never explained what he meant by "significant" problem. On this record, we are not inclined to find that claimant did in fact have a "significant" problem between 1970 and 1997. There is no evidence that claimant was working in anything other than an unrestricted manner prior to the compensable March 1997 injury. Moreover, there is no evidence that claimant was under treatment prior to March 1997 or that he was experiencing back pain. There is also no evidence to contradict claimant's testimony that he never previously experienced leg symptoms. While it is clear that claimant did require chiropractic treatment in 1988 and 1989, we cannot say without more explanation from Dr. Farris that there were "significant" problems such that Dr. Farris' second opinion should be given greater weight than his first opinion.

Therefore, based on our *de novo* review of the record, we conclude that a preponderance of the medical evidence establishes that claimant's current "combined" condition is compensable. We now proceed to the penalty issue.

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 light of all the evidence available at the time of the denial. *Brown v. Argonaut Insurance Company*, 93 Or App 588 (1988).

In this case, we conclude that the employer had "legitimate doubt" regarding its liability for claimant's current "combined" condition based on Dr. Farris' second report, which was submitted prior to the October 7, 1997 denial. Although we have ultimately concluded that Dr. Farris' opinion expressed in that report is unpersuasive, we cannot say that the employer unreasonably relied on it to

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[3] Claimant also testified that he fell from the top of a truck in 1995. However, claimant also testified that the pain was confined to the buttocks. (Tr. 13).

issue its denial. Moreover, the ALJ's citation to *Magnuson* (the legislature intended that evidence warranting a "back-up" denial under ORS 656.262(6)(a) "come about" after the insurer's original acceptance) was misplaced, inasmuch as this case does not involve a "back-up" denial, but rather a denial of claimant's current combined condition pursuant to ORS 656.262(6)(c). Finally, even if we agreed with claimant that the employer's denial was procedurally invalid under the *Lyda* decision, we cannot say that the application of that case was so clear that the employer could not have had legitimate doubt regarding its liability for claimant's combined condition. Accordingly, we set aside that portion of the ALJ's order that assessed a penalty for an allegedly unreasonable denial.

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

ORDER

The ALJ's order dated February 9, 1998 is reversed in part and affirmed in part. That portion of the ALJ's order that assessed a penalty for an allegedly unreasonable denial is reversed. The remainder of the ALJ's order is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,000, to be paid by the employer.

June 3, 1998 Cite as 50 Van Natta 1073 (1998)

In the Matter of the Compensation of
JOHN DENTON, Claimant
Own Motion No. 98-0209M
OWN MOTION ORDER ON RECONSIDERATION
Emmons, Kropp, et al, Claimant Attorneys
EBI Companies, Insurance Carrier

Claimant requests reconsideration of our May 12, 1998 Own Motion Order, in which we authorized the reopening of claimant's 1978 injury claim to provide temporary disability benefits beginning March 5, 1998, the date claimant was hospitalized for surgery. Specifically, claimant is requesting that temporary disability benefits awarded in our order should include the period of time between July 1, 1997 through October 30, 1997. Claimant contends that during this period of time he was unable to work due to his compensable condition and that he underwent outpatient procedures which are surgical in nature. We disagree.

Pursuant to ORS 656.278(1)(a), temporary disability benefits may be awarded only when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. We have previously interpreted "surgery" to be an invasive procedure undertaken for a curative purpose and which is likely to temporarily disable the worker. *Fred E. Smith*, 42 Van Natta 1538 (1990).

Claimant submitted evidence that he underwent epidural injections on three different occasions, August 1, 1997, August 13, 1997 and September 25, 1997. Claimant was taken off work for 7 days following the first injection and then returned to light duty for 4 hours a day. Following the second injection he was still unable to perform his regular duties and by the third injection, he was able to increase his hours of work until October 30, 1997, when he was returned to full duty with a 15 pound restriction. Although these injections may have improved claimant's current condition, they do not qualify as "surgery" within the meaning of ORS 656.278(1)(a).

Moreover, because the epidural steroid injections were done on an outpatient basis and did not require an overnight stay in the hospital, we find that the procedures involved in administering the injections do not qualify as "other treatment requiring hospitalization." *Tamera Frolander*, 45 Van Natta 968 (1993). Thus, we conclude that we are not authorized to award temporary disability benefits for the period between July 1, 1997 and October 30, 1997.

Therefore, we withdraw our May 12, 1998 order. On reconsideration, as supplemented herein, we adhere to and republish our May 12, 1998 order, in its entirety. The parties' right of reconsideration and appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
GLENDA JENSEN, Claimant
WCB Case No. 95-07344
SECOND ORDER ON REMAND
Ransom & Gilbertson, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Claimant has requested reconsideration of our Order on Remand which reversed the Administrative Law Judge (ALJ's) order that held that the insurer improperly terminated claimant's temporary total disability (TTD) and assessed a penalty for unreasonable claim processing. In our prior order, based on the Court of Appeals' conclusion that the insurer's modified job offer satisfied the requirement in OAR 436-60-030(12)(c) (1996) that it state "the duration of the job, if known," *Liberty Northwest Insurance Corporation v. Jensen*, 150 Or App 548 (1997), we held that the insurer properly terminated TTD when claimant refused the job. *Glenda Jensen*, 50 Van Natta 346 (1998). In her motion for reconsideration, claimant contends that our prior order neglected to address her alternative argument that the insurer's modified job offer was unreasonable because the offered job was for a shift that claimant could not accept due to her personal circumstances.

On March 20, 1998, we abated our prior order to allow for additional time to consider the motion. After considering the parties' supplemental briefs, we now proceed with our reconsideration.

We summarize the relevant facts. Claimant has an accepted claim for a left shoulder injury she suffered in December 1993 while working as a certified nurse assistant for the employer-hospital. At the time of injury, her work shift was from 6 a.m. to 2:30 p.m. She underwent shoulder surgery in July 1994 and initially returned to a modified job with the employer as a receptionist and seamstress. Claimant was unable to perform the sewing activities and was released from the modified job. Her attending physician subsequently approved a modified job as a switchboard operator for the employer. On November 29, 1994, the employer offered the temporary position to claimant with the hours from 4:30 p.m. to 1 a.m.

Claimant refused the position due to child care concerns. Because her husband was unavailable to care for their small children after midnight (due to his work schedule), claimant was concerned that, if she accepted the modified position, there would be no one to care for her children from midnight to approximately 1:30 a.m. Claimant asked if she could accept the position at a different shift. She was told that it was not possible. Based on claimant's refusal of the employer's job offer, the insurer terminated TTD on December 1, 1994.

On reconsideration, asserting that there is an implied covenant of good faith and fair dealing in her employment contract with the employer, claimant argues that the employer violated its covenant by offering her a modified job at a different shift from her regular day shift. Alleging that the employer used subterfuge to terminate TTD based on her family situation, claimant contends that the modified job offer was unreasonable and invalid. The insurer responds that claimant failed to raise her "contract" argument at any time prior to her motion for reconsideration and that it therefore should not be addressed.

Contrary to the insurer's response, we do not find that claimant is raising a new issue or argument. At hearing, claimant raised her challenge to the insurer's termination of TTD, arguing that the employer's modified job offer was "unreasonable." (Tr. 3). We conclude that claimant's assertion, here on remand, that the employer violated its covenant of "good faith" and "fair dealing" is intended to support claimant's argument that the employer's job offer was unreasonable. Because claimant's assertion of a contractual relationship is encompassed within the "reasonableness of job offer" issue raised at hearing, we may properly consider it.

On the merits, we are not persuaded by claimant's argument. ORS 656.268(3)(c) authorizes the insurer to terminate TTD when "[t]he attending physician advises the worker and documents in writing that the worker is released to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment." In accordance with that provision, the Director had set forth the following conditions for termination of TTD:

> "(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." OAR 436-60-030(12) (WCD Admin. Order 94-055, eff. August 28, 1994).

Here, the employer has complied with all of the statutory and regulatory requirements for terminating TTD. It offered claimant a modified job that was within her physical capabilities, and claimant refused the offer. Although claimant's personal circumstances apparently prevented her from accepting the modified job at the offered shift, the insurer nevertheless was authorized to terminate TTD pursuant to ORS 656.268(3)(c). *See, e.g., Robert E. Dixon*, 48 Van Natta 46 (1996) (Board Member Hall dissenting) (inconvenience of securing transportation to modified job site did not prevent authorization to terminate TTD); *Antonio Garcia*, 46 Van Natta 862 (1994) (Board Member Hall dissenting) (lack of practical transportation to modified job site did not prevent authorization for termination of TTD); *Diana M. Cooper*, 45 Van Natta 1211 (1993). While we understand that claimant had legitimate family needs that outweighed her interest in returning to available modified employment with the employer, we find that her decision represented a personal choice based on considerations that are outside the parameters of the statute and rules authorizing termination of TTD. Neither the statutes nor rules require an employer to offer a modified job at the same work shift as the job at injury, in order to terminate TTD.[1] If anything, the statutory term "modified employment" contemplates a *change* in the terms of the original employment contract between the employer and the worker. *See PGE v. Bureau of Labor and Industries*, 317 Or 606, 611 (1993) (rule of statutory construction that words of common usage typically should be given their plain, natural, and ordinary meaning). In our view, such a contemplated change would include a different shift than the shift of the job-at-injury.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our March 9, 1998 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] Claimant acknowledges that there is no "reasonableness" clause in ORS 656.268(3)(c), but she argues that such a clause can be found in the employment reinstatement statute, ORS 659.415, and the interpretive rules promulgated under that statute. However, because our subject matter jurisdiction is limited to controversies concerning a claim arising under ORS Chapter 656, *see* ORS 656.726(2), we lack jurisdiction to consider matters arising outside of the chapter, including employment reinstatement disputes under ORS Chapter 659. Such disputes must be resolved in a different forum.

In the Matter of the Compensation of
FRED T. HARDY, Claimant
WCB Case No. 97-01626
ORDER ON REVIEW (REMANDING)
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

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

FINDINGS OF FACT

Claimant filed a request for hearing on February 24, 1997. The matter was initially set for hearing on May 15, 1997, but was postponed after claimant failed to attend an insurer-arranged medical examination (IME). The matter was rescheduled for hearing on October 29, 1997, but was again postponed after claimant once more failed to attend an IME.

Claimant did not appear in person or through an attorney at the hearing rescheduled on March 25, 1998. On March 27, 1998, the ALJ issued an order dismissing claimant's hearing request pursuant to OAR 438-006-0071(2), on the ground that claimant had abandoned his request for hearing.

Thereafter, the Board received a request for review of the ALJ's order. Stating that he had to move to Southern California in order to work, claimant asserts that "communications were lost."

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 March 27, 1998 dismissal order, claimant states that "communications were lost" after he moved to Southern California. In light of these circumstances, which indicate that claimant's failure to attend the hearing may have been due to a change in residence, we interpret this 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]

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[1] We note that, in *Brent Harper*, 50 Van Natta 499 (1998), we remanded for further development of the record regarding the claimant's explanation for failing to appear at hearing. In that case, the claimant provided some explanation prior to convening of the hearing regarding why he could not attend the proceedings, and the ALJ used a "combined" dismissal order consisting of both a "show cause" and a "dismissal" order. This case differs from *Harper* in that claimant provided no "pre-hearing" explanation of why he could not attend the hearing. In addition, the ALJ did not use a "combined" dismissal order. Where an ALJ dismisses a hearing request with a standard dismissal order and the claimant provides a "post-dismissal order" explanation for his or her failure to attend a hearing, we continue to follow the above precedent authorizing remand to the ALJ for a determination of whether a postponement is warranted.

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 claimant'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 claimant's hearing request is justified. *Jennie S. Debelloy*, 49 Van Natta 134 (1997).[2]

Accordingly, the ALJ's March 27, 1998 order is vacated. This matter is remanded to ALJ Brazeau to determine whether postponement of claimant's hearing request is justified. In making this determination, the ALJ shall have the discretion to proceed in any manner that will achieve substantial justice and that will insure a complete and accurate record of all exhibits, examination and/or testimony. If the ALJ finds that a postponement is justified, the case will proceed to a hearing on the merits at an appropriate time as determined by the ALJ. If the ALJ finds that a postponement is not justified, the ALJ shall proceed with the issuance of a dismissal order.

IT IS SO ORDERED.

[2] Although the carrier asserts that there are no "extraordinary circumstances" to justify postponement of the hearing, it can challenge claimant's explanation for his failure to appear at hearing on remand. The carrier also asserts that dismissal was appropriate given claimant's failure to attend previously scheduled IME's. *See Ronald C. Fuller*, 49 Van Natta 2067 (1997), *on recon* 50 Van Natta 100 (1998). While claimant's failure to attend previously scheduled IME's was relevant to prior postponements, we do not perceive this as being directly relevant to the current issue of whether claimant is entitled to a postponement. That is, we view this case as concerning dismissal for failure to appear at hearing, rather than dismissal for failure to attend an IME. In any event, the affect, if any, of claimant's failure to attend prior IME's is a matter for the ALJ to consider on remand.

June 4, 1998 Cite as 50 Van Natta 1077 (1998)

In the Matter of the Compensation of
MICHAEL A. PHILLIPS, Claimant
WCB Case No. 97-04114
ORDER ON REVIEW (REMANDING)
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Bock and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Thye's order that dismissed claimant's request for hearing. On review, the issue is dismissal. We vacate the ALJ's order and remand.

FINDINGS OF FACT

On May 19, 1997, claimant, through his former attorney, requested a hearing. After the first scheduled hearing was postponed, a hearing was set for January 14, 1998 with ALJ Thye. On January 16, 1998, ALJ Thye dismissed claimant's request for hearing on the basis that the request had been withdrawn.

On January 30, 1998, claimant, *pro se*, filed with the Board a request for a "new hearing." On May 11, 1998, the Board acknowledged claimant's request as an appeal of the ALJ's January 16, 1998 order.[1]

CONCLUSIONS OF LAW AND OPINION

The Board may remand a case to ALJ Thye for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. *Bailey v. SAIF*, 296 Or 41, 45 n 3 (1985). Here, no documentary or testimonial evidence was admitted concerning the dismissal of

[1] The Hearings Division initially processed claimant's request as a request for hearing. (WCB Case No. 98-00989). A hearing regarding that request is currently scheduled for June 18, 1998 in The Dalles before ALJ Peterson.

claimant's request for hearing. Furthermore, the file contains no indication that claimant, or his former attorney, withdrew the request for hearing. Under such circumstances, we find the record incompletely and insufficiently developed. *See, e.g., Donald R. Roth*, 42 Van Natta 1091 (1990).

Therefore, we remand this matter to ALJ Thye with instructions to determine if the dismissal was justified.[2] Should the ALJ find that claimant's hearing request should not be dismissed, this matter shall proceed to hearing on the merits of the issues raised in claimant's hearing request.

ORDER

The ALJ's order dated January 16, 1998 is vacated. Claimant's request for hearing is reinstated and this matter is remanded to ALJ Thye for further proceedings consistent with this order.

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[2] A briefing schedule has not been implemented. However, because the record is devoid of evidence regarding the pivotal issue for our resolution (*i.e.*, whether claimant or his attorney withdrew the hearing request), we conclude that substantial justice is achieved by immediately remanding to the ALJ for further development of this incomplete record. *See Lonnie B. Dirks*, 49 Van Natta 1765 n. 1 (1997); *Robert K. Hedlund*, 47 Van Natta 1041, 1043 n.1 (1995). Moreover, we note that both parties will have the opportunity to present their respective positions regarding this "withdrawal" issue to the ALJ on remand.

Finally, as noted in footnote 1, claimant's request for Board review has also been processed as a request for hearing, which is currently pending before ALJ Peterson. In light of such circumstances, it could be argued that it would be more efficient for this matter to be remanded to ALJ Peterson for consolidation with the other pending case. Nonetheless, because ALJ Thye issued the dismissal order finding that claimant's hearing request in this case had been withdrawn, we consider it appropriate to remand this matter to ALJ Thye for further consideration. Notwithstanding this "remand" decision, should the parties wish to explore the possibility of having WCB Case No. 98-00989 referred to ALJ Thye, that is a matter that they may wish to present to ALJs Thye and Peterson.

In the Matter of the Compensation of
DAVID A. STEINER, Claimant
WCB Case No. TP-98003
THIRD PARTY DISTRIBUTION ORDER
Pozzi, Wilson, et al, Claimant Attorneys

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation, as paying agency, has petitioned the Board for an order resolving a dispute regarding the distribution of proceeds from a third party judgment. Specifically, SAIF seeks an order enforcing our prior April 1, 1991 Third Party Distribution Order, which directed claimant's counsel to forward the sum of $1,759.46 to SAIF as its remaining share of the third party recovery.

For the reasons set forth herein, we conclude that claimant's counsel is liable to SAIF for the unreimbursed $1,759.46.

FINDINGS OF FACT

Claimant was compensably injured in July 1984, while working as an installer. He retained legal counsel to pursue a third party action for damages, which resulted in a judgment in claimant's favor of $383,585.75.

SAIF notified claimant of its third party lien, which totaled $30,465.92. In August 1989, shortly after the third party judgment became final, claimant's counsel forwarded to SAIF the sum of $28,706.46. Claimant contended that the balance ($1,759.46) was not reimbursable as a claim cost because it represented an "out of compensation" attorney fee which, claimant asserted, did not constitute compensation under ORS 656.593(1)(c). Around the same time, claimant's counsel disbursed the remainder of the third party judgment proceeds to claimant (less costs and attorney fees).

SAIF petitioned the Board seeking to recover the unreimbursed balance of its lien. On April 1, 1991, we issued a Third Party Distribution Order which held that "out of compensation" attorney fees are "compensation" reimbursable from claimant's third party recovery. *See David A. Steiner*, 43 Van Natta 817 (1991). In so holding, we specifically directed claimant's counsel to forward the $1,759.46 to SAIF. *Id.* at 819.

The day after our order issued, SAIF wrote to claimant's counsel requesting payment of $1,759.46. Claimant's counsel advised SAIF that claimant was in the process of deciding whether to appeal the order and stated that, if claimant were to appeal, "we will await the outcome of the appeal before any funds are disbursed." Shortly thereafter, claimant did appeal. On July 8, 1992, the Court of Appeals affirmed our order. *Steiner v. E.J. Bartells Co.*, 114 Or App 22 (1992).

Following the appellate decision, SAIF again requested payment of the $1,759.46. Claimant's counsel responded that he would advise claimant of SAIF's request. Neither claimant nor his counsel sent the payment to SAIF.

In 1995, SAIF wrote to claimant's counsel requesting a status report on its unpaid lien. In June 1996, SAIF demanded that claimant's counsel immediately pay the $1,759.46. SAIF took the position that claimant's counsel was ultimately responsible for the debt because the third party proceeds were improperly distributed. Claimant's counsel responded that the obligation to repay SAIF was claimant's alone. SAIF's petition followed.

CONCLUSIONS OF LAW AND OPINION

SAIF contends that, to the extent claimant's counsel improperly disbursed SAIF's share of the third party judgment to claimant, the attorney is jointly and severally responsible with claimant for the $1,759.46 owed to SAIF. In response, claimant contends that the Board lacks authority to direct his counsel to pay SAIF the unpaid portion of its lien. Claimant also asserts that his counsel did not engage in improper conduct. For the reasons set forth below, we agree with SAIF that claimant's counsel is responsible for the $1,759.46.

We have previously held that we retain jurisdiction to enforce and/or clarify a prior final third party order where the parties continue to have a dispute regarding the distribution of the third party proceeds. *See, e.g. Kenneth D. Legore*, 49 Van Natta 1581 (1997) (Board had authority under ORS 656.591 to enforce its prior third party order and to direct the parties and their counsel to take whatever actions necessary to ensure that the carrier receive the entire $10,000 settlement as partial reimbursement for its lien); *see also Chris A. Meirndorf*, 42 Van Natta 2835 (1990) and *Steven B. Lubitz*, 40 Van Natta 450 (1988), discussed *infra*.

In this case, our prior order (which became final following the Court of Appeals' affirmance[1]) expressly directed "claimant's counsel" to forward the $1,759.46 to SAIF for its entire share of the third party recovery. *See David A. Steiner*, 43 Van Natta at 819.[2] In light of this prior directive, claimant's current contention (*i.e.*, that we lack the authority to order his attorney to pay) constitutes a collateral attack of our prior final order.

As a general rule, collateral attacks on final orders of the Board are not permitted. *See, e.g. Jeld-Wen, Inc. v. Bartz*, 142 Or App 433, 436 (1996); *SAIF v. Reddekopp*, 137 Or App 102 (1995); *Tri-Met v. Shields*, 107 Or App 468 (1991). Indeed, unless claimant can demonstrate that we lacked jurisdiction to issue the underlying third party order in the first instance, the order is enforceable and not subject to collateral attack *See generally, Ketcham v. Selles*, 304 Or. 529, 534 (1987) (explaining that once a judgment has become final, any errors in the judgment are ordinarily beyond remedy, although a "jurisdictional

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[1] *See Steiner v. E.J. Bartells*, 114 Or App at 25.

[2] It is evident from our prior order that claimant's counsel was responsible for distributing the proceeds of the third party judgment. The order acknowledged that claimant had retained counsel to pursue a third party action for damages, that the third party action had resulted in a judgment in excess of $383,000, and that claimant's counsel had forwarded a partial lien payment of $28,706.46 to SAIF shortly after the third party judgment became final. 43 Van Natta at 817-18.

defect" can sometimes form the basis for a collateral attack); *see also SAIF v. Reddekopp*, 137 Or App at 106 (holding that, even assuming the Board was wrong as a factual matter when it determined that the claimant's aggravation rights had expired, the Board had subject matter jurisdiction to determine whether the claimant's claim came within its "own motion" jurisdiction; once the own motion order became final, it was not subject to collateral attack).

ORS 656.593 gives the Board jurisdiction over the worker and a paying agency and over the subject matter of a worker's recovery from a direct third-party action. *See SAIF v. Wright*, 312 Or 132 (1991). More specifically, ORS 656.593(1)(d) expressly authorizes the Board to resolve "any conflict as to the amount of the balance which may be retained by the paying agency." Because our prior Third Party Distribution Order resolved a conflict as to the amount of SAIF's lien (specifically, whether SAIF was entitled to recover attorney fees payable out of compensation as part of its lien) we had jurisdiction to issue the order. To the extent claimant objected to that part of the order directing his counsel to forward the $1,759.46 to SAIF, he should have raised that challenge on judicial review. Now that the prior Third Party Distribution Order has become final, claimant's collateral attack on its directive must fail. *SAIF v. Reddekopp*, 137 Or App at 106.

Furthermore, even if claimant was not otherwise precluded from challenging our authority to order his attorney to pay the $1,759.46 to SAIF, we would find, on the merits, that his attorney is liable to SAIF for this amount.

In this case, as in all third party judgment cases, ORS 656.593(1) provides in detail exactly how, and in what order, the damages shall be distributed. First, pursuant to ORS 656.593(1)(a), costs and attorney fees shall be paid. Then, under subsection (1)(b), the worker shall receive at least 33-1/3 percent of the balance of the recovery. Next, the paying agency is entitled to be paid and retain the balance of the recovery to the extent it is compensated for its expenditures for compensation and the present value of its reasonably to be expected future claim costs. ORS 656.593(1)(c). Thereafter, any remaining balance shall be paid to the worker. ORS 656.593(1)(d).

Here, in August 1989, after the deducting his costs and attorney fees from the $383,585.75 third party judgment, claimant's counsel distributed to SAIF what he believed to be the full amount of SAIF's lien, less an "out of compensation" fee awarded by a prior litigation order. Notwithstanding SAIF's contention that the "out of compensation" fee was also subject to the lien, claimant's counsel distributed the remaining balance of the proceeds (including the disputed $1,759.46) to claimant. Thereafter, on SAIF's petition to the Board, we determined that the disputed $1,759.46 was, in fact, reimbursable as a claim cost, and directed that the sum be forwarded to SAIF as its share of the third party recovery.

Although claimant's counsel's distribution to claimant of the remainder of the judgment proceeds preceded the final order directing that SAIF recover the disputed $1,759.46, claimant's counsel's actions were nevertheless in contravention of the provisions ORS 656.593(1).[3] As a result of claimant's counsel's actions, SAIF has not recovered its full statutory entitlement. Under such circumstances, we conclude that SAIF may recover the unpaid portion of its lien from claimant's attorney. *See Chris A. Meirndorf*, 42 Van Natta at 2838; *Steven B. Lubitz*, 40 Van Natta at 452.

In *Chris A. Meirndorf*, as in this case, the claimant's counsel had forwarded to the claimant a sum in excess of his statutory 1/3 share of the third party proceeds prior to the Board's third party distribution order. After we determined that a distribution of the settlement proceeds in accordance with ORS 656.593(1) was "just and proper," and specifically directed the claimant's counsel to forward the sum of $20,394.03 to the worker's compensation carrier,[4] the claimant's attorney sent the carrier a check for $18,295.08 (the remaining balance of the settlement proceeds) as payment in full of the claimant's obligation. In a subsequent order, we held that the check constituted only a partial payment of the carrier's share of the settlement proceeds and did not absolve the claimant's liability for the entire

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[3] Indeed, in third party distribution cases, we often see the claimant's attorney holding the disputed proceeds in his or her trust account pending final resolution of the dispute. *See, e.g. Robert Aagesen (Brown)*, 46 Van Natta 1663 (1994); *Mary E. Bigler*, 44 Van Natta 752 (1992); *Timothy E. Dooley*, 43 Van Natta 2743 (1991).

[4] *See Chris A. Meirndorf*, 41 Van Natta 962 (1989).

$20,394.03 ordered payable under the prior order. In so holding, we specifically found that, in disbursing more to the claimant than his statutory 1/3 of the proceeds without retaining sufficient funds to cover the carrier's lien, the claimant's counsel had acted in contravention of the statutory distribution scheme. Consequently, we concluded that it was the claimant's attorney's responsibility to remedy the matter. 42 Van Natta at 2837-38.

Similarly, in *Steven B. Lubitz,* we held that regardless of the claimant's and his counsel's intentions, the claimant's attorney's distribution of a portion of the third party settlement proceeds directly to the claimant's treating physician was in direct contravention of the statutory distribution scheme. Where the attorney's unauthorized action resulted in the worker's compensation carrier receiving less than half of the $4,292.04 to which it was statutorily entitled, we held the attorney responsible to the carrier for the unpaid balance. 40 Van Natta at 452. *See also Dennis Youngstrom,* 47 Van Natta 1622 (1995) (Board held a claimant's attorney jointly and severally responsible for reimbursing the paying agency its unpaid lien where the claimant's attorney unilaterally deducted one-fourth of the lien for an additional attorney fee); *Manuel A. Ybarra,* 43 Van Natta 376 (1991) (Board held that the paying agency was entitled to recover the unpaid portion of its lien from the claimant's attorney where the attorney paid $750 of the proceeds as reimbursement of a "PIP lien" rather than distributing the third party settlement proceeds in accordance with the statutory scheme).

Accordingly, in light of the reasoning discussed above and the rationale articulated in *Chris A. Meirndorf* and *Steven B. Lubitz,* we conclude that SAIF is entitled to recover its unpaid lien from claimant's attorney. We therefore direct claimant's attorney to pay SAIF the sum of $1,759.46, as the remaining balance of SAIF's statutory share of the third party judgment.

IT IS SO ORDERED.

June 4, 1998 Cite as 50 Van Natta 1081 (1998)

In the Matter of the Compensation of
DONNA M. WILSON, Claimant
WCB Case No. 94-10507
ORDER ON REMAND
Cole, Cary, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

This matter is before the Board on remand from the Supreme Court. Wilson v. State Farm Insurance, 326 Or 413 (1998). The Supreme Court has reversed the Court of Appeals opinion, 142 Or App 205 (1996), that had affirmed our prior order, Donna M. Wilson, 47 Van Natta 2160 (1995), that had found that claimant's leg ("Achilles tendon") injury did not arise out of her employment. The Court has concluded that the fact that claimant's employer did not contemplate or expect her precise method of rounding a corner at her employer's workplace as she returned to her office did not render her resulting leg injury noncompensable. Determining that claimant satisfied the "arising out of" prong of the work-connection test by showing a causal link between her injury and her work, the Supreme Court has remanded the case for further proceedings.

Consistent with the Court's holding, we find that claimant's injury arose out of her employment. Inasmuch as it is uncontested that claimant's injury occurred "in the course of" her employment, we conclude that her claim is compensable.

Accordingly, the Administrative Law Judge's order dated December 30, 1994 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law.

IT IS SO ORDERED.

In the Matter of the Compensation of
CATHERINE L. BOSS, Claimant
Own Motion No. 97-0522M
OWN MOTION ORDER
Glen J. Lasken, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation initially submitted claimant's request for temporary disability compensation for her compensable cervical strain and contusion. Claimant's aggravation rights on that claim expired on August 21, 1996.

On November 7, 1997, SAIF denied the responsibility for claimant's current significant and severe rotator cuff tendinitis with impingement involving the right shoulder condition. Claimant requested a hearing. (WCB Case No. 97-09159).

An Order of Dismissal dated March 31, 1998 was issued by Administrative Law Judge (ALJ) Brazeau inasmuch as claimant had withdrawn her request for hearing regarding her SAIF claim.[1] That order was not appealed, and has become final by operation of law.

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.

The effect of ALJ Brazeau's March 31, 1998 dismissal order has on claimant's request for own relief is that the current condition and ensuing medical treatment for which claimant had requested own motion relief, remain in denied status. As a result, we are not authorized to grant claimant's request for own motion relief. See Id.

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

IT IS SO ORDERED.

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[1] Responsibility for claimant's current right shoulder condition was accepted by a non-own motion carrier through a Stipulation and Order of Dismissal approved by ALJ Brazeau on March 19, 1998.

In the Matter of the Compensation of
CAROLYN L. GREMAUD, Claimant
WCB Case No. 97-05470
ORDER ON REVIEW
Ronald A. Fontana, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Hall and Moller.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Tenenbaum's order that directed it to amend its claim acceptance to include the condition of depression. In her respondent's brief, claimant contends that the ALJ should have assessed a penalty and related attorney fee for SAIF's allegedly unreasonable processing of the claims for post-traumatic stress syndrome and depression. On review, the issues are compensability and penalties. We modify in part and affirm in part.

FINDINGS OF FACT

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

We do not adopt the finding that claimant suffered a separate compensable mental disorder consisting of depression, in addition to post-traumatic stress disorder (PTSD), in relation to the compensable injury and that SAIF's acceptance should be modified to include the depression condition.

CONCLUSIONS OF LAW AND OPINION

Compensability

On review, SAIF alleges that claimant implicitly waived her claim for depression when her attorney did not mention the depression claim in his statement of the issues at hearing. SAIF therefore argues that the ALJ erred in addressing the depression claim and ordering its acceptance.

We do not need to address SAIF's waiver argument because, based on our review of the medical record, we find that claimant's depression is a symptom of her PTSD and therefore should be processed under the PTSD claim, rather than as a separate condition/claim. In this regard, we agree with, and adopt, the ALJ's conclusion that the most persuasive medical opinion regarding the diagnosis and etiology of claimant's psychological condition was rendered by Dr. Martindale, claimant's treating psychologist. Unlike the ALJ, however, we do not find that Dr. Martindale's opinion supported an inference that claimant suffered clinical depression as a separate and independent condition from PTSD. Rather, in diagnosing claimant with PTSD, Dr. Martindale specifically listed depression among the "symptoms" of the PTSD, not as a separate psychological condition. (Ex. 41-1). Based on Dr. Martindale's persuasive opinion, we modify that portion of the ALJ's order that directed SAIF to amend its acceptance notice to include depression.

Penalties

On review, claimant contends that she is entitled to a penalty and/or penalty-related attorney fee for SAIF's allegedly untimely acceptance of her mental disorder. However, this particular issue was not raised at hearing. Rather, at hearing, claimant stated that a penalty was sought "for the failure to accept the [PTSD]." (Tr. 6). Thus, claimant requested a penalty for SAIF's refusal to accept PTSD, not for untimely processing/acceptance of the claim. Because claimant did not raise the untimeliness of claim processing as a basis for a penalty, we decline to consider that basis for the first time on review. See Stevenson v. Blue Cross, 108 Or App 247, 252 (1991).

As to the raised basis for a penalty, that is, SAIF's allegedly unreasonable refusal to accept PTSD, we agree with the ALJ's conclusion that SAIF's refusal was not unreasonable. In determining whether SAIF's refusal to accept the PTSD claim was unreasonable, the question is whether SAIF had a legitimate doubt as to its liability for the PTSD claim at the time of its refusal to accept the claim. See Brown v. Argonaut Insurance Co., 93 Or App 588, 591 (1988).

At the time of SAIF's July 2, 1997 letter, which effectively advised claimant that the PTSD diagnosis was not being accepted, SAIF was in receipt of Dr. Klein's examination report. (Exs. 50, 55). In that report, Dr. Klein wrote:

"Some people would consider [claimant's] reaction a [PTSD]. In my own mind, she really does not fit that category entirely although she certainly has some symptoms of it. I do feel she has a situational reaction with mixed features." (Ex. 50-10).

Treating physician, Dr. Zeller, concurred with Dr. Klein's report. (Ex. 54). Subsequently, SAIF issued its July 2 letter that amended its claim acceptance to include "situational reaction with mixed features." (Ex. 55).

Based on Dr. Klein's report and Dr. Zeller's concurrence with that report, we find that SAIF had a legitimate doubt as to its liability for the PTSD claim. For this reason, SAIF's refusal to accept the claim was not unreasonable, and a penalty or penalty-related fee is not warranted.

Attorney Fees

Because SAIF has prevailed in having the separate depression claim disallowed on review, claimant's attorney is not entitled to an assessed fee under ORS 656.382(2) for services devoted to the compensability issue. Claimant's attorney also is not entitled to an assessed fee for services devoted to the penalty issue.

ORDER

The ALJ's order dated December 10, 1997 is modified in part and affirmed in part. That portion of the ALJ's order that directed SAIF to amend its claim acceptance to include PTSD and depression, is modified to direct SAIF to accept PTSD only. The ALJ's order is otherwise affirmed.

In the Matter of the Compensation of
DAVID M. McALLISTER, Claimant
WCB Case No. C8-01213
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Pamela A. Schultz, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Member Bock and Biehl.

On May 28, 1998, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration for 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 CDA.

On the summary page, and on page 3, paragraph 13 of the CDA, the attorney fee has been increased by handwritten interlineation from $1,475 to $2,875 and the remaining portion of the CDA proceeds to claimant has been decreased from $14,525 to $13,125. The change has been initialed by claimant and his attorney and the CDA also indicates that the carrier's attorney had been advised of and had approved the modification to the distribution of the CDA proceeds.

The handwritten change does not affect the amount of consideration ($16,000) to be paid by the carrier or any of the substantive provisions in the CDA. Moreover, only the distribution of proceeds between claimant and his attorney has been modified and the proposed attorney fee does not exceed the maximum attorney fee allowed by the Board's administrative rule. OAR 438-015-0052(1). Because the change does not affect the total consideration for the CDA and has been approved by claimant, his attorney, and the carrier's attorney, we approve the CDA as amended.

As interpreted herein, the CDA is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' CDA is approved. An attorney fee of $2,875, payable to claimant's counsel, is also approved.

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

IT IS SO ORDERED.

June 5, 1998 Cite as 50 Van Natta 1085 (1998)

In the Matter of the Compensation of
JILL M. MILLER, Claimant
WCB Case Nos. 97-02015 & 96-10166
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) upheld Liberty Northwest Insurance Corporation's responsibility denial of claimant's occupational disease/new injury claim for an overuse syndrome; (2) dismissed for lack of jurisdiction her hearing request regarding the SAIF Corporation's denial of claimant's aggravation claim for the same condition; and (3) declined to award a penalty for SAIF's allegedly unreasonable claim processing. On review, the issues are responsibility, jurisdiction, penalties and attorney fees.

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

The ALJ found that claimant had not sustained a new injury or occupational disease claim based on her employment after October 1990 for Liberty Northwest's insured (Stoel, Rives). In addition, the ALJ found that SAIF, the carrier which accepted a bilateral elbow condition resulting from claimant's employment for a different employer (Walton, Nilsen & Walker) in 1989, was not responsible for an "aggravation" claim because claimant's aggravation rights had expired on or about October 1, 1993. *See* ORS 656.273(4).

On review, claimant contends that she established a new injury/occupational disease claim based on her employment for Stoel, Rives. Alternatively, claimant asserts that she proved a compensable aggravation claim against SAIF.

We agree with the ALJ's conclusion that the medical evidence does not establish that claimant sustained a new injury/occupational disease claim based on her employment for Stoel, Rives. Moreover, we agree with the ALJ that SAIF cannot be responsible for an "aggravation" of its compensable bilateral elbow claim because claimant's aggravation rights have expired.[1]

While the ALJ stated that SAIF cannot be responsible for claimant's "current condition," we note that claimant retains entitlement to medical services insofar as such services are attributable to her compensable 1988 claim with SAIF. However, no issue was raised at hearing regarding SAIF's responsibility for medical services. Instead, the issues were whether claimant proved a new injury/occupational disease claim against Liberty or, alternatively, whether SAIF was responsible for an aggravation claim. Inasmuch as responsibility for medical services under the SAIF claim was not in dispute, we do not address that issue.

ORDER

The ALJ's order dated October 1, 1997, as reconsidered on October 16, 1997, is affirmed.

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[1] This conclusion should not be misinterpreted to mean that claimant no longer has the right to additional temporary disability for the compensable condition or that SAIF is no longer responsible for the compensable condition accepted by SAIF. Rather, the right to additional temporary disability under the SAIF claim is now subject to the Board's Own Motion jurisdiction.

In the Matter of the Compensation of
LORI NEVEAU, Claimant
WCB Case No. C8-00827
ORDER DENYING RECONSIDERATION
OF CLAIM DISPOSITION AGREEMENT
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Member Biehl and Haynes.

On May 14, 1998, the Board approved 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, who is unrepresented, released her rights to future workers' compensation benefits, except medical services, for the compensable injury.

On May 29, 1998, we received the claimant's faxed letter stating that "I Lori Neveau would like to get out of my claims disp. agrement [sic]."

We treat the claimant's letter as a motion for reconsideration of the approved CDA. In order to be considered, a motion for reconsideration of the CDA must be received by the Board within 10 days of the date of mailing of the final order. OAR 438-009-0035(1),(2).

Here, the CDA was approved and mailed on May 14, 1998. We received the "fax" of claimant's letter requesting "disapproval" of the CDA on May 29, 1998, 15 days after the CDA was approved.[1] Inasmuch as the motion for reconsideration was untimely, we cannot consider it. OAR 438-009-0035(1),(2).

Moreover, we approved the CDA in a final order pursuant to ORS 656.236. Under ORS 656.236(2), an approved CDA is final and is not subject to review. ORS . Consequently, we lack statutory authority to alter the previously approved CDA.[2]

IT IS SO ORDERED.

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[1] Pursuant to our administrative rules, a "fax" transmission is not considered "filing." *See OAR 438-005-0046(1)(d).* However, even if "faxing" the motion was considered proper filing, the motion would still be untimely for the reasons explained in this order.

[2] We also note that ORS 656.236(1)(a)(C) allows us to disapprove a CDA if "[w]ithin 30 days of submitting the disposition for approval, the worker, the insurer or self-insured employer requests the board to disapprove the disposition." Here, the 30 day period had expired prior to our May 14, 1998 approval of the CDA. Under such circumstances, even if claimant's motion for reconsideration had been timely, we would have been unable to disapprove the agreement under ORS 656.236(1)(a)(C) because the 30 day period had already expired.

In the Matter of the Compensation of
STEVE L. PAUL, Claimant
WCB Case No. 97-09986
ORDER ON REVIEW
Reinisch, Mckenzie, et al, Claimant Attorneys

Reviewed by Board Members Hall and Moller.

Claimant, *pro se*,[1] requests review of Administrative Law Judge (ALJ) McWilliams' order that dismissed his request for hearing. On review, the issue is the propriety of the dismissal order. We affirm.

FINDINGS OF FACT

On November 26, 1997, claimant signed a retainer agreement employing his then-attorney of record to represent him in connection with his workers' compensation claim. A provision of that retainer agreement stated: "My attorneys are authorized to sign my name and in all other respects to act for me in connection with my claim."

On December 12, 1997, claimant, through his then-attorney, requested a hearing and raised the following issues: (1) partial, de facto denial of a current condition; and (2) penalties and attorney fees. A hearing was scheduled for March 9, 1998.

By letter dated March 5, 1998, claimant's then-attorney withdrew the hearing request. On March 11, 1998, the ALJ issued an order dismissing claimant's hearing request.

Thereafter, claimant appealed the ALJ's order and requested an opportunity to go before an ALJ. In that letter, which claimant copied to the insurer's attorney, claimant also contended that his physical condition was getting worse. The Board acknowledged claimant's request for review of the ALJ's order.

On review, claimant contends that his physical condition has been worsening since the November 12, 1987 injury. He also asserts that, although his settlement entitled him to lifetime medical benefits, the insurer was "fight[ing] [him] all the way."

CONCLUSIONS OF LAW AND OPINION

The ALJ dismissed claimant's hearing request. We treat claimant's letters as a request for review of that Order of Dismissal. In doing so, we emphasize that the sole issue before us is whether claimant's hearing request should have been dismissed. In other words, we cannot address the merits of claimant's claim (that is, his entitlement to further benefits) unless and until we resolve the question of whether the ALJ properly dismissed claimant's hearing request. Based on the following reasoning, we find the ALJ's dismissal order was appropriate.

By letter dated March 5, 1998, claimant's then-attorney withdrew the hearing request. In addition, the retainer agreement between claimant and his then-attorney authorized claimant's then-attorney to act on claimant's behalf. Finally, the record establishes that claimant was represented by his former attorney at the time in question.

Accordingly, we find that claimant, through his former attorney, withdrew his request for hearing. Although claimant may be dissatisfied with his former attorney's action, he does not dispute his former attorney's authority to act on his behalf, nor does he dispute the fact that the ALJ dismissed his request for hearing on this claim in response to his former attorney's withdrawal of the hearing request. Under these circumstances, we find no reason to alter the dismissal order. William A. Martin, 46 Van Natta 1704 (1994); Mike D. Sullivan, 45 Van Natta 900 (1993); Eul G. Moody, 45 Van Natta 835 (1993).

ORDER

The ALJ's order dated March 11, 1998 is affirmed.

[1] Although represented at hearing, claimant's attorney withdrew as claimant's counsel as of April 16, 1998.

In the Matter of the Compensation of
THOMAS E. SUBY, Claimant
WCB Case No. 97-04655
ORDER ON REVIEW
Gloria D. Schmidt, Claimant Attorney
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) McWilliams' order that affirmed an Order on Reconsideration awarding no temporary disability benefits, no scheduled permanent disability compensation, and an additional 10 percent (32 degrees) unscheduled permanent disability for a low back condition, for a total award of 29 percent (92.8 degrees) unscheduled permanent disability. On review, the issues are temporary disability compensation and extent of scheduled and unscheduled permanent disability. We affirm.

FINDINGS OF FACT AND ULTIMATE FACT

We adopt the ALJ's "Findings of Fact" with the following additional findings.

Claimant's inability to work following the May 9, 1996 fusion surgery was entirely due to that surgery.

Claimant's compensable injury was medically stationary as of February 27, 1996.

The medical arbiter's finding of 4/5 strength loss in claimant's lower extremities is not attributable to nerve damage resulting from claimant's compensable injury.

CONCLUSIONS OF LAW AND OPINION

We adopt and affirm the ALJ's "Conclusions of Law and Reasoning" with the following supplementation.

On review, claimant challenges the ALJ's ruling that claimant is not entitled to benefits for disability resulting from his May 9, 1996 fusion surgery. Specifically, claimant contends that he is entitled to substantive temporary disability benefits following the surgery, increased unscheduled permanent disability based on an impairment value for the surgery itself, and scheduled permanent disability for a bilateral loss of strength in his lower extremities.

Resolution of these issues is controlled by our recent decision in Thomas E. Suby (Suby I), 50 Van Natta 718 (1998). In Suby I, the same parties involved in this case litigated claimant's entitlement to procedural temporary disability benefits following the May 6, 1996 fusion surgery. We concluded that claimant was not entitled to those benefits pursuant to the res judicata doctrine of issue preclusion. North Clackamas School Dist. v. White, 305 Or 48, 53 (1988).[1] In so ruling, we relied on the Department's final determination that the May 9, 1996 surgery was not appropriate for the compensable injury. We reasoned that the Department's final determination established that the surgery was not a compensable consequence of the injury and, therefore, precluded claimant from asserting that the time loss he sustained as a result of the surgery was a compensable consequence of the accepted injury. We also noted that our ruling was consistent with the court's recognition, in the "consequential condition" context, that the reasonableness and necessity of treatment for an accepted injury is an essential link in the chain of compensability between the accepted injury and a subsequent injury suffered as a result of the treatment. See Barrett Business Services v. Hames, 130 Or App 190, rev den 320 Or 492 (1994) (where necessary and reasonable treatment of a compensable injury is the major contributing cause of a new injury, a distinction between the compensable injury and its treatment is artificial). By analogy, we concluded that the Director's final determination that the May 9, 1996 surgery was not appropriate treatment for the accepted injury had broken the chain of causation between the accepted injury and time loss resulting from the inappropriate surgery.

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[1] The rule of issue preclusion provides that, if a claim is litigated to final judgment, the decision on a particular issue or determinative fact is conclusive in a later or different action between the same parties if the determination was essential to the judgment. White, 305 Or at 53.

Whereas Suby I concerned claimant's entitlement to procedural temporary disability benefits flowing from the May 9, 1996 surgery, the present case concerns claimant's entitlement to substantive temporary disability benefits for the same surgery. Notwithstanding this difference, we conclude that the rationale expressed in Suby I is equally applicable here. Specifically, issue preclusion bars claimant from asserting a claim for substantive temporary disability sustained as a result of the noncompensable surgery; and the Director's final determination that the surgery was not appropriate treatment has broken the chain of causation between the accepted injury and the associated substantive temporary disability benefits.

We reach the same conclusion in regard to claimant's entitlement to additional permanent disability benefits. To be entitled to an award of permanent disability, claimant must establish that his impairment is "due to" the compensable 1988 injury. ORS 656.214(5) and 656.266. Here, the Director's final ruling that the surgery was not appropriate broke the requisite chain of causation and established an issue preclusion bar to any claim for permanent disability flowing from that surgery, including the requested impairment value for the surgery. Moreover, the record does not establish that claimant's strength loss is due to nerve damage related to the compensable injury. While Dr. Karasek did note mild hamstring weakness in March 1993, claimant subsequently demonstrated normal strength at three examinations conducted prior to the May 9, 1996 surgery. Drs. Karasek, Coletti, Strum and Brooks found no evidence of neurologic involvement of the legs, and treating surgeon Hacker has not opined otherwise. Finally, the medical arbiter expressly attributes the strength loss to "give way." On this record, we are not persuaded that claimant's strength loss is due to nerve damage resulting from his compensable injury.

In summary, given the Department's final determination that the May 9, 1996 surgery was not appropriate, we conclude that claimant is not entitled to substantive temporary disability for time loss associated with that surgery or a permanent impairment value for the surgery. Nor has claimant established entitlement to an award of scheduled permanent disability for strength loss in the lower extremities. Consequently, the ALJ did not err in declining to award these benefits.

ORDER

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

June 11, 1998 Cite as 50 Van Natta 1089 (1998)

In the Matter of the Compensation of
BARBARA M. JOHNSON, Claimant
Own Motion No. 98-0045M
OWN MOTION ORDER OF ABATEMENT
Malagon, Moore, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation requests reconsideration of our May 12, 1998 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
DEAN L. WATKINS, Claimant
WCB Case No. 97-05601
ORDER ON REVIEW
Bradley P. Avakian, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Myzak's order that: (1) set aside its denial of claimant's right knee suprapatellar plica and chondromalacia conditions; and (2) awarded an assessed attorney fee of $3,500. On review, the issues are compensability and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

On April 26, 1995, claimant sustained a compensable injury to his right knee. The insurer accepted a disabling right knee strain on June 22, 1995. (Ex. 15).

Claimant began treating with Dr. Colville on June 9, 1995. (Ex. 11). He showed no improvement after several months of conservative care and Dr. Colville felt that claimant might have a cartilage injury to the lateral femoral condyle that could be causing his symptoms. (Ex. 26). He recommended arthroscopic surgery. On April 12, 1996, Dr. Colville performed a right knee arthroscopy, arthroscopic excision of suprapatellar plica, and arthroscopic debridement of the medial and lateral femoral condyles. (Ex. 35).

On April 2, 1997, claimant's attorney submitted a formal notice of a claim for suprapatellar plica and chondromalacia to the insurer. (Ex. 40). Claimant's attorney indicated that the conditions had occurred as a direct result or as a subsequent condition of the April 26, 1995 work injury. (Id.) On July 2, 1997, the insurer denied the claim on the basis that insufficient evidence existed to justify that the suprapatellar plica and chondromalacia arose as a direct result or as subsequent conditions of the original right knee strain. (Ex. 42). Claimant requested a hearing.

The ALJ rejected the insurer's arguments that claimant was not credible. The ALJ found no evidence of a preexisting condition and analyzed the case as an injury claim. The ALJ relied on the opinions of Drs. Mayhall and Colville to establish compensability.

Credibility

The insurer argues that claimant is not credible and that he did not sustain a twisting injury to his right knee on April 26, 1995. Although the ALJ found claimant credible, she made no express credibility findings based upon claimant's demeanor. When the issue of credibility concerns the substance of a witness' testimony, the Board is equally qualified to make its own determination of credibility. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987).

After our de novo review of the record, we agree with the ALJ's analysis. We adopt and affirm the ALJ's analysis and conclusions in the first four full paragraphs on page 2, although we delete footnote 2 in the first full paragraph.

Causation

We replace the portion of the ALJ's order beginning at the last paragraph on page 2 with the following analysis.

Claimant contends that this case should be analyzed as an injury under a material contributing cause standard. He relies on the opinion of Dr. Mayhall, as supported by Dr. Colville, to establish compensability.

The insurer argues that claimant failed to establish that the April 1995 accident was the major contributing cause of the claimed conditions. The insurer contends that claimant's chondromalacia preexisted the April 26, 1995 injury. To support its argument, the insurer relies on a letter to Dr. Gambee summarizing a conversation with the insurer's legal assistant. (Ex. 43). The letter, however, was not signed by Dr. Gambee. Dr. Gambee's written response to the insurer did not specifically state that claimant's chondomalacia preexisted the April 26, 1995 injury. (Ex. 44). In his first report, Dr. Gambee said that claimant had denied any previous difficulty with his knees. (Ex. 37-5). At hearing, claimant testified that he had no knee problems before the April 1995 injury. (Tr. 13). Dr. Gambee did not explain why, if the chondromalacia preexisted the work injury, claimant had no previous knee problems. Under these circumstances, we are not persuaded that claimant's chondomalacia preexisted the April 26, 1995 injury.

Moreover, we find no persuasive evidence that a preexisting condition combined with claimant's plica condition to cause disability or a need for medical treatment. Dr. Gambee commented that "if [claimant] had preexisting degenerative changes in his knee, this would very nicely explain the plica." (Ex. 44-2; emphasis added). Because we find no persuasive evidence that claimant had degenerative changes in his knee before the April 1995 injury, we are not persuaded that claimant's plica condition was a "combined" condition.

Next, the insurer contends that claimant had preexisting obesity that combined with the injury to cause his current knee condition and, therefore, the major contributing cause standard under ORS 656.005(7)(a)(B) applies. The insurer again relies on Dr. Gambee's opinion.

Under ORS 656.005(24), a "preexisting condition" is "any injury, disease, congenital abnormality, personality disorder or similar condition that contributes or predisposes a worker to disability or need for treatment[.]" In this case, we are not persuaded that claimant's obesity contributed or predisposed him to disability or need for treatment for the knee conditions.

Dr. Colville was claimant's treating physician. Although Dr. Colville was aware of claimant's weight (Exs. 31, 33-2), we find no evidence that he related claimant's knee problems to his weight. Compare Sharon D. Dan, 49 Van Natta 1025 (1997) (physicians encouraged the claimant to lose weight to treat her back condition).

On the other hand, Dr. Gambee examined claimant on one occasion. He diagnosed claimant with morbid obesity, among other things, and he felt that claimant's chondromalacia was "presumably causally related" to the obesity. (Ex. 37-5). In his second report, Dr. Gambee related "essentially all of [claimant's] problems to morbid obesity." (Ex. 44-2). Dr. Gambee did not explain how claimant's obesity caused chondromalacia. Furthermore, he did not explain why claimant's preexisting obesity had not caused any knee problems before the April 1995 injury or why claimant's treating physicians had not related his knee problems to the obesity. Consequently, we are not persuaded that claimant's obesity constituted a "preexisting condition" as defined in ORS 656.005(24) or that it combined with his knee conditions to cause disability or a need for medical treatment.

The insurer contends that the chondromalacia and plica conditions should be analyzed as an occupational disease because they developed gradually. However, we find no evidence that the chondromalacia and plica conditions were caused by claimant's employment conditions in general. See ORS 656.802. Rather, Drs. Mayhall and Colville opined that the knee conditions resulted from the April 26, 1995 injury. We agree with the ALJ that the claim should be analyzed as an injury.

Furthermore, we are not persuaded by the insurer's argument that claimant's knee conditions developed as a secondary consequence of the compensable injury and must be analyzed under the major contributing cause standard pursuant to ORS 656.005(7)(a)(A).

Dr. Mayhall diagnosed claimant with a direct contusion to the right knee with twisting injury, MRI evidence of bone bruise and contusion and "[d]evelopment of chondromalacia (degenerative change), medial femoral and lateral femoral condyles and development of plica syndrome in the suprapatellar area." (Ex. 39A-4). He explained:

> "Specifically, the development of a 'plica syndrome' after direct contusion with bruising in the suprapatellar area is reasonable. Indeed, some physicians have described anterior knee pain syndrome which includes chondromalacia, plica, malalignment, etc. In that regard, direct blow to the patella or suprapatellar area could create scar and cause a pathological plica.
>
> "It is my impression that the twisting portion and contusion are forces directed through the femur into the tibia are reasonable for the chondromalacia primarily seen on the lateral femoral condyle. Indeed, the mechanism of injury is described by Dr. Colville and the development of pathologic changes which are seen on MRI scan as well as confirmed arthroscopy are reasonable in relation to the injury described." (Ex. 39A-5).

Dr. Colville concurred with Dr. Mayhall's opinion. (Ex. 45).

Based on Dr. Mayhall's opinion,[1] as supported by Dr. Colville, we conclude that claimant's chondromalacia and plica conditions resulted directly, although belatedly, from the April 26, 1995 injury. See Albany General Hospital v. Gasperino, 113 Or App 411, 415 (1992) (a condition that arises directly, even if belatedly, from the original injury is subject to a material contributing cause standard). Therefore, claimant must establish that April 1995 injury was a material contributing cause of the chondromalacia and plica conditions.

Dr. Mayhall concluded that the treatment and course of the development of claimant's pathology was "reasonably related to the injury." (Ex. 39A-5). Dr. Colville, claimant's treating physician, concurred with Dr. Mayhall's opinion. (Ex. 45). We generally rely on the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983). Here, we find no persuasive reason not to rely on Dr. Colville's opinion. We are persuaded by Dr. Mayhall's opinion, as supported by Dr. Colville's concurrence, that claimant's April 1995 injury was a material contributing cause of the chondromalacia and plica conditions.

The insurer relies on the opinion of Dr. Gambee to argue that the claim is not compensable. For the following reasons, we are not persuaded by Dr. Gambee's opinion.

In his first report, Dr. Gambee reported that he did not believe the chondromalacia was related to the April 1995 injury, although he said he would defer to Dr. Colville in this matter. (Ex. 37-5). He said the chondromalacia was "presumably causally related" to the morbid obesity. (Id.) In his second report, Dr. Gambee said that claimant's chondromalacia was more causally related to the obesity than the work injury. (Ex. 44-2). However, Dr. Gambee did not discuss or consider the effect of the twisting mechanism of injury on claimant's condition. Moreover, for the reasons discussed earlier, we are not persuaded by Dr. Gambee's conclusion that claimant's obesity was the major contributing cause of his knee conditions.

Dr. Gambee's opinions as to the plica condition are inconsistent. He initially reported that the plica condition was "presumably causally related to the direct blow of the knee." (Ex. 37-5). In his second report, he acknowledged that it was "conceivable" that claimant's plica condition could have been caused by a direct blow. (Ex. 44-2). However, he said that "if [claimant] had preexisting degenerative changes in his knee, this would very nicely explain the plica." (Id.) Later in the report, he related "essentially all of [claimant's] problems to morbid obesity." (Id.) As we discussed earlier, we are not persuaded that claimant had degenerative changes in his knee before the April 1995 injury. Although Dr. Gambee initially felt the plica condition was caused by the work injury, he later said it was caused by obesity. Because Dr. Gambee did not explain his apparent change of opinion regarding causation of claimant's plica condition, we do not find his opinion persuasive. See Kelso v. City of Salem, 87 Or App 630 (1987).

In conclusion, we find that, based on Dr. Mayhall's opinion, as supported by Dr. Colville's concurrence, claimant's April 26, 1995 injury was a material contributing cause of his chondromalacia and plica conditions.

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[1] The insurer argues that Dr. Mayhall's opinion is defective because it failed to discuss claimant's intervening August 1995 twisting injury. We are not persuaded that the intervening injury was particularly important. Dr. Mayhall's report referred specifically to claimant's twisting injury in therapy in August 1995. (Ex. 39A-2). However, Dr. Mayhall did not discuss any consequences resulting from that injury. We note that Dr. Gambee did not refer to a twisting injury in August 1995.

Attorney Fees

The ALJ awarded claimant's attorney a $3,500 assessed attorney fee for his services at hearing. The insurer argues that the ALJ's attorney fee award should be reduced.

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

The issue in dispute was compensability of claimant's chondromalacia and plica conditions. Forty-nine exhibits were received into evidence, three of which were generated or submitted by claimant's counsel. The hearing lasted one hour, twenty-five minutes. Two witnesses testified, including claimant. Because claimant's chondromalacia and plica conditions have been found compensable, he is entitled to workers' compensation benefits, and the value of the interest involved and the benefit secured for claimant are significant. The value of the claim may potentially include permanent disability benefits. The parties' attorneys were skilled and presented their positions in a thorough, well-reasoned manner. No frivolous issues or defenses were presented. Finally, there was a significant risk that claimant's counsel's efforts might go uncompensated. Considering all these factors, we find that $3,500 is a reasonable fee for claimant's counsel's services at hearing concerning compensability of the knee conditions.

Claimant's attorney is also entitled to an attorney fee for services on review. ORS 656.382(2). Because claimant's attorney did not submit an affidavit of time or statement of services indicating how much time was expended in advocating claimant's claim on review, we have based our determination on the record on review. Compare Schoch v. Leupold & Stevens, 325 Or 112 (1997) (the claimant submitted an affidavit and summary of services rendered by counsel). 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 regarding the compensability issue is $1,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review concerning the attorney fee issue. See Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986).

ORDER

The ALJ's order dated November 3, 1997 is affirmed. For services on review, claimant's attorney is awarded an attorney fee of $1,500, payable by the insurer.

In the Matter of the Compensation of
TROY A. EDMONDS, Claimant
WCB Case No. 97-02790
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Snarskis, Yager, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Peterson's order that set aside its denials of claimant's claims for degenerative disc disease in the low back. 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 and ultimate fact.

CONCLUSIONS OF LAW AND OPINION

We adopt and affirm the ALJ's opinion and conclusion that claimant's occupational disease claim for degenerative disc disease (DDD) in the low back is compensable, with the following supplementation.

On review, the insurer argues that, because there are conflicting medical opinions in the record, deference should be accorded to the opinion of the treating physician, Dr. Hoppert, who did not support the claim. We disagree. The causation of claimant's DDD presents an issue involving expert analysis rather than expert external observation and, therefore, special credit is not given to the treating physician's opinion. *See Hammons v. Perini Corp.*, 43 Or App 299 (1979); *David L. Porter*, 50 Van Natta 134 (1998). Instead, we rely on those medical opinions that are well-reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263 (1986). Like the ALJ, we find that Dr. Gritzka's opinion was complete and better-reasoned than the opinions of Drs. Fuller and Hoppert. Based on Dr. Gritzka's opinion, we conclude that claimant has proved his occupational disease claim by a preponderance of the evidence. Accordingly, we affirm the ALJ's order setting aside the insurer's denial letter dated November 19, 1997.

We reverse the portion of the ALJ's order that purported to set aside the insurer's February 6, 1997 partial denial of claimant's claim for the low back DDD. Inasmuch as the DDD has been found compensable as an occupational disease, and the occupational disease theory was the sole theory asserted in support of the DDD claim at hearing, (Tr. 3-6), the appropriate action was to set aside the insurer's denial of the occupational disease claim and uphold its February 6, 1997 partial denial.[1]

Claimant is entitled to an assessed attorney fee for services on review. *See* ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,600, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated February 9, 1998 is reversed in part and affirmed in part. The portion of the order that set aside the insurer's February 6, 1997 partial denial of claimant's DDD claim for low back DDD is reversed. The February 6, 1997 partial denial is reinstated and upheld. The remainder of the order (which set aside the insurer's November 19, 1997 denial of claimant's occupational disease claim) is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,600, payable by the insurer.

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[1] As the carrier acknowledges, setting aside the "injury" denial of February 6, 1997 was "harmless enough error", but technically the claim is compensable as an occupational disease and not as an injury.

In the Matter of the Compensation of
GUY R. PECK, Claimant
WCB Case No. 97-06983
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorneys
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that affirmed an Order on Reconsideration that awarded no permanent disability for a back injury. On review, the issue is extent of unscheduled permanent disability.

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

On review, claimant argues that his back impairment findings were not invalid under the Director's rule, OAR 436-035-0007(27), and therefore should have been rated for an unscheduled permanent disability award. We disagree.

OAR 436-035-0007(27) provides, in pertinent part, that "findings of impairment which are determined to be ratable pursuant to these rules shall be rated unless the physician determines the findings are invalid and provides a written opinion, based on sound medical principles, explaining why the findings are invalid." (WCD Admin. Order 96-072).

Here, claimant's attending physician, Dr. Purtzer, initially ratified the findings of reduced ranges of motion (ROM) made by the examining physician, Dr. Potter. (Ex. 18). In addition, the medical arbiter, Dr. Neumann, measured reduced ROM in claimant's thoracic spine during his examination. (Ex. 32-7). Subsequently, however, after Drs. Purtzer and Neumann viewed a surveillance videotape showing claimant engaged in roofing activities that apparently exceeded the functional capacities he demonstrated during the earlier examinations, each doctor questioned the validity of the impairment findings and stated that claimant's back ROM was "normal." (Exs. 24, 32-2, 32-4).

We find that Drs. Purtzer and Neumann based their invalidity findings on sound medical principles. They observed that the videotape showed claimant demonstrating "normal" ROM and performing other back-intensive activities (*e.g.*, carrying 90 pounds without discomfort, bending, and twisting) that were inconsistent with the impaired back function that was demonstrated during earlier examinations. (Exs. 24, 32-2). The apparent inconsistencies between claimant's videotaped function and his clinical presentation were the basis for the doctors' opinion that their impairment findings were invalid. Given the doctors' medical expertise and experience in evaluating permanent impairment, we conclude that they provided ample reasoning, based on sound medical principles, to support their conclusion that the impairment findings were invalid. *See* OAR 436-035-0007(27). Accordingly, we affirm the ALJ's order.

ORDER

The ALJ's order dated February 19, 1998 is affirmed.

June 8, 1998 Cite as 50 Van Natta 1095 (1998)

In the Matter of the Compensation of
JESUS PEREZ, Claimant
WCB Case No. 97-04340
ORDER ON REVIEW
Rasmussen, Tyler, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that upheld the insurer's denial of his right great toe injury claim. On review, the issue is compensability.

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

Claimant contends that the ALJ improperly declined to admit Exhibit 10, a letter in Spanish purportedly written by Jose Perez, claimant's uncle and supervisor. We disagree.

Ms. Kinnaman, the employer's office manager at the time claimant filed his injury claim, testified that she filled out Line 53[1] of the Form 801 according to what Jose Perez told her. (*Id.*). The insurer subpoenaed Jose Perez to testify at hearing. (Ex. 9, Tr. 19). However, Jose Perez did not honor the subpoena and failed to appear at hearing. (Tr. 19).

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[1] Line 53 is on the employer's portion of Form 801 and asks, in part, how the injury or disease occurred. That line was filled in as follows:

"Foreman says that no one saw injury acure [sic]. Said he had a problem with his foot previously. Was told he was going to see a doctor but not an on the job injury. Surprised he filed a claim." (Ex. 3).

At hearing, claimant submitted a letter in Spanish purportedly written by Jose Perez and containing hearsay statements regarding claimant's alleged injury. (*Id.*). Claimant offered this letter "solely for the purpose of essentially supplementing Exhibit Number 9, which is the [insurer's] proof of service [of the subpoena]." (*Id.*). The ALJ sustained the insurer's objection to admission of this letter, finding that the reliability of the document was suspect and Jose Perez was not there "to testify about the authenticity of the document or anything else." (Tr. 20).

On review, claimant argues the ALJ erred in refusing to admit this letter into evidence, noting that it "was offered for the sole purpose of showing why the supervisor failed to honor the subpoena" and contained statements that contradicted statements attributed to Jose Perez on the Form 801.

ORS 656.283(7) provides that the ALJ is not bound by common law or statutory rules of evidence and may conduct a hearing in any manner that will achieve substantial justice. That statute gives the ALJ broad discretion on 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. *Rose M. LeMasters*, 46 Van Natta 1533 (1994), *aff'd mem* 133 Or App 258 (1995).

In this case, we find no abuse of discretion. The insurer subpoenaed Jose Perez to testify at hearing and he failed to honor that subpoena. As the ALJ found, there was no way to authenticate the letter in Jose Perez' absence. Furthermore, to allow this letter into evidence would, in effect, allow a person who failed to honor a subpoena to testify through a written document and, thus, avoid any questioning at hearing. Such a ruling would not achieve substantial justice. Under these circumstances, we conclude that the ALJ did not abuse his discretion in declining to admit the letter into evidence.

ORDER

The ALJ's order dated February 23, 1998 is affirmed.

In the Matter of the Compensation of
SCOTT W. WILSON, Claimant
WCB Case No. 97-08740
ORDER ON REVIEW
Charles G. Duncan, Claimant Attorney
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Myzak's order that set aside its denial of claimant's injury claim for a current low back strain condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

Claimant did not provide examining and treating physicians with an accurate and complete history regarding prior low back problems. (*See* Tr. 25, 28, 31; Exs. 3, 5, 7, 12, 16, 29, 39).

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the insurer's denial of claimant's current low back condition, based on the opinion of Dr. Andresen, treating physician. In reaching this conclusion, the ALJ reasoned that claimant's accepted April 3, 1997 low back strain remained a material contributing cause of his current low back condition. We disagree.

Because there are a number of potential contributing causes for claimant's ongoing low back problems, this case presents a complex medical question requiring expert medical evidence for its resolution. *See Uris v. Compensation Department*, 247 Or 420 (1967); *Kassahn v. Publishers Paper Co.*, 76 Or App 105 (1985), *rev den* 300 Or 546 (1986). We rely on medical evidence which is well-reasoned and based on an accurate and complete history. *Somers v. SAIF*, 77 Or App 259 (1986).

The medical evidence supporting the claim is provided by Dr. Andresen, who began treating claimant's low back on May 13, 1997.

Claimant told Dr. Andresen (and numerous other physicians) that he had no back injuries before the April 3, 1997 accident at work. (Ex. 12; *see* Exs. 3, 5, 7, 16, 29, 39; Tr. 20-22). However, the insurer introduced evidence impeaching the accuracy of claimant's reporting in this regard.[1] (Exs. A, B, C; *see* Tr. 25-38).

Under these circumstances, and considering the potentially contributing noncompensable causes identified,[2] we cannot say that Dr. Andresen's causation opinion is based on an accurate and complete history. Consequently, we find Dr. Andresen's conclusions unpersuasive. *See Somers*, 77 Or App at 261; *see also Weiland v. SAIF*, 64 Or App 810 (1983). Because we find no persuasive evidence supporting claimant's claim for a current low back strain, we conclude that the insurer's denial must be upheld.

ORDER

The ALJ's order dated February 27, 1998 is reversed in part and affirmed in part. That portion of the order that set aside the insurer's denial of claimant's claim for a current low back strain is reversed. The denial is reinstated and upheld. The ALJ's attorney fee award is reversed. The remainder of the order is affirmed.

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[1] Claimant apparently believes that his prior low back complaints differed from his current problems and the prior problems are therefore not relevant to his current condition. (*See* Tr. 14, 32, 36-37). However, because claimant is not a medical expert, his conclusion in this regard is not reliable. *See Weston C. Foucher*, 45 Van Natta 1617, 1618 (1993) (Causation is a question for medical experts in a medically complex case)

[2] *See* Exs. 48, 51, 53; Tr. 25, 28, 31.

June 9, 1998 Cite as 50 Van Natta 1097 (1998)

In the Matter of the Compensation of
DEBRA L. COTTON, Claimant
WCB Case No. 97-07748
ORDER ON RECONSIDERATION
Craine & Love, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

The self-insured employer requests abatement of our May 18, 1998 Order on Review that affirmed the Administrative Law Judge's (ALJ's) order that directed the employer to pay claimant interim compensation. The employer further requests that this matter be held in deferred status pending the completion of Board review of another ALJ's order in WCB Case 97-10186 that upheld the employer's compensability denial of the claim for radial entrapment neuropathy. The employer contends that the upholding of its compensability denial of the underlying claim would remove the basis for the award of interim compensation. Claimant opposes the employer's motion, contending that the outcome of her appeal on the compensability denial would have no bearing on her right to interim compensation.

We deny the motion for deferral. As we stated in our prior order, it is well-settled law that the purpose of interim compensation is to compensate an injured worker for leaving work prior to acceptance or denial of the claim, even if the worker left work due to a noncompensable condition. *See Bono v. SAIF*, 298 Or 405, 410 (1984). When there is interim compensation due and payable pending acceptance or denial of the claim, as there was in this case, that compensation must be paid regardless of whether the claim is ultimately found compensable. *See Bono*, 298 Or at 410; *Jerry E. Bishop*, 48 Van Natta 1090 (1997).

The employer cites *Rustee R. St. Jean*, 49 Van Natta 2161 (1997) for the proposition that interim compensation is payable only if the worker has suffered a loss of wages due to "a work-related injury or disease." However, the issue in *St. Jean* was whether the *attending physician* related the claimant's disability to a work-related injury, not whether the claimed injury or disease was ultimately found compensable. We reasoned that, to trigger payment of interim compensation, the attending physician had to relate the claimant's disability to a work-related condition. Concluding that the attending physician did not relate the claimant's disability to a work-related condition, we held that interim compensation was not due and payable before issuance of the carrier's denial.

In this case, claimant's attending physician, Dr. Long, released claimant from her regular job and restricted her to "very light, non-repetitive hand work" due to chronic forearm and wrist pain. (Ex. 18-4). Dr. Long diagnosed radial entrapment neuropathy and indicated that it was related to, and a continuation of, claimant's compensable condition in 1993. (*Id.*) Therefore, we conclude that Dr. Long related claimant's disability to a work-related condition, thus triggering the employer's obligation to pay interim compensation.

Because claimant's entitlement to interim compensation was triggered by Dr. Long's reports and is not contingent on the compensability of her underlying claim, we conclude that the outcome of her appeal in WCB Case 97-10186 has no bearing on this case. Accordingly, we withdraw our May 18, 1998 order. On reconsideration, as supplemented herein, we republish our May 18, 1998 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

June 9, 1998 Cite as 50 Van Natta 1098 (1998)

In the Matter of the Compensation of
JAMES P. COZART, JR., Claimant
WCB Case No. 97-06540
ORDER ON RECONSIDERATION
Martin L. Alvey, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

On May 21, 1998, we abated our April 28, 1998 order that affirmed an Administrative Law Judge's (ALJ's) order that: (1) admitted Exhibit 22 (a post-reconsideration corrective report from the medical arbiter) into evidence; and (2) reduced claimant's award of scheduled permanent disability for a left arm condition from 13 percent (19.5 degrees), as awarded by an Order on Reconsideration, to 3 percent (4.5 degrees). We took this action to consider claimant's motion for reconsideration. Having received the SAIF Corporation's response, we proceed with our reconsideration.

In our initial order, we adopted the ALJ's conclusion that Exhibit 22 (a post-reconsideration corrective report from the medical arbiter) was admissible. On reconsideration, claimant again contends that the ALJ erred in admitting Exhibit 22 and that the ALJ's reliance on *Larry A. Thorpe*, 48 Van Natta 2608 (1996) was misplaced. For the following reasons, we disagree with claimant's contention.

In *Thorpe*, we held that ORS 656.268(6)(e) provided an exception to the general evidentiary prohibition set forth in ORS 656.283(7) and allowed the admission of a supplemental or clarifying report from the medical arbiter. In reaching this conclusion, we reiterated our prior conclusion in *Daniel L. Bourgo*, 46 Van Natta 2505 (1996), *aff'd Tinh Xuan Pham Auto v. Bourgo*, 143 Or App 73 (1996) that such reports were admissible if requested by the Department or when the initial report indicated that it was not complete. *Larry A. Thorpe*, 46 Van Natta at 2610. Conversely, "supplemental or clarifying" reports requested by a party are not considered "medical arbiter" reports for purposes of ORS 656.268(6)(e) and, therefore, are not admissible. *Id.; see also Constance I. Gassner*, 48 Van Natta 2596 (1996).

Here, there is no contention that Exhibit 22 was generated in response to a request from either party. In fact, the attached letter is from the Department and indicates that it had "received a corrected page from the recent medical arbiter report for this worker." Claimant's counsel did not contest this assertion. Under these circumstances, we continue to conclude that the ALJ properly admitted Exhibit 22 into evidence. *See Constance I. Gassner*, 48 Van Natta at 2597 n. 3.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our April 28, 1998 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
LANDY J. HAYHURST, Claimant
Own Motion No. 98-0158M
OWN MOTION ORDER
Employers Ins. of Wausau, Insurance Carrier

On April 20, 1998, claimant submitted a letter to the Board which we interpret as a request for penalties for the insurer's allegedly unreasonable delay in processing his own motion claim.

On April 7, 1998, the insurer submitted claimant's request for temporary disability compensation for his compensable herniated disc at L5-S1. The insurer recommended that we authorize the payment of temporary disability compensation. On April 9, 1998, we issued our order reopening claimant's claim for the provision of temporary total disability compensation beginning the date claimant is hospitalized for surgery. Claimant underwent surgery on April 10, 1998.

Claimant contends that he first notified the insurer of his worsened condition on March 9, 1998 and that the insurer was obligated to submit the claim for processing and approve the proposed surgery on that date. In the alternative, claimant contends that, in ordering an independent medical examination to determine the compensability as well as medical necessity of the proposed surgery, the insurer was unreasonably delaying the processing of the claim. Claimant further notes that had the insurer authorized the proposed surgery when the claim was first presented he would have been four weeks post surgery at the time of the reopening and would not have suffered the additional financial burden of waiting until April 9, 1998, when the claim was reopened.

By letter dated April 24, 1998, the insurer submitted its rebuttal. It points out that when the first chart notes were received on March 11, 1998, it immediately began processing the claim. The insurer further notes that the request for surgery was not submitted until March 23, 1998 and that the independent medical examination was scheduled on an expedited basis accommodating claimant's requests. Finally, the insurer concludes that it handled the claim within the timelines required by OAR 438-012-0030. We agree.

While we empathize with claimant's frustration over the administrative processing involved in this claim, we do not find that the insurer unreasonably delayed in processing claimant's request for own motion benefits. Accordingly, even assuming that we were authorized to assess penalties for an insurer's "pre-claim reopening order," claimant's request for penalties would be denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
GEORGE A. PAYNE, Claimant
WCB Case No. 96-07520
ORDER ON REMAND
Michael A. Bliven, Claimant Attorney
Roy Miller (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Pursuant to the court's June 3, 1998 order, we have been directed to consider the parties' settlement. The parties have submitted a proposed "Stipulation and 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 SAIF Corporation's denial, as supplemented in the agreement, "shall remain in full force and effect." The agreement further stipulates that "claimant withdraws the Request for Hearing," which "shall be dismissed with prejudice."

We have approved the parties' settlement, thereby fully and finally resolving this dispute, in lieu of all prior orders.[1] Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

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[1] A provision in the parties' settlement states that a portion of claimant's share of the proceeds shall be provided to a "non-workers' compensation insurance carrier" who has "reimbursed medical providers for a portion of their bills." Inasmuch as the parties' compensability dispute is being resolved by means of a Disputed Claim Settlement, only medical service providers may be directly reimbursed from the settlement proceeds. ORS 656.313(4)(c). (Health insurance providers may be directly reimbursed by the workers' compensation carrier when "the services are determined to be compensable." ORS 656.313(4)(b).) Nonetheless, because proceeds from a Disputed Claim Settlement are not considered "compensation," a claimant's assignment of all or a portion of his share of the proceeds is not prohibited by ORS 656.234. *Robert D. Surina*, 40 Van Natta 1855 (1988); *Theodule Lejeune, Jr.*, 40 Van Natta 493 (1988).

Here, we do not interpret the aforementioned settlement provision to represent that a non-workers' compensation insurance carrier will receive reimbursement directly from the workers' compensation carrier. Rather, in granting our approval of the settlement, we have interpreted the settlement as stating that claimant has assigned a portion of his share of the settlement proceeds to the non-workers' compensation carrier. Pursuant to *Lejeune* and its progeny, such an assignment is not contrary to ORS 656.234. Moreover, because the settlement also includes a list of medical service providers with outstanding billings on the date the settlement terms were agreed on, as well as the parties' acknowledgment that the proposed reimbursement complies with the statutory formula prescribed by ORS 656.313(4)(d), the agreement has received our approval. *See* ORS 656.313(4)(c); OAR 438-009-0010(2)(g), (h).

In the Matter of the Compensation of
RALPH W. MOORE, Claimant
WCB Case No. 97-09940
SECOND ORDER OF DISMISSAL
Bischoff, Strooband & Ousey, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

On May 29, 1998, we dismissed claimant's request for review of Administrative Law Judge (ALJ) Brown's April 2, 1998 order. Finding that claimant's request was not provided to the other parties within 30 days after the ALJ's April 2, 1998 order, we concluded that we lack jurisdiction to review the ALJ's order. We have now received another letter from claimant.[1] Claimant outlines his reasons for having missed his hearing and requests "any consideration for a new hearing date." We treat claimant's submission as a request for reconsideration of our May 29, 1998 order.

As noted in our May 29, 1998 Order of Dismissal, on April 2, 1998, ALJ Brown issued an order dismissing claimant's request for hearing. The order contained a statement explaining the parties' appeal rights which included a notice that a request for Board review must be mailed to the Board and to the other parties to the proceeding within 30 days following the issuance of the order.

On May 2, 1998, the Board received a hand-written letter from claimant In the letter, which was undated, claimant requested review of the ALJ's order.[2] Claimant's request did not indicate that copies had been provided to the other parties.

On May 29, 1998, we dismissed claimant's request for review of the ALJ's order, concluding that claimant's request was not timely provided to the other parties to the proceeding. Consequently, we held that we lacked jurisdiction to review the ALJ's order. *See* ORS 656.289(3); 656.295(2).

In reaching our decision, we recognized that claimant's request for review was timely received by the Board. However, we found that the employer's first notice occurred when it received a copy of the Board's May 7, 1998 letter acknowledging claimant's request for review. Since May 7, 1998 was beyond the 30-day appeal period, we determined that such notice was untimely. Our order also advised claimant that if he could establish that he mailed a request for review of the ALJ's order to the Board and to the other parties to the proceeding, within 30 days of the ALJ's April 2, 1998 order, he should submit the written information for our consideration. Finally, claimant was admonished to respond as soon as possible because our authority to reconsider our decision expired within 30 days after the date of our order.

In his most recent request, claimant reiterates his reasons for having missed his hearing before ALJ Brown. However, he does not address the issue of the untimely notice of his appeal to the other parties to the proceeding. Under such circumstances, we continue to conclude that we lack jurisdiction to review the ALJ's order and the reason for the dismissal of claimant's hearing request.[3]

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[1] Inasmuch as it does not appear that a copy of claimant's letter was mailed to the employer, we have included a copy with the employer's attorney's copy of this order.

[2] The request also sought abatement of the ALJ's April 2, 1998 order. As noted in our previous order, the 30-day period from the ALJ's order had expired by the time the request was brought to the ALJ's attention. Thus, the request was forwarded to the Board as an appeal of the ALJ's order.

[3] As noted in our previous order, we are mindful that claimant has taken these actions without benefit of legal representation. 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, since claimant is unrepresented, he 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, we withdraw our May 29, 1998 order. On reconsideration, as supplemented herein, we republish our May 29, 1998 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

June 10, 1998 Cite as 50 Van Natta 1102 (1998)

In the Matter of the Compensation of
RICHARD C. PURDY, Claimant
WCB Case No. 96-04364
ORDER ON REMAND
Scott McNutt, Sr., Claimant Attorney
Lundeen, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Pursuant to the court's June 3, 1998 order, we have been directed to consider the parties' settlement. 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 agreement further stipulates that "the Request for Hearing shall be dismissed with prejudice."

We have approved the parties' settlement, thereby fully and finally resolving this dispute, in lieu of all prior orders.[1] Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

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[1] The settlement provides that "there are no outstanding medical bills eligible for payment under ORS 656.313." In granting this approval, we interpret that provision as the parties' representation that there were no unpaid medical service provider billings in the insurer's possession on May 19, 1998 (the date the settlement terms were agreed on). *See* ORS 656.313(4)(c); OAR 438-009-0010(2)(g); *Robert E. Wolford*, 46 Van Natta 522 (1994).

In the Matter of the Compensation of
GARY R. MYHRE, Claimant
WCB Case Nos. 97-04446 & 96-11354
ORDER DENYING MOTION TO DISMISS
Foss, Whitty, et al, Claimant Attorneys
Cummins, et al, Defense Attorneys
Zimmerman & Nielsen, Defense Attorneys

Connecticut Indemnity has requested review of Administrative Law Judge (ALJ) Johnson's April 21, 1998 order that: (1) set aside its December 10, 1996 denial insofar as it pertained to claimant's degenerative lumbar condition; (2) set aside its April 16, 1997 denial insofar as it pertained to claimant's degenerative neck condition; (3) granted Georgia-Pacific Corporation's motion to dismiss claimant's request for hearing regarding Georgia-Pacific; (4) assessed Connecticut Indemnity a penalty for allegedly unreasonable claims processing; and (5) awarded claimant carrier-paid attorneys fees totaling $15,560.00, to be paid by Connecticut Indemnity. Representing that Connecticut Indemnity is not contesting its dismissal from the proceeding and noting that claimant has not filed a cross-request for review of the ALJ's order, Georgia-Pacific requests its dismissal as a party. The motion to dismiss is denied.

FINDINGS OF FACT

Claimant filed two separate requests for hearing regarding denials issued by Connecticut Indemnity and Georgia-Pacific. WCB Case No. 97-04446 pertained to Georgia-Pacific's May 19, 1997 denial of responsibility regarding claimant's cervical condition. WCB Case No. 96-11354 pertained to Connecticut Indemnity's December 10, 1996 and April 16, 1997 denials of claimant's lumbar and cervical conditions. These hearing requests were consolidated.

At the hearing held on September 3, 1997, Georgia-Pacific requested dismissal of claimant's request for hearing regarding his claim with Georgia-Pacific. On October 1, 1997, the ALJ issued an Interim Order of Dismissal dismissing claimant's hearing request regarding Georgia-Pacific. On April 21, 1998, ALJ Johnson issued an Opinion and Order. Pursuant to that order, the ALJ reaffirmed his interim dismissal order.

On May 12, 1998, Connecticut Indemnity timely requested Board review of ALJ Johnson's order. On May 14, 1998, the Board mailed letters to all parties to the proceeding acknowledging the request for review.

On May 27, 1998, Georgia-Pacific, after obtaining verbal confirmation from Connecticut Indemnity, informed the Board that it was not Connecticut Indemnity's intention in requesting review to "keep Georgia-Pacific in this matter, or to assert that there was any impropriety in dismissing Georgia-Pacific from the case." Consequently, Georgia-Pacific seeks dismissal of Connecticut Indemnity's appeal insofar as it pertains to WCB Case No. 97-04446.

CONCLUSIONS OF LAW AND OPINION

Although the ALJ's conclusions and opinions in consolidated cases may be separately stated, if the ALJ's decisions are contained in one final order, we retain jurisdiction to consider all matters contained therein. *Billy O'Neal*, 48 Van Natta 930 (1996); *Donald L. Melton*, 47 Van Natta 2290 (1995); *Riley E. Lott, Jr.*, 42 Van Natta 239 (1990); *William E. Wood*, 40 Van Natta 999 (1988).[1]

Here, the ALJ's determinations in WCB Case No. 96-11354 and dismissal of claimant's request for hearing in WCB Case No. 97-04446 were contained in one final, consolidated order. Inasmuch as that consolidated order has been appealed, we retain jurisdiction over that entire decision, and WCB

[1] As we have previously reasoned, had the ALJ issued separate, final, appealable orders to address the two separate case numbers and decisions, Connecticut Indemnity could have requested Board review of one or all of the separate orders. However, inasmuch as the April 21, 1998 order contained all final decisions and referenced both cases numbers, the ALJ's decisions cannot be separated by means of "dismissing" particular WCB case numbers. *See Shawn C. Mann*, 47 Van Natta 855 (1995); *Jerry R. Miller*, 44 Van Natta 1444 (1992).

Case Nos. 96-111354 and 97-04446 remain consolidated. *See Zurich Ins. Co. v. Diversified Risk Management*, 300 Or 47 (1985); *Mosley v. Sacred Heart Hospital*, 113 Or App 234 (1992); *Donald L. Melton, supra.* Nevertheless, since none of the parties apparently wish to contest the ALJ's decision regarding WCB Case No. 97-04446, any issue arising from the ALJ's dismissal of claimant's hearing request in that case will not be considered on review unless subsequently raised by one of the parties.

Accordingly, Georgia-Pacific's motion to dismiss is denied. The briefing schedule shall continue as previously implemented. Once the briefing schedule has been completed, the case will be docketed for Board review.

IT IS SO ORDERED.

In the Matter of the Compensation of
RANDAL S. LAW, Claimant
WCB Case No. C8-01225
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Cathcart & Borden, Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Member Bock and Biehl.

On May 29, 1998, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for his compensable injury. We approve the proposed disposition.

The first page of the proposed CDA provides that the total proceeds due claimant is $10,000 and the total due claimant's attorney is $2,000. This would equal a total consideration of $12,000. However, the total recited on the third page of the document is "$10,000" instead of $12,000. On page four of the CDA, the total consideration is consistently given as $12,000, with $2,000 payable as an attorney fee. Thus, the lone reference on page three of the document to a total consideration of $10,000 appears to be an error. Accordingly, we interpret the agreement as providing for a total consideration of $12,000, with a $2,000 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 $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.

In the Matter of the Compensation of
VERNA C. FLESCHER (FKA LOWELL), Claimant
WCB Case Nos. 96-11318 & 96-08459
ORDER ON REVIEW (REMANDING)
Malagon, Moore, et al, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) set aside its denial of claimant's claim for depression; (2) set aside its aggravation and current condition denial for claimant's low back condition; (3) declined to address an August 30, 1996 Order on Reconsideration that awarded 40 percent (128 degrees) unscheduled permanent disability for claimant's low back condition, 3 percent (4.5 degrees) scheduled permanent disability for the loss of use or function of her left leg and 6 percent (9 degrees) scheduled permanent disability for the loss of use or function of her right leg; and (4) declined to address a May 12, 1997 Order on Reconsideration that found no change in the previous award for permanent disability. Claimant cross-requests review.[1] On review, the issues are compensability, aggravation, extent of unscheduled and scheduled permanent disability and permanent total disability. We reverse in part, affirm in part, vacate in part, and remand in part.

FINDINGS OF FACT

Claimant compensably injured her low back on February 28, 1995 while working as a certified nursing assistant. (Ex. 15). The employer originally accepted a disabling low back strain on March 27, 1995. (Ex. 23). An MRI on April 7, 1995 showed a probable herniated disc with free fragment at L4-5, mild levoscoliosis of the lower lumbar spine with mild spondylolisthesis of L4-5 and diffuse degenerative changes. (Ex. 26).

On April 17, 1995, Dr. Kirkpatrick reported that claimant had "[s]evere bilateral lumbar radiculopathy secondary to L4-5 disk injury, pre-existing chronic disease, spondylosis and stenosis with instability." (Ex. 28-3). He recommended surgery.

The employer amended the acceptance to include a disabling "severe bilateral lumbar radiculopathy secondary to L4-5 disc injury." (Ex. 29).

On May 15, 1995, Dr. Kirkpatrick performed a bilateral L4-5 hemilaminectomy and nerve root decompression. (Ex. 31-4). He found that the disk space was calcified firmly on both sides at L4-5 and there was no actual disk herniation. (Exs. 31-3, 33). After surgery, claimant had persistent back and right leg pain and Dr. Kirkpatrick ordered further tests. Dr. Kirkpatrick performed a second surgery on June 26, 1995, which consisted of an L3-S1 laminectomy and nerve root decompression. (Ex. 36-2).

On September 27, 1995, Dr. Boice reported that claimant was "more depressed" and was crying at times. (Ex. 46). He diagnosed "[s]ituational depression related to back" and prescribed medication. (*Id.*)

A physical capacity evaluation performed on December 19, 1995 indicated that claimant was capable of sedentary/light activity. (Ex. 59). Dr. Boice concurred with the evaluation. (Exs. 63, 69).

On December 21, 1995, Dr. Church examined claimant on behalf of the employer. (Ex. 60). He concluded that 90 percent of claimant's problems were secondary to the preexisting spine condition and 10 percent due to soft tissue changes secondary to the work incident. (Ex. 60-25). He felt that claimant could perform sedentary work. (Ex. 60-30). Dr. Kirkpatrick concurred with Dr. Church's report. (Ex. 66).

After Dr. Boice retired, claimant began treating with Dr. Berven. On February 20, 1996, Dr. Berven reported that claimant's main problem had been arthritis and complications of a low back injury. (Ex. 70-1). He reported that she "has a history of depression that seems independent from her back difficulties, although certainly worsened by them." (*Id.*)

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[1] Although claimant filed a cross-request for review, she did not file a brief. The cross-request for review merely indicates that the ALJ erred as to the findings of fact and conclusions of law.

On March 5, 1996, claimant was determined to be eligible for vocational assistance. (Ex. 71-8). A vocational consultant recommended training services to increase claimant's earning capacity to a point closer to her adjusted weekly wage. (Ex. 74-1).

Drs. Kirkpatrick and Boice agreed that claimant was medically stationary on February 5, 1996. (Exs. 72, 73). A Determination Order dated April 10, 1996 awarded 29 percent unscheduled permanent disability for claimant's low back condition, 4 percent scheduled permanent disability for the loss of use or function of her left leg and 4 percent scheduled permanent disability for the loss of use or function of her right leg. (Ex. 76). Claimant requested reconsideration. (Ex. 82). Dr. Neumann performed an arbiter examination. (Ex. 91).

An Order on Reconsideration issued on August 30, 1996 awarded 40 percent unscheduled permanent disability for claimant's low back condition, 3 percent scheduled permanent disability for the loss of use or function of her left leg and 6 percent scheduled permanent disability for the loss of use or function of her right leg. (Ex. 94).

Claimant began a keyboarding class in June 1996 and an authorized training program in September 1996. (Exs. 87-1, 96). On October 24, 1996, Dr. Berven reported that claimant had numbness in both hands and pain in her arms. (Ex. 115-1). He diagnosed "thoracic outlet syndrome vs. carpal tunnel syndrome" and commented that it "seems to be related to her position at the computer." (*Id.*) Dr. Grant performed an electrodiagnostic evaluation and diagnosed bilateral carpal tunnel syndrome (CTS), moderately severe and chronic in nature. (Ex. 104-2).

On November 5, 1996, claimant's attorney filed a claim for upper extremity symptoms, asserting that the keyboarding and writing claimant had to do for the authorized training program were the major contributing cause of her present condition and need for treatment. (Ex. 100). Claimant's authorized training program ended on November 11, 1996 because her physician discontinued her classroom activities. (Ex. 103). On December 2, 1996, the employer denied the claim for current upper extremity problems. (Ex. 107). The employer indicated that the February 28, 1995 injury was not the major contributing cause of claimant's current upper extremity problems, including bilateral CTS. (*Id.*)

On November 22, 1996, Dr. Kirkpatrick reported that there was a "significant worsening" in claimant's status between claim closure in February 1996 and his recent evaluations in August and September 1996. (Ex. 105). He reported that claimant had a multilevel lumbar disc disease and spondylosis with spondyolisthesis and recurring lumbar radiculopathy. (*Id.*) He said claimant would probably require further surgery.

Dr. Peterson examined claimant on December 10, 1996. He diagnosed severe and progressive low back and bilateral leg pain due to spondylolisthesis at L4-5 and L5-S1, with probable spondylosis at L4 on the left, probable foraminal stenosis, lumbar disk desiccation, lumbar spondylosis and postlaminectomy syndrome. (Ex. 109-3). He recommended surgery.

Dr. Berven signed a "Notice of Claim for Aggravation of Occupational Injury or Disease" on December 5, 1996. (Ex. 110). Dr. Peterson signed a similar form on December 23, 1996. (Ex. 114).

On December 17, 1996, a Determination Order issued, awarding additional temporary disability compensation, but finding no change in the previous award for permanent disability. (Ex. 112). The Determination Order was corrected on December 23, 1996 (Ex. 113). Claimant requested reconsideration. (Ex. 116). On January 28, 1997, the Department dismissed claimant's request for reconsideration because she had requested withdrawal. (Ex. 121). Claimant subsequently requested reconsideration of the December 17, 1996 Determination Order. (Ex. 128).

On January 22, 1997, claimant was examined by Drs. Marble and Rich on behalf of the employer. They were unable to make any distinction as to what predated claimant's February 28, 1995 injury and what was present as a consequence of that injury. (Ex. 119-6). They said "two operations and almost two years down the road we are not going to be able to tell you today what portion of her complaints are related to the pre-existing pathology and what portion of her complaints are related to the effects of the injury combined wih the surgical procedures." (Ex. 119-7). However, Drs. Marble and Rich felt that it was reasonable to give claimant the "benefit of the doubt" and allow treatment to continue under the industrial insurance program. (*Id.*)

On February 4, 1997, Dr. Kirkpatrick reported that claimant had a complex syndrome secondary to multiple factors including lumbar disk injury with secondary deterioration, spondylosis and spondylolisthesis. (Ex. 124). He felt her condition was 45 percent secondary to her February 1995 work injury and 55 percent secondary to degeneration and previous disease. (*Id.*) Dr. Kirkpatrick was later deposed by the parties. (Ex. 139).

In February 1997, Dr. Peterson said he deferred to Dr. Kirkpatrick regarding the major contributing cause of claimant's need for treatment. (Exs. 126, 127). He agreed that claimant's current complaints included post-surgical instability, spondylosis and similar iatrogenic changes, as well as diffuse, preexisting degenerative disease. (Ex. 127). Dr. Peterson agreed it was impossible to offer an opinion as to the major cause of the current need for treatment. (*Id.*) Dr. Peterson was later deposed by the parties. (Ex. 140).

On February 28, 1997, Dr. Peterson performed an L3 to S1 posterolateral fusion. (Ex. 129-7). His postoperative diagnoses were "[s]tatus post L3-S1 decompression with recurrent multi-level foraminal stenosis, right worse than left, rotatory listhesis at L4-5 and spondylolisthesis at L5-S1." (*Id.*)

On March 7, 1997, the employer denied claimant's aggravation claim on the basis that the preexisting degenerative disease of the lumbar spine was the major cause of her current condition and need for treatment. (Ex. 130).

Dr. Laubengayer performed a records review for claimant on March 11, 1997. (Ex. 131). He opined that claimant's CTS was more than 50 percent related to the keyboarding work she began in Summer 1996. (Ex. 131-1).

On May 5, 1997, Dr. Sasser examined claimant on behalf of the employer. He reported that claimant did not currently have a diagnosable psychiatric condition. (Ex. 132-5). Based on his review of claimant's medical records and his discussion with claimant, Dr. Sasser concluded that there was no indication claimant's depression was related to her low back injury. (*Id.*)

A May 12, 1997 Order on Reconsideration affirmed the December 17, 1996 Determination Order, which was corrected on December 23, 1996. (Ex. 133). Among other things, the Department found that claimant failed to show she was permanently and totally disabled based on medical and non-medical factors. (Ex. 133-3).

On May 13, 1997, the employer denied claimant's claim for depression as a consequential condition of her February 28, 1995 injury. (Ex. 134). The employer asserted that the February 28, 1995 injury was not the major contributing cause of the depression and it contended that the depression claim was not filed in a timely manner. (*Id.*)

CONCLUSIONS OF LAW AND OPINION

Aggravation and Current Condition Denial

The ALJ concluded that claimant's current condition was compensable and the claim must be reopened for a third surgery. The ALJ found that Dr. Kirkpatrick was in the best position to weigh the causal factors and his testimony indicated that causation was "too close to call." Nevertheless, the ALJ reasoned that Dr. Kirkpatrick had no opinion on the accuracy of the diagnosis of spondylolisthesis and if that additional cause was added to the compensability side of Dr. Kirkpatrick's conclusion, claimant sustained her burden of proof.

The employer argues that claimant failed to prove that the compensable injury remains the major contributor to her low back problems and need for treatment.

Under ORS 656.273(1), a worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings. Two elements are necessary to establish a compensable aggravation: (1) a compensable condition; and (2) an "actual worsening." *Gloria T. Olson*, 47 Van Natta 2348, 2350 (1995). If the allegedly worsened condition is not a compensable condition, compensability must first be established under ORS 656.005(7)(a). *Id.*

We begin our analysis with a determination of whether claimant's current low back condition is a compensable condition. The employer initially accepted a disabling low back strain on March 27, 1995. (Ex. 23). The employer later amended the acceptance to include a disabling "severe bilateral lumbar radiculopathy secondary to L4-5 disc injury." (Ex. 29).

On November 22, 1996, Dr. Kirkpatrick reported that claimant had a multilevel lumbar disc disease and spondylosis with spondyolisthesis and recurring lumbar radiculopathy. (Ex. 105). On December 10, 1996, Dr. Peterson diagnosed severe and progressive low back and bilateral leg pain due to spondylolisthesis at L4-5 and L5-S1 with probable spondylosis at L4 on the left, probable foraminal stenosis, lumbar disk desiccation, lumbar spondylosis and postlaminectomy syndrome. (Ex. 109-3). He recommended surgery.

Because the diagnoses of claimant's current low back condition include spondylosis, spondyolisthesis and multilevel lumbar disc disease, we conclude that claimant's current low back condition is not the same as the low back strain and "severe bilateral lumbar radiculopathy secondary to L4-5 disc injury" accepted in 1995. Therefore, claimant must first establish that her current low back condition is a compensable condition.

As a fact finder, it is our obligation to apply the appropriate legal standards to determine the compensability of a worker's claim. *Daniel S. Field*, 47 Van Natta 1457 (1995) (citing *Hewlett-Packard v. Renalds*, 132 Or App 288 (1995)). The medical evidence establishes that claimant has preexisting degenerative changes in her lumbar spine. (Exs. 16-3, -4, 28-3, 60, 119-6, 139). Furthermore, the medical reports on causation establish that claimant's current low back condition combined with the preexisting degenerative disease in the lumbar spine. (Ex. 60-24, 119-6, -7, 124, 138, 139). Therefore, ORS 656.005(7)(a)(B) applies to this case. To establish compensability, claimant must prove that the February 28, 1995 compensable injury was the major contributing cause of the disability or need for treatment of her current combined condition. ORS 656.005(7)(a)(B). *See Gloria T. Olson*, 47 Van Natta at 2350-51.

After reviewing the record, we conclude that none of the medical opinions persuasively establish that claimant's February 28, 1995 compensable injury was the major contributing cause of the disability or need for treatment of her current combined low back condition.

Drs. Marble and Rich were unable to make any distinction as to what predated claimant's February 28, 1995 injury and what was present as a consequence of that injury. (Ex. 119-6). They said "two operations and almost two years down the road we are not going to be able to tell you today what portion of her complaints are related to the pre-existing pathology and what portion of her complaints are related to the effects of the injury combined wih the surgical procedures." (Ex. 119-7). Although they felt that it was reasonable to give claimant the "benefit of the doubt" and allow treatment to continue under the industrial insurance program, their opinion is not sufficient to establish compensability because it supports only a possibility that claimant's current condition is related in major part to the compensable injury. This is insufficient to carry claimant's burden. *See Gormley v. SAIF*, 52 Or App 1055 (1981) (probability, not possibility, is the requisite standard of proof).

Similarly, Dr. Kirkpatrick's opinion is not sufficient to establish compensability. Dr. Berven deferred to Dr. Kirkpatrick's opinion. (Ex. 123). Dr. Kirkpatrick performed claimant's first two back surgeries and he continued to treat her current low back condition. On February 4, 1997, Dr. Kirkpatrick reported that claimant had a complex syndrome secondary to multiple factors including lumbar disk injury with secondary deterioration, spondylosis and spondylolisthesis. (Ex. 124). At that time, he felt her condition was 45 percent secondary to her February 1995 work injury and 55 percent secondary to degeneration and previous disease. (*Id.*) In a letter from claimant's attorney dated May 28, 1997, Dr. Kirkpatrick agreed that it was "more probable than not that the injury, the surgeries, and the degeneration that is a direct consequence of the injury and surgeries are the major contributing cause (greater than 50%) for her recent surgery[.]" (Ex. 138-2).

However, in a deposition, Dr. Kirkpatrick said that he no longer agreed with his May 28, 1997 opinion. (Ex. 139-15, -16). He explained that there were three factors to claimant's condition: the preexisting degeneration of the spine, the injury and surgeries, and the extent to which they destabilized the spine. (Ex. 139-13, -14). Regarding causation, Dr. Kirkpatrick said that it was "such a close call" and he might change his mind morning to night. (Ex. 139-15). On the day of the deposition,

he would quantify causation as "50/50." (Ex. 139-16). He agreed with Dr. Marble that it was difficult, if not impossible, to determine what portion of claimant's problems was related to the preexisting pathology and what portion was related to the effects of the injury combined with the surgical procedures. (Ex. 139-16, -17). He agreed that causation was "too close to call." (Ex. 139-18). However, later in the deposition, he felt that "50 point 1 percent of the problems are due to the injury and 49 point 9 percent are due to preexisting disease." (Ex. 139-24).

In light of Dr. Kirkpatrick's statement that causation was "too close to call" and the equivocal nature of his testimony, we conclude that his opinion is not sufficient to establish compensability. Dr. Kirkpatrick agreed that it was difficult, if not impossible, to determine causation.

Dr. Peterson performed claimant's third back surgery. In February 1997, Dr. Peterson said he deferred to Dr. Kirkpatrick's opinion on causation of claimant's current low back condition. (Exs. 126, 127). Dr. Peterson agreed that the complexity of claimant's condition was such that it was impossible for him to determine which contributor was the major cause of claimant's need for treatment. (Ex. 127). On June 3, 1997, Dr. Peterson said that claimant's current condition was "indirectly related" to the work injury and subsequent treatment. (Ex. 135). In a later report, he said: "If previous surgeries were performed to treat sequela of the 2/28/95 injury then the most recent surgery should also be considered as treatment for the 2/28/95 injury." (Ex. 137-3).

In a deposition, Dr. Peterson testified that it was too difficult to determine the major cause of claimant's current low back condition and with new information after surgery, it was even more difficult to determine. (Ex. 140-11, -12). At surgery, Dr. Peterson found that claimant had spondylolisthesis and a rotatory listhesis. (Ex. 140-10). He testified that the conditions were either due to degenerative changes or possibly related to having had portions of her facet joints removed at previous surgery, but he could not determine which was the major cause. (*Id.*) He agreed with Dr. Kirkpatrick that causation was too close to call. (Ex. 140-13).

There are no other opinions that establish that claimant's February 28, 1995 injury was the major contributing cause of her current low back condition. Because claimant has not established a compensable condition, we need not address whether she has established an "actual worsening" pursuant to ORS 656.273. *See Gloria T. Olson*, 47 Van Natta at 2351.

Depression

The ALJ concluded that claimant had sustained her burden of proving compensability of the depression condition. The ALJ apparently relied on Dr. Sasser's opinion.

On review, the employer argues that the depression claim was filed untimely and the Board should dismiss the claim for lack of jurisdiction. Alternatively, the employer contends that the ALJ misinterpreted the medical evidence.

Although the employer asserts that claimant submitted the depression claim in 1997, we cannot determine from the record when the depression claim was actually submitted. In any event, although the employer's denial indicated that the depression claim was not filed in a timely manner pursuant to ORS 656.807 (Ex. 134), the employer did not pursue that argument at hearing. Claimant's attorney asserted that claimant sought treatment for situational depression from Dr. Boice in 1995 and requested that it be included in her claim. (Tr. 2). The employer's attorney asserted that there were no cross-issues on appeal. (Tr. 3). We find no evidence that the employer argued at hearing that the depression claim was not filed in a timely manner. For those reasons, we do not address the merits of employer's timeliness argument.

Because of the multiple possible causes of claimant's disability or need for treatment, this issue presents a complex medical question that must be resolved on the basis of expert medical evidence. *See Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 281 (1993).

We find no medical evidence that claimant's depression arose directly from her February 28, 1995 injury. The record indicates that depression was first diagnosed by Dr. Boice on September 27, 1995 (Ex. 46), three months after her second low back surgery. 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). In order to establish the compensability of her depression as a consequence of her

compensable low back condition, claimant must prove that her compensable injury was the major contributing cause of her consequential condition. ORS 656.005(7)(a)(A).

On September 27, 1995, Dr. Boice reported that claimant was "more depressed" and was crying at times. (Ex. 46). He diagnosed "[s]ituational depression related to back" and prescribed medication. (*Id.*) On October 24, 1995, Dr. Boice reported that claimant's "nerves are slightly worse" and she requested an increase in medication. (Ex. 49). One month later, Dr. Boice reported that claimant had depression secondary to back pain. (Ex. 56). Dr. Boice continued to diagnose depression in December 1995. (Ex. 61).

After Dr. Boice retired, claimant began treating with Dr. Berven. On February 20, 1996, Dr. Berven reported that claimant's main problem had been arthritis and complications of a low back injury. (Ex. 70-1). He reported that she "has a history of depression that seems independent from her back difficulties, although certainly worsened by them." (*Id.*) Although Dr. Berven prescribed "Prozac," he did not include depression in his list of diagnosable conditions. (*Id.*)

On May 5, 1997, Dr. Sasser examined claimant on behalf of the employer. He reported that claimant did not currently have a diagnosable psychiatric condition. (Ex. 132-5). Based on his review of claimant's medical records and his discussion with claimant, Dr. Sasser concluded that there was no indication that claimant's depression was a direct consequence of, or related to, her back problem. (*Id.*) He opined that it was not possible to determine from Dr. Boice's chart notes whether claimant's depression was a consequential condition because "his notes are so inadequate[.]" (*Id.*)

We agree with the employer the opinions of Dr. Sasser and Dr. Berven do not establish compensability. Dr. Berven's only comment as to causation of claimant's history of depression was that it seemed "independent from her back difficulties, although certainly worsened by them." (Ex. 70-1). Dr. Sasser concluded that there was no indication claimant's depression was related to her low back injury. (Ex. 132-5).

Similarly, we conclude that Dr. Boice's opinion is not sufficient to establish compensability. Dr. Boice's diagnosis of "[s]ituational depression related to back" is conclusory and lacks any explanation as to how the compensable injury led to the depression condition. He did not explain whether or not claimant's work injury was the major contributing cause of her depression.

Moreover, Dr. Boice did not evaluate the relative contribution of other possible causes of claimant's psychological condition. Beginning on March 30, 1992, Dr. Boice diagnosed claimant with a "[c]hronic stress reaction." (Ex. 10-2). He continued to diagnose a "chronic stress reaction" and "stress reaction" at various times through February 3, 1995, shortly before the compensable injury. (Exs. 10, 13, 14). 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. *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.* Dr. Boice did not comment on whether claimant's previous chronic stress reaction had any effect on her depression. Because Dr. Boice did not evaluate the relative contribution of other possible causes of claimant's psychological condition, we conclude that Dr. Boice's conclusory statements regarding claimant's depression are not sufficient to establish compensability.

There are no other medical opinions that establish compensability of claimant's depression. Consequently, we conclude that claimant did not sustain her burden of proving compensability of the depression condition.

Carpal Tunnel Syndrome

Citing *Edward J. Nicks*, 45 Van Natta 1613 (1993), the ALJ concluded that claimant had not established legal causation of her carpal tunnel syndrome (CTS). The ALJ also determined that claimant had not established medical causation.

We agree with the employer that, even if claimant developed CTS from keyboarding during the authorized training program, that does not establish compensability under ORS 656.005(7)(a)(B), because the major contributing cause is neither the original injury nor any medical treatment associated with that injury. *See Rogers v. Cascade Pacific Ind.*, 152 Or App 624 (1998); *Kephart v. Green River Lumber*, 118 Or App 76, *rev den* 317 Or 272 (1993) (upholding denial of shoulder injury sustained in the course of vocational rehabilitation; the compensable injury was not the major contributing cause of shoulder injury).

Moreover, we agree with the ALJ that claimant has not established medical causation. Dr. Laubengayer performed a records review and provided a conclusory, temporal analysis, indicating that because claimant's CTS symptoms occurred after she began keyboarding, the CTS was more than 50 percent related to the keyboarding work. (Ex. 131). In contrast, Dr. Grant was concerned that the chronic neuropathic disease showed a problem longer in duration than five months. (Ex. 104-3). Dr. Grant commented that the highest incidence of idiopathic CTS was in females who are middle-aged. He concluded that, at best, claimant's CTS was "equally related to idiopathic/premorbid factors mixed with the activity involved in the computer classes." (*Id.*) We agree with the ALJ that Dr. Laubengayer's opinion is not persuasive and claimant's bilateral CTS is not compensable.

Extent of Permanent Disability

The ALJ made no findings on extent of disability, concluding that claimant's current condition was compensable and the claim must be reopened for a third surgery.[2] Because we have upheld the employer's denial of claimant's current low back condition and depression, we must address claimant's requests for hearing on the August 30, 1996 Order on Reconsideration and the May 12, 1997 Order on Reconsideration. Although claimant has not submitted a brief on review, the ALJ's order indicates that claimant was appealing the extent of disability in both Orders on Reconsideration.

OAR 436-030-0155(6) provides for delivery to the Hearings Division of the original or certified copy of the record on reconsideration when a hearing is scheduled following the appeal of a reconsideration order and the parties or the ALJ requests such record. *See also* OAR 438-007-0018(7). In this case, we are unable to determine from the current record which documents were part of the record on reconsideration for either the August 30, 1996 Order on Reconsideration or the May 12, 1997 Order on Reconsideration. (Exs. 94, 133).

Under ORS 656.295(5), we may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. *Bailey v. SAIF*, 296 Or 41, 45 n. 3 (1985). In order to satisfy this standard, a compelling reason must be shown for remanding. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986). Here, there is an absence of evidence in the record showing specifically which documents were submitted on each reconsideration.[3] We find such absence renders the record incompletely developed and, thus, there is a compelling reason for remanding. *See Lillian L. Hornik*, 49 Van Natta 57 (1997).

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[2] In light of the ALJ's determination that the condition was compensable and required reopening, the ALJ should have rated claimant's extent of disability based on the accepted conditions at those claim closures. In evaluating claims at closure, the focus is on *accepted* conditions. *See James L. Mack*, 50 Van Natta 338, 339 (1998). Under *amended* ORS 656.262(7)(c), if a condition is found compensable *after* claim closure, the carrier is required to reopen the claim for processing regarding that condition. Thus, even if we were affirming the ALJ's compensability determination, we would remand to the ALJ to determine the "reconsideration record" and to rate claimant's extent of disability based on the accepted conditions at those claim closures.

[3] Although the Orders on Reconsideration contain some information describing the reconsideration record, it is not sufficient for our review. The worksheet attached to the August 30, 1996 Order on Reconsideration states that "the record developed at the time of claim closure on 4-10-96, and the medical arbiter report, will be considered in this reconsideration." (Ex. 94-4). However, we cannot determine from the present record what constituted the "record developed at the time of claim closure."

The worksheet attached to the May 12, 1997 Order on Reconsideration states:

> "Additional information was submitted by both parties for the record. The worker's attorney submitted copies of documents that were already a part of the claim file at closure, and also the following: Change of MD form dated 12-10-96, signed 12-23-96, surgery information form, 2-03-97 letter by Dr. Berven, vocation report date 2-06-97. The insurer submitted a 1-22-97 IME by Drs. Marble & Rich, 1-23-97 vocational closing reports, Dr. Kirkpatrick's 2-04-97 report, 1-12-97 ER notes by Dr. Hale at Merle West Medical Center, Dr. Berven's 2-03-97 letter and chart notes after claim closure from 12-16-96 through 2-04-97. These are accepted into the record and only considered to the extent that they clarify the worker's condition at the time of claim closure. See OAR 436-030-0155 and ORS 656.268(6)." (Ex. 133-2).

Although that worksheet contains some information as to the documents reviewed on reconsideration, we are unable to determine what documents claimant's attorney submitted "that were already part of the claim file at closure."

Accordingly, the issues regarding the August 30, 1996 Order on Reconsideration and the May 12, 1997 Order on Reconsideration are remanded to ALJ Stephen Brown for further proceedings consistent with this order. Those proceedings may be conducted in any manner that the ALJ determines achieves substantial justice. Following those further proceedings, the ALJ shall issue a final, appealable order regarding those issues.

ORDER

The ALJ's order dated December 17, 1997 is reversed in part, affirmed in part, and vacated in part. The portions of the ALJ's order that set aside the employer's aggravation and current condition denial, and the depression denial, are reversed. The employer's aggravation and current condition denial and its depression denial are reinstated and upheld. The ALJ's attorney fee awards are reversed. The portion of the ALJ's order that declined to address the August 30, 1996 and May 12, 1997 Orders on Reconsideration is vacated and that portion of the ALJ's order is remanded to the ALJ for further proceedings consistent with this order. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
GEORGE L. GRANT, Claimant
Own Motion No. 97-0361M
SECOND OWN MOTION ORDER ON RECONSIDERATION (DISMISSING)
Pozzi, Wilson, et al, Claimant Attorneys
Thomas A. Andersen, Defense Attorney

On August 27, 1997, we issued our Order on Reconsideration, in which we withdrew our August 7, 1997 Own Motion Order wherein we declined to reopen claimant's claim for the payment of temporary disability benefits because he failed to establish that his current condition required surgery or hospitalization. We found that the additional information claimant submitted regarding the surgery issue established that his current condition had worsened requiring surgery. However, we referred the case to the Hearings Division for a consolidated hearing with WCD Case No. 97-06418, since litigation was pending regarding the compensability of claimant's current condition, and claimant's work force status was at issue.

The insurer initially submitted claimant's request for temporary disability compensation for claimant's compensable 1982 industrial injury. Claimant's aggravation rights on that claim expired on January 16, 1982.

On March 31, 1998, we approved the parties' Claim Disposition Agreement (CDA), whereby claimant released his rights to the following workers' compensation benefits: temporary disability benefits, permanent disability benefits, vocational rehabilitation, survivor's benefits and aggravation rights, and all other workers' compensation benefits except compensable medical services under ORS 656.245.[1]

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[1] We also note that on March 19, 1998, Administrative Law Judge (ALJ) Herman approved a "Stipulation and Order for a Disputed Claim Settlement," which resolved the parties' dispute concerning the compensability of claimant's current back condition which includes, but is not limited to, lumbar degenerative disc disease, post laminectomy syndrome, unilateral left sided L5 spondylolysis, and large extruded free fragment/disc herniation at L4-5, with radiculopathy, which was pending before the Hearings Division. Pursuant to that settlement, claimant agreed that the insurer's August 1, 1997 denial would remain in full force and effect. In addition, claimant stipulated that his request for hearing "shall be dismissed with prejudice," and that payment shall be accepted in full settlement of "all issues raised or raisable."

In light of the parties' settlement, the current condition for which claimant requests own motion relief remains in denied status. Consequently, if claimant had not released his own motion rights through the Claims Disposition Agreement, we would still not be authorized to reopen claimant's 1982 injury claim with the insurer as he is not entitled to temporary disability compensation.

Inasmuch as the CDA resolves all pending own motion matters, claimant's request for Own Motion relief is dismissed.

IT IS SO ORDERED.

June 12, 1998 Cite as 50 Van Natta 1113 (1998)

In the Matter of the Compensation of
PATRICIA F. HARTNER, Claimant
WCB Case No. C8-01233
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Hollander, et al, Claimant Attorneys
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

On May 28, 1998, 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 CDA lists three dates of injury: May 11, 1996, December 31, 1996 and May 6, 1996 and three claim numbers: 20217242, 20274456 and 20285085. Based on the Department of Consumer and Business Services' records, the December 31, 1996 (20274456) and May 6, 1996 (20285085) claims are in denied status. Furthermore, the Board's records confirm that those claims have been resolved by a disputed claim settlement (DCS). Finally, the substance of the CDA is addressed solely to the May 11, 1996 (20217242) claim.

We have previously disapproved CDAs which attempted to dispose of denied claims. *See Salvador Preciado*, 48 Van Natta 1559 (1996); *Debra L. Smith-Finucane*, 43 Van Natta 2634 (1991). However, although the CDA lists the dates of injury of the December 31, 1996 and May 14, 1997 denied claims, the agreement itself disposes of only the May 11, 1996 claim. Under such circumstances, notwithstanding the reference to the December 31, 1996 and May 6, 1996 denied claims, we interpret the agreement as pertaining only to the May 11, 1996 accepted claim. *See Cynthia M. Bradley*, 50 Van Natta 137 (1998).

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 $1,750, payable to claimant's council, 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
RICARDO MENDOZA, Claimant
WCB Case No. C8-01065
ORDER ON RECONSIDERATION APPROVING CLAIM DISPOSITION AGREEMENT
Steven Schoenfeld, Claimant Attorneys
M. Kathryn Olney, Defense Attorney

Reviewed by Board Member Biehl and Bock.

On May 18, 1998, the Board approved 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 released his rights to future workers' compensation benefits, except medical services, for the compensable injury.

On May 28, 1998, we received the parties' addendum to the CDA clarifying the parties' intent to retain attorney fees for all future medical services disputes. The addendum also indicated that the total amount of permanent disability benefits awarded on the claim was 9 percent scheduled permanent disability and 55 percent unscheduled permanent disability. We treat the parties' addendum as a motion for reconsideration of the approved CDA.

In order to be considered, a motion for reconsideration of the approved CDA must be received by the Board within 10 days of the date of mailing of the final order. OAR 438-009-0035(1),(2). Because the request for reconsideration was received on May 28, 1998, within 10 days of the mailing of the order of approval, it is timely. OAR 438-009-0035(1). Thus, we grant the request for reconsideration.

The addendum clarifies that the parties intend a partial release of attorney fees. Specifically, the addendum amends the CDA so that attorney fees for all future medical services disputes are not released. The CDA also provides the amount of permanent disability awarded on the claim.[1] *See OAR 438-009-0022(4)(c).*

We find that the agreement, as amended by the parties' addendum, is in accordance with the terms and conditions prescribed by the Board. ORS 656.236(1). We do not find any statutory basis for disapproving the agreement. *Id.* Accordingly, by this order, the CDA is approved, as amended by the parties' addendum.

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.

[1] Although the addendum provides the amount of permanent disability awarded on the claim, the body of the CDA indicates that the first claim closure was rescinded by an Order on Reconsideration. As originally submitted, the CDA indicated that no permanent disability benefits had been awarded. Under such circumstances, we interpret the agreement to mean that permanent disability was initially awarded, but that a subsequent Order on Reconsideration rescinded the claim closure.

In the Matter of the Compensation of
DELFINO CERVANTES-LOPEZ, Claimant
WCB Case Nos. 97-07813 & 97-05567
ORDER ON REVIEW
Stanley Fields, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Johnson'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.

In its reply brief, the employer moves to strike claimant's respondent's brief as untimely filed. Under OAR 438-011-0020(2), the respondent shall file its brief within 21 days after the date of mailing of the appellant's brief. According to its certificate of mailing, the employer mailed its appellant's brief on April 13, 1998, *See* OAR 438-011-0020(2); OAR 438-005-0046 (filing of a brief may be accomplished by first class mail with postage pre-paid; an attorney's certificate indicating that a brief was deposited in the mail on the stated date is proof of mailing). Thus, claimant had until May 4, 1998 to file his respondent's brief. Claimant's brief, however, was not filed until May 5, 1998, the date his brief was mailed to the Board. Consequently, the brief was not timely filed and we do not consider it on review. *See Jim Wheeler,* 49 Van Natta 1607, *on recon* 49 Van Natta 1896 (1997) (declining to consider untimely respondent's brief); *Pablo A. Solorio,* 49 Van Natta 1066 (1997) (same).

We note, however, that our review is *de novo.* Therefore, we perform a complete review of the record, with or without claimant's brief.

Furthermore, insofar as we have rejected claimant's brief as untimely, no attorney fee pursuant to ORS 656.382(2), for services on Board review shall be awarded. *See Shirley M. Brown,* 40 Van Natta 879 (1988) (an untimely brief does not qualify as "legal representation . . . for the claimant . . . [upon] review on appeal" as that phrase is used in ORS 656.382(2)); *see also Robert B. Chambers,* 48 Van Natta 113 (1996); *Donald McNurlin,* 47 Van Natta 2232 (1995).

ORDER

The ALJ's order dated February 11, 1998 is affirmed.

In the Matter of the Compensation of
SANDRA M. GOODSON, Claimant
WCB Case No. 95-12846
ORDER ON REVIEW
Bischoff, Strooband, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Myzak's order that: (1) found that claimant's low back injury claim was not precluded by a prior Stipulation; (2) found that claimant timely filed a claim for a low back injury; (3) set aside the employer's denial of the low back injury claim; and (4) assessed a penalty for the employer's allegedly unreasonable failure to process the low back injury claim. On review, the issues are issue preclusion, timeliness, compensability, and penalties. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following exception and supplementation. We do not adopt the ALJ's second footnote.

The employer raised the issue of claim preclusion by the prior October 23, 1995 Stipulation at the beginning of the hearing. (Tr. 7). Although claimant responded that claim preclusion did not apply, she did not contend she was surprised by this issue or request a continuance of the hearing. (Id.)

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that the ALJ concluded that, because the employer failed to issue a written denial as required pursuant to ORS 656.262(6), the employer was precluded from raising any affirmative defenses, including preclusion by stipulated agreement and medical causation. In support of this finding, the ALJ stated that a carrier is bound by the express language of its denial, citing Tattoo v. Barrett Business Services, 118 Or App 348, 351-52 (1993).

After the ALJ's order was issued, the court decided SAIF v. Ledin, 149 Or App 94 (1997), in which it clarified that a carrier may amend its denial at hearing. In making this clarification, the court stressed that its earlier decision in Tattoo, 118 Or App at 351-52, did not hold that a carrier could not amend its denial at hearing.

Furthermore, 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 for continuance. Id.; OAR 438-006-0031, OAR 438-006-0036; OAR 438-006-0091.

We acknowledge that the denial in Ledin was a written denial, whereas in this case claimant's hearing request challenged the employer's failure to issue a written denial. Nevertheless, whether an amendment to issues raised at hearing is based on a written denial or a failure to issue a denial, the same policy considerations apply to freely allow the parties to amend the issues raised and relief requested at hearing. OAR 438-006-0031, OAR 438-006-0036. In addition, a motion for continuance would provide the same remedy to a party surprised or prejudiced by a late-raised issue whether that new issue was based on a written or oral denial.

Moreover, the sanction for failing to issue a timely written denial is the assessment of a penalty, where appropriate, for unreasonable claims processing. ORS 656.262(11). The sanction does not include a prohibition against raising affirmative defenses, provided that those defenses are timely raised at hearing and the claimant has the opportunity to request a continuance to cure any surprise or prejudice. Ted Hickman, 48 Van Natta 1073, 1075 n.2 (1996) (where compensability denial was litigated on one basis, additional basis first raised in closing argument not considered on review); Lawrence E. Millsap, 46 Van Natta 2112, 2112-13 (1995) ("We have consistently held that we will not consider an issue raised for the first time during closing argument." (citations omitted)).

Accordingly, for the above reasons, we find that the employer is not prevented from amending its response to claimant's hearing request and raising affirmative defenses at hearing, provided that claimant had the opportunity to request a continuance to cure any surprise or prejudice. Here, there is no indication that claimant was surprised or prejudiced by the issues of timeliness, claim preclusion, and medical causation. In this regard, claimant did not contend that she was surprised or prejudiced by these issues and did not request a continuance. Instead, at hearing, claimant submitted evidence, testimony, and argument regarding all of these issues. See Weyerhaeuser Co. v. Bryant, 102 Or App 432, 435 (1990) (when it is apparent from the record that the parties tried a case by agreement with a particular issue in mind, it was improper for the ALJ and Board not to decide that issue); Gary M. Emmerson, 49 Van Natta 1080 (1997) (where the parties tried the issue of causation by implicit agreement, i.e., without objection, the issue was properly before the ALJ). Therefore, we proceed to the merits.

Timeliness

Claimant has two compensable claims with this employer: (1) a compensable bilateral foot condition; and (2) a compensable lumbar strain condition that was caused by an altered gait resulting from treatment of the compensable foot condition. Neither of those claims is at issue in the present case. The issues in this case relate to a specific work incident that occurred in mid-March 1994 when claimant felt a pop/snap in the right side of her low back as she was standing on a ladder, reaching and twisting to the right to place a box weighing about ten pounds on an overhead shelf.

The parties agree that, because this claim arose before the passage of Senate Bill 369, former ORS 656.265 applies to determine whether the claim was timely filed. In this regard, the terms of amended ORS 656.265 do not apply retroactively because those amendments would materially affect the time limits for taking action. Or. Laws 1995, ch. 332, § 66(6); Norstadt v. Murphy Plywood/Liberty Northwest Ins. Corp., 148 Or App 484, 492 fn. 2 (1997) (relying on SB 369 § 66(6), court found 1995 amendments to ORS 656.265(1) would not be applied retroactively).

Former ORS 656.265(1) required that a claimant give an employer notice of an accident resulting in injury within 30 days. Failure to give timely notice barred the claim, unless the employer had knowledge of the injury or had not been prejudiced by its failure to receive notice. Former ORS 656.265(4). It is claimant's burden to establish that her claim was timely filed. ORS 656.266; see Donald H. Becker, 44 Van Natta 390 (1992); Marty Winn, 42 Van Natta 1013 (1990). If the claim was not timely filed, the burden is on the employer to prove prejudice due to lack of notice. Argonaut Insurance Co. v. Mock, 95 Or App 1, 6, rev den 308 Or 79 (1989). Passage of time alone is not sufficient to meet the employer's burden of proving actual prejudice due to lack of notice. Id.

Even assuming that claimant did not timely file her back injury claim, the employer has not proven actual prejudice by failure to receive timely notice. The employer states that it was prejudiced because, in the interim between the alleged March 1994 work injury and the November 1995 request for hearing on that injury, a prior ALJ had found claimant's lumbar strain condition compensable as a consequential condition caused by an altered gait due to her compensable bilateral foot condition. However, the back injury presently at issue, the L5-S1 annular fissure, is separate from the lumbar strain condition caused by claimant's altered gait which was at issue in the prior hearing. As claimant argues, the fact that there were separate hearings involving separate claims does not prove actual prejudice. Therefore, even assuming claimant untimely filed her back injury claim, the employer failed to prove actual prejudice. Accordingly, we proceed to the merits.

Claim Preclusion

On October 23, 1995, the parties entered into a Stipulation and Order regarding nonpayment of medical bills related to claimant's accepted bilateral foot condition. (Ex. 37). The parties agreed that the Stipulation "resolve[d] all issues or claims that were raised or that could have been raised as of the date of approval of this settlement." (Ex. 37-2).

At hearing and on review, the employer argued that this prior Stipulation precluded claimant from raising the present issue of compensability of a low back injury. The ALJ found, and claimant argues, because the employer did not issue a written denial, it is precluded from relying on claim preclusion as a defense against the present low back injury claim. We have found above that the employer permissibly amended its position at hearing to raise the issue of claim preclusion. Nevertheless, we need not address this argument because we find that claimant's back injury claim fails even if it is not precluded.

Compensability

As with the claim preclusion issue, the ALJ found, and claimant argues, because the employer did not issue a written denial, it is precluded from raising the issue of medical causation. However, we have found above that the employer permissibly amended its position at hearing to raise the issue of medical causation. Therefore, we proceed to the merits.

Claimant has a compensable bilateral foot condition and a compensable low back strain as a consequence of treatment for that foot condition. The issue before us is the compensability of a discrete low back injury, which occurred in mid-March 1994.

The record establishes and the parties do not dispute that claimant had preexisting degeneration at L5-S1 which combined with the March 1994 work injury and that both the preexisting condition and the work incident contributed to claimant's need for treatment. (Exs. 39, 46, 47-10). Therefore, in order to establish compensability, claimant must prove that the work injury in mid-March 1994 was 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 149 Or App 309, 312 (1997). Determination of the major contributing cause involves evaluating the relative contribution of different causes of claimant's need for treatment of the combined condition and deciding which is the primary cause. Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev dismissed 320 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). Claimant asserts that she has met this burden of proof. We disagree.

Only the opinions of claimant's later treating physicians, Drs. Karasek, M.D., and Miller, neurosurgeon, might support a finding that the March 1994 work injury was the major contributing cause of claimant's need for medical treatment or disability for her combined condition. However, for the following reasons, we find their opinions do not meet claimant's burden of proof.

A January 1996 diskogram revealed diffuse degenerative changes in claimant's L5-S1 disc, with a broad tear in the annulus. (Ex. 38A). Based on this diskogram, Dr. Miller determined that claimant had a one level degenerative disc disease that was entirely responsible for her pain. (Ex. 42). He also stated that claimant had a "primary degenerative condition of L5-S1 related to an industrial injury with ongoing severe unrelenting pain." (Id.) Because of claimant's failure to respond to conservative measures, Dr. Miller recommended an L5-S1 interbody fusion. (Id.)

In a February 14, 1996 conversation summary presented by the employer's attorney, Dr. Miller indicated that the mechanism of the March 1994 work incident would not likely have caused the annulus tear in the absence of the preexisting degenerative disk. (Ex. 45-1). He stated that the March 1994 work incident combined with the preexisting degenerative process and precipitated claimant's need for treatment. He also indicated that it was not possible to state whether the degenerative disease, the specific incident or neither was the major contributing cause of claimant's need for treatment or disability. (Id.) Dr. Miller added the following handwritten comment to this conversation summary: "I think it is significant that [claimant's] chronic pain problem started only after her work injury. I do not think that can be ignored and therefore I do think the injury likely played a significant role in her present pain problem." (Id.) (Emphasis in original).

In a March 27, 1996 conversation summary presented by claimant's attorney, Dr. Miller indicated that claimant sustained an annular fissure caused by the work incident, which caused further pathological change to an already degenerated disc. (Ex. 46-1). He agreed with Dr. Karasek that the work incident constituted a major contributing cause of claimant's present back condition and need for surgery. (Id.) Finally, he indicated that his handwritten comment quoted above was "meant to convey the fact that the twisting incident at work constituted a major event that caused [claimant's] present pain problem and annular fissure in her disc." (Id.)

Dr. Miller was deposed and testified that "the degenerative change leads to the fissure" and, with a "normal disc, lifting and twisting something is not going to cause a painful anulare [sic] fissure." (Ex. 47-9). He agreed that claimant's condition is a combination of the degenerative condition and the specific incident. (Ex. 47-10). He agreed that his handwritten statement at the bottom of Exhibit 45 was consistent with his prior statements in that conversation summary. (Ex. 47-17-19). He testified that the work incident caused the fissure and the fissure is what needs treatment. (Ex. 47-21). However, when

asked if he could tell whether the work incident did anything more than precipitate the fissure, Dr. Miller responded that he did not know. (Ex. 47-24). He stated that without the incident, claimant would not have needed treatment, but without the degenerative condition, she would not have "had that." Id.

Dr. Karasek initially opined that the twisting incident at work "probably was a further tear of an already degenerative annulus," which led to claimant's need for treatment. (Ex. 39). In a conversation summary, Dr. Karasek agreed that the work "incident was the cause, in major part, to additional tearing of the annulus of this disc and of [claimant's] need for treatment." (Ex. 40-1). Subsequently, Dr. Karasek opined that the "annular fissure then, by history, was probably precipitated by the twisting event and is the cause for [claimant's] seeking care." (Ex. 44-1). Although Dr. Karasek stated that the fissure was the cause of claimant needing treatment at this time, he also stated that whether the preexisting degenerative change or the activity leading to the acute annular fissure was the major contributing cause of claimant's current pain condition was a "legal point," not a "medical point." (Ex. 44-2).

Although isolated parts of Dr. Miller's opinion might support claimant's position, when read as a whole, his opinion simply contains too many inconsistencies to be persuasive. At most, Dr. Miller opined that the work incident precipitated the L5-S1 annular fissure. Dr. Karasek expressed the same opinion regarding the work incident being the precipitating event. However, the "precipitating" or immediate cause of an injury may or may not be the "major contributing cause." Dietz v. Ramuda, 130 Or App at 401. Neither Dr. Miller nor Dr. Karasek weighed the relative contributions from claimant's preexisting degenerative condition and the work incident, nor did they explain why the work injury contributed more to the claimed condition than the preexisting degenerative condition. In the end, both physicians seemed unable to provide this explanation. SAIF v. Nehl, 149 Or App at 312; Dietz v. Ramuda, 130 Or App at 401; see 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 her burden of proof under ORS 656.005(7)(a)(B).

Penalties

Because we find that claimant failed to prove compensability of her back injury claim, there are no amounts "then due" upon which to assess a penalty for the employer's unreasonable failure to process the claim. ORS 656.262(11); Anderson v. E.B.I. Companies, 79 Or App 345 (1986) (no assessment of penalty where the claimant had failed to prove compensability of an aggravation claim that had been "de facto" denied).

ORDER

The ALJ's order dated May 5, 1997 is reversed. The self-insured employer's denial is upheld. The ALJ's attorney fee award is reversed.

June 12, 1998 Cite as 50 Van Natta 1119 (1998)

In the Matter of the Compensation of
ERIC S. GUNN, Claimant
WCB Case No. 97-00901
ORDER OF ABATEMENT
Black, Chapman, et al, Claimant Attorneys
Charles L. Lisle, Defense Attorney

Pursuant to our May 15, 1998 Order on Review, we upheld the self-insured employer's partial denial of claimant's injury claim for left shoulder rotator cuff tendinitis and subacomial bursitis, reduced an Administrative Law Judge's (ALJ's) attorney fee award from $3,600 to $1,800, and affirmed the ALJ's award of interim compensation between November 12, 1996 and February 6, 1997. The employer seeks reconsideration of our interim compensation award, contending that claimant is not entitled to these benefits because he voluntarily left modified work with the employer for reasons unrelated to his compensable injury.

In order to further consider this matter, we withdraw our May 15, 1998 order. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 14 days from the date of this order. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
BRUCE R. PALANUK, Claimant
WCB Case No. 97-06874
ORDER ON RECONSIDERATION
Cole, Cary & Wing, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

On May 22, 1998, we abated our April 22, 1998 order that affirmed an Administrative Law Judge's (ALJ's) order that: (1) set aside the SAIF Corporation's partial denial of claimant's injury claim for a right knee condition; (2) awarded a $3,400 carrier-paid attorney fee under ORS 656.386(1); and (3) assessed SAIF a penalty for untimely claim processing. We took this action to consider SAIF's motion for reconsideration.

SAIF asks us to reconsider the portion of our order which did not address the ALJ's penalty assessment. Specifically, contending that its conduct was not unreasonable, SAIF seeks reversal of the ALJ's penalty assessment. Having considered SAIF's motion and claimant's response, we proceed with our reconsideration.

The issues on review were compensability and the amount of the attorney fee for services on review. SAIF did not contest the ALJ's penalty assessment in its appellate briefs. Because SAIF seeks to revisit an issue addressed by the ALJ but not raised on review until reconsideration, we decline to consider it. *See Estella M. Cervantes*, 49 Van Natta 336, 336-37 (1997); *Annette E. Farnsworth*, 48 Van Natta 508, 509 (1996); *Betty J. Lowe-Harpole*, 46 Van Natta 2343, 2343-44 (1994).

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our April 22, 1998 order.[1] The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] Inasmuch as penalties do not constitute "compensation" for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for his counsel's services on reconsideration. *Saxton v. SAIF*, 80 Or App 631 (1986).

In the Matter of the Compensation of
CAROL J. INGRAM, Claimant
WCB Case No. 97-06351
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Reinisch, Mckenzie, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Galton's order that set aside its partial denial of claimant's occupational disease claim for right radial tunnel syndrome (RTS) and right cubital tunnel syndrome (CTS) conditions. On review, the issue is compensability.[1] We reverse in part, modify in part, and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Radial Tunnel Syndrome

The ALJ set aside the insurer's denial of claimant's RTS condition, based on the opinion of Dr. Puziss, treating physician. The insurer argues that claimant does not have RTS. We agree that the record fails to establish that claimant has RTS.

Claimant is correct that the medical evidence includes numerous references to radial nerve symptoms. (*See* Exs. 4-2, 6-1, 7-4, 7-6, 8-1-2, 9-2-3, 13, 16-1, 23, 24-2, 32d-7). However, in light of claimant's multiple upper extremity complaints, the diagnostic import of these symptoms is unclear. On some occasions, Dr. Puziss suspected "possible" RTS (*see e.g.*, Exs. 8, 13, 16); on one occasion, he referred to "probable" RTS (Ex. 24); on other occasions, he failed to mention RTS at all (*see e.g.*, Exs. 4, 6, 25, 27, 28, 30). Accordingly, on this inconsistent record (specifically, Dr. Puziss' apparent uncertainty), we cannot say that claimant has RTS.

Nonetheless, we note that, after the July 11, 1997 partial denial, Dr. Puziss stated: "I am not presently diagnosing radial tunnel syndrome, however, although I have in the past." (Ex. 33-1). Thus, based on Dr. Puziss' assertion that he *had* diagnosed RTS in the past, we find that the partial denial of RTS was a procedurally valid precautionary denial when it issued.[2] *See Reynolds Metals v. Mendenhall*, 133 Or App 428, 434 (1995) (Where the insurer could reasonably interpret the claim to encompass the denied condition, the denial was proper); *Weyerhaeuser Co. v. Warrilow*, 96 Or App 34, *rev den* 308 Or 184 (1989) (same); *Alton D. Simons*, 48 Van Natta 860, 861-62 (1996) (same). Moreover, because there is no persuasive evidence indicating that claimant does have RTS, we reverse the portion of the ALJ's order that directed the insurer to accept and process a claim for RTS.

Cubital Tunnel Syndrome

We adopt the ALJ's reasoning and conclusion regarding claimant's CTS condition, with the following exception, modification, and supplementation.

We do not find Dr. Wilson's opinion unpersuasive based on his "refusal to accept the law of the case." (*See* Opinion and Order p.5).

Because claimant's CTS condition results from repetitive overuse at work, we apply ORS 656.802, rather than ORS 656.005(7).

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[1] In her brief, claimant requests an attorney fee for services related to the insurer's pre-hearing rescission of its partial denial of claimant's current condition.

[2] There is no contention that the insurer previously accepted a "combined condition" or that the claim for RTS was a claim for a "new medical condition" filed after claim acceptance. Therefore ORS 656.262(7)(a) & (b) do not apply. *See Vicki L. Davis*, 49 Van Natta 603 (1997); *Ramona E. Hamilton*, 48 Van Natta 2438 (1996); *Robin W. Spivey*, 48 Van Natta 2362 (1996).

Finally, we acknowledge the insurer's contention that Dr. Puziss' opinion is insufficient to establish compensability because it is based solely on temporal circumstances and deductive reasoning. However, we find that Dr. Puziss had an accurate history regarding claimant's work activities and his opinion is based on the nature of those activities (and the likely interaction between claimant's multiple compensable overuse conditions), as well as the absence of off-work, preexisting, and constitutional contributors. Under these circumstances, we agree with the ALJ that Dr. Puziss' opinion persuasively supports claimant's CTS claim.

Attorney Fees

Because we have concluded that the insurer's denial of claimant's RTS claim should be upheld, we modify the ALJ's $3,000 attorney fee award as follows. After considering the factors set forth 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 the hearing level regarding the CTS claim and rescission of the current condition denial is $2,250, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by the record and claimant's counsel's fee requests), the complexity of the issues, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Claimant's attorney is also entitled to an assessed fee for services on review regarding the CTS denial which remains set aside. 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 that issue is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated December 2, 1997 is reversed in part, modified in part, and affirmed in part. That portion of the ALJ's order that set aside the insurer's partial denial of claimant's right RTS condition is reversed. That portion of the denial is reinstated and upheld. The ALJ's $3,000 attorney fee is modified. In lieu of the ALJ's attorney fee award, claimant is awarded a $2,250 attorney fee, payable by the insurer. The remainder of the ALJ's order is affirmed. For services on review regarding the right CTS condition denial, claimant is awarded an $1,000 attorney fee, to be paid by the insurer.

In the Matter of the Compensation of
DONALD ROWLAND, JR., Claimant
WCB Case No. 97-04593
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
Thaddeus J. Hettle, Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Nichols' order that upheld the self-insured employer's partial denial of claimant's injury claim for a cervical disc condition. On review, the issue is compensability.[1]

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

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[1] We acknowledge the employer's arguments that: (1) Exhibits 51A and 52 (a November 4, 1997 letter from claimant's counsel to Dr. Camacho and Dr. Camacho's December 2, 1997 response) should be excluded from the record; and (2) proposed Deposition Exhibit 51(1) (an August 22, 1997 letter from the employer's counsel to Dr. Camacho) should be admitted. We do not address these arguments because the result would be the same even if we considered the latter and did not consider the former.

We agree with the ALJ that Dr. Camacho's delayed and limited contacts with claimant do not justify deference based on "treating physician" status. *See McIntyre v. Standard Utility Contractors,* 135 Or App 298, 302 (1995) ("A treating physician's opinion [] is less persuasive when the physician did not examine the claimant immediately following the injury.") (citing *Kienow's Food Stores, Inc. v. Lyster,* 79 Or App 416, 421 (1986); *Marshall v. Boise Cascade,* 82 Or App 130, 134 (1986)); *William D. Brizendine,* 50 Van Natta 21, 22 (1998).

We also conclude that Dr. Camacho's opinion does not persuasively support the claim, for the following reasons. First, there is no indication that Dr. Camacho was aware of claimant's pre-injury upper back symptoms. (*See* Exs. 11, 16, 24-3, 46-2; Tr. 8). Consequently, we cannot say that the doctor's opinion is based on an accurate and complete history. *See Somers v. SAIF,* 77 Or App 259 (1986).

In addition, we note that Dr. Camacho specifically reported that claimant had cervical disease and acknowledged that this condition contributed to claimant's "discomfort related to his injury on September 20, 1996." (Ex. 48A; *see also* Exs 46-6-8, 51-20-21). However, we find no indication that Dr. Camacho evaluated and weighed the relative contributions from claimant's preexisting disc condition and his work injury in reaching his causation opinion. Under these circumstances, we agree with the ALJ that Dr. Camacho's opinion is inadequately explained. *Richard A. Longbotham,* 48 Van Natta 1257, 1258 (1996) (Because a finding of major causation requires a comparison between off-work and work-related causes and doctor performed no such analysis, his conclusions were insufficiently supported) (citing *Dietz v. Ramuda,* 130 Or App 397 (1994)). Accordingly, for these reasons, as well as those set out by the ALJ, we conclude that the claim must fail.

ORDER

The ALJ's order dated February 18, 1998 is affirmed.

June 16, 1998 Cite as 50 Van Natta 1123 (1998)

In the Matter of the Compensation of
KATHRYN C. LOEKS, Claimant
Own Motion No. 96-0571M
OWN MOTION ORDER OF ABATEMENT
Kemper Ins. Co., Insurance Carrier

Claimant requests reconsideration of our May 18, 1998 Own Motion Order, in which we denied claimant's request for review the insurer's January 29, 1998 Notice of Closure because her request was untimely. Because we are unable to determine whether claimant submitted a copy to the insurer, we are forwarding a copy of claimant's June 11, 1998 request for reconsideration to the insurer.

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
JONI M. VARAH, Claimant
WCB Case No. 97-06270
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by the Board en banc.

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

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The SAIF Corporation issued a Notice of Acceptance that accepted claimant's claim as a "thoracolumbar muscular back strain, resolved." (Ex. 4). Claimant filed a hearing request, raising the issue of an improper "prospective denial." In response, SAIF issued a modified acceptance notice, eliminating the word "resolved" and accepting the compensable condition as a "thoracolumbar muscular strain." (Ex. 6). Claimant then filed a supplemental hearing request, requesting an attorney fee under ORS 656.386(1) for obtaining rescission of a denial prior to an ALJ's decision.

While acknowledging case authority interpreting former ORS 656.386(1) that would support the award of an assessed fee,[1] the ALJ nevertheless declined claimant's request for an attorney fee. The ALJ reasoned that, because amended ORS 656.386(1) now required an express refusal to pay compensation, an implication that future compensation might be denied no longer satisfied the statute.[2]

On review, claimant contends that she is entitled to an assessed fee pursuant to ORS 656.386(1). We agree.

Subsequent to the ALJ's order, in Galbraith v. L.A. Pottsratz Construction, 152 Or App 790, the court, in banc, reversed our decision in Michael J. Galbraith, 48 Van Natta 351 (1996), that had declined to award the claimant a carrier-paid attorney fee under ORS 656.386(1) when the carrier accepted a claim at a hearing. Finding that the carrier's response to the claimant's hearing request (which stated that the claimant was "entitled to no relief") did not constitute an "express denial of compensation," we held that claimant had not prevailed over a "denied claim."

The court reversed. Determining that the claimant's claim for fractures related to his accepted paraplegia was a claim for a consequential condition, the court concluded that the carrier's response to the claimant's hearing request regarding a "de facto" denial (which stated that the claimant was entitled to no relief) constituted an express denial of the claim on the basis that claimant's injury did not give rise to an entitlement to any compensation. Although the claimant's medical bills had been paid when the carrier accepted the claim, the court reasoned that the "relief" to which the claimant was entitled was the acceptance of the "consequential condition" claim (which included the recovery for any further loss of earning capacity or for any later worsening or aggravation).

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[1] The ALJ cited our decision in Gary L. Best, 46 Van Natta 1691 (1994), in which the carrier accepted the claimant's osteomyelitis condition as "resolved." We held that the term "resolved" implied that the carrier was no longer responsible for future benefits for the claimant's condition, and, therefore, that the carrier's notice constituted an improper denial of future responsibility relating to an accepted claim. Under such circumstances, we further held that the claimant's counsel was entitled to an attorney fee under former ORS 656.386(1) for efforts in setting aside the carrier's "prospective denial."

[2] The legislature in 1995 amended ORS 656.386(1) to provide that "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 added). In 1997, the legislature renumbered the relevant portion of the statute but did not change the wording. See ORS 656.386(1)(b).

The Galbraith court relied on Kimberly Quality Care v. Bowman, 148 Or App 292 (1997), where a carrier's response to a hearing request (stating that the claimant had not sustained a work-related injury or disease) was an express denial on the grounds that the claimed conditions were not related to the employment. In Bowman, the court acknowledged that a carrier's "check-the-box" notation in its response did not satisfy the requirements for a denial. Nonetheless, the Bowman court reasoned that the response unequivocally expressed the carrier's denial of compensability and, upon its rescission, entitled the claimant to an attorney fee award.

Here, SAIF did not literally state that claimant was entitled to no relief. Nevertheless, when SAIF issued its acceptance of a "resolved" condition, it was well-settled (based on Best and its progeny) that such an acceptance constitutes a denial of further benefits under the claim. In light of such circumstances, and consistent with the Galbraith and Bowman holdings, we find that SAIF's written acceptance of a "resolved" condition constitutes an express denial of the claim on the basis that the condition will not give rise to an entitlement to any compensation.[3] Thus, when SAIF rescinded its denial after claimant's hearing request, claimant's counsel became entitled to an assessed fee under ORS 656.386(1).[4] Galbraith v. L.A. Pottsratz Construction, 152 Or App at 795.

We now turn to the determination of that fee. After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's pre-hearing services in obtaining rescission of SAIF's prospective denial is $1,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated November 14, 1997 is reversed. Claimant's counsel is awarded an assessed fee of $1,000 pursuant to ORS 656.386(1), payable by SAIF.

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[3] The ALJ also concluded that our decision in Charles L. Wallace, 49 Van Natta 52, on recon 49 Van Natta 472 (1997), a case decided under amended ORS 656.386(1), did not support an assessed fee in this case. In Wallace, we held that a denial which attempted to limit a carrier's acceptance to a "resolved" low back strain was an impermissible denial of future responsibility where the carrier had unequivocally accepted a low back strain. Without discussion, we awarded an assessed fee pursuant to amended ORS 656.386(1) for the claimant's counsel's efforts in setting aside the prospective denial. The ALJ concluded that, given the lack of discussion of the amended statute in Wallace and his belief that our decision in that case was contrary to our holding in cases such as Michael Galbraith, Wallace was not intended to hold that an assessed fee under ORS 656.386(1) is available for an attorney who is instrumental in obtaining rescission of an implied denial of future responsibility for a condition. We need not determine the effect of our holding in Wallace, inasmuch as the court's Galbraith rationale provides sufficient authority for our conclusion that an assessed fee pursuant to ORS 656.386(1) is available in this case.

[4] The dissent asserts that SAIF's use of the word "resolved" was likely "superfluous." Considering the longstanding rationale expressed in Best and its progeny, we do not share the dissent's interpretation of the inclusion of the word "resolved" in an acceptance. Because it is well settled that the term "resolved" carries with it the connotation of a denial of future claims for benefits, its inclusion in an "acceptance" essentially represents a notice to the injured worker discouraging him/her from seeking further benefits for their "resolved" condition. To find that the removal of the word "resolved" from a carrier's acceptance does not warrant an attorney fee under ORS 656.386(1) for finally prevailing over a "denied claim" would also mean that there are no consequences for the carrier's acceptance of a "resolved" condition. The concern regarding future claims was at the heart of our decision in Best. 46 Van Natta at 1696. Moreover, we disagree with the dissent's characterization that "resolved" is a mere "qualification" of an acceptance. To the contrary, acceptance of a "resolved" condition carries the implication that claimant is no longer entitled to relief for her compensable condition.

Board Members Moller and Haynes dissenting.

Rejecting the ALJ's conclusion that the 1995 amendments to ORS 656.386(1) overruled cases such as Gary L. Best, 46 Van Natta 1691 (1994), the majority holds that claimant's counsel became entitled to an assessed fee under ORS 656.386(1) when SAIF rescinded its "denial" of claimant's back condition after claimant's hearing request. Because we believe the ALJ reached the proper conclusion in this case, we respectfully dissent.

In Best, the carrier accepted the claimant's osteomyelitis condition as "resolved." We held that the term "resolved" implied that the carrier was no longer responsible for future benefits for the claimant's condition, and, therefore, that the carrier's notice constituted an improper denial of future responsibility relating to an accepted claim. Applying former ORS 656.386(1), we held that, under those circumstances, the claimant's counsel was entitled to an assessed fee. Prior to the 1995 amendments to ORS 656.386(1), we followed our reasoning in Best in other cases. Steven P. Grossaint, 46 Van Natta 1737 (1994); Linda J. Miossec, 46 Van Natta 1730 (1994); see also Nancie A. Stimler, 47 Van Natta 1116 (1995) (distinguishing Best).[1]

In 1995, the legislature amended ORS 656.386(1) to define a "denied claim" as one that "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 light of the legislature's requirement that a "denied claim" involve a refusal to pay compensation on the "express ground" that an injury or condition is not compensable or otherwise does not give rise to an entitlement to any compensation, it seems clear that the concept of an implied denial of future benefits as articulated in cases such as Best did not survive the 1995 legislative amendments.

The majority's conclusion notwithstanding, the court's recent decision in Galbraith v. L.A. Pottsratz Construction, 152 Or App 790 (1998), does not require that we award an assessed fee in this case. In Galbraith, the claimant suffered a compensable injury that left him without the use of his legs. He later suffered a non-work-related injury concerning a fractured right hip and femur. His attending physician determined that the fractures were "clearly related to his paraplegia and caused substantially by the paraplegia." The claimant's compensation claim was, therefore, a claim for a consequential condition and not a claim for further payment under the earlier paraplegia claim. The court reasoned that the claimant was thus entitled to have the carrier accept or deny the new claim. The carrier did neither within the time period specified by ORS 656.262(6), but it did pay for the claimant's medical treatment under the paraplegia claim. Having received no response to his new claim, the claimant requested a hearing on the ground that there had been a "de facto" denial of that claim.

The carrier responded to that request by stating that the claimant was "entitled to no relief" on his claim. The claimant proceeded in the face of that statement, and only then did the carrier accept the claim. The carrier argued that the statement was not an express denial of the claim. The court stated that it was "at a loss to understand how [the carrier's] statement can be understood as anything but an express denial of the claim." (emphasis in original). By taking the position that the claimant was entitled no relief for the fracture injuries, the court held that the carrier necessarily refused to pay any benefits for those injuries on the express ground that the injuries did not give rise to an entitlement to compensation.

Unlike Galbraith, where the carrier denied the claim by taking the position that the claimant was "entitled to no relief," here SAIF did not deny the back claim, but rather accepted the claim with the qualification that the condition had subsequently resolved. Thus, there was no claim that SAIF refused to pay on the "express ground" that the injury was not compensable or otherwise did not give rise to an entitlement to "any compensation."[2]

Accordingly, because Galbraith is distinguishable on its facts, and because the result in this case is clearly contrary to the intent of the legislature in 1995 when it amended ORS 656.386(1) to require an express refusal to pay compensation, we conclude that the majority's decision in this case is incorrect. For that reason, we must dissent.

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[1] As the majority correctly notes, we awarded an assessed fee pursuant to amended ORS 656.386(1) in a "post-1995 amendment" case in which a "prospective" denial was set aside. Charles L. Wallace, 49 Van Natta 52, on recon 49 Van Natta 472 (1997). However, there was no discussion of the merits of the attorney fee issue in Wallace. Therefore, we do not believe that we are bound by our decision in Wallace.

[2] SAIF's notation on its original acceptance that the strain was "resolved" was likely superfluous. SAIF remained responsible for continued processing of the claim. Had claimant made a claim in the future for further benefits, and had SAIF either denied those benefits in reliance on its limited acceptance or responded that claimant was "entitled to no relief," as stated in Galbraith, then the issue of entitlement to an ORS 656.386(1) attorney fee may have arisen. Such was not the case here, however.

In the Matter of the Compensation of
ART L. WETZEL, Claimant
WCB Case No. 97-07454
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Lane, Powell, et al, Defense Attorneys

Reviewed by the Board en banc.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that: (1) held that claimant was seeking reclassification of his claim pursuant to ORS 656.277; (2) dismissed his request for hearing for lack of jurisdiction; and (3) did not assess a penalty for the self-insured employer's allegedly unreasonable claims processing. On review, the issues are dismissal, claims processing, and penalties. We reinstate claimant's hearing request and direct the employer to reopen claimant's cervical strain injury claim for processing of the additional thoracic strain condition that was accepted after claim closure.

FINDINGS OF FACT

We adopt the ALJ's findings of fact. We do not adopt the ALJ's findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Dismissal

Claimant injured his neck and upper back at work in August 1996. He was diagnosed with cervical and thoracic strains. The employer accepted claimant's cervical strain as a disabling injury. The claim was closed by a February 27, 1997 Notice of Closure that awarded temporary disability benefits and 5 percent unscheduled permanent disability for claimant's neck. A June 25, 1997 Order on Reconsideration increased claimant's unscheduled permanent disability to 9 percent.

On June 26, 1997, claimant wrote to the employer requesting acceptance of the upper thoracic strain. On July 24, 1997, the employer accepted the upper thoracic strain as a "nondisabling" injury. Claimant filed a request for hearing, alleging improper reclassification of the claim from disabling to non-disabling and requesting a penalty-related attorney fee for unreasonable claim processing.[1]

The ALJ found that the employer properly processed claimant's thoracic strain as a "new" claim pursuant to ORS 656.005(6) and 656.262(6), which it could classify as disabling or nondisabling, independent of the original accepted disabling cervical strain claim. In support of this view, the ALJ relied on *Patricia A. Dropinski*, 49 Van Natta 206, 212 (1997), *Bernard G. Hunt*, 49 Van Natta 223 (1997), and *Anthony J. Telesmanich*, 49 Van Natta 49, *on recon* 49 Van Natta 166 (1997), which held that, depending on the circumstances and the medical evidence, the processing of "post-reconsideration" accepted conditions may, or may not, involve the "reopening" of the claim and a redetermination of extent of permanent disability. Thus, because claimant's claim for the thoracic strain condition constituted a "new" claim for compensation after issuance of the Order on Reconsideration, the ALJ found that the employer appropriately processed the second claim as a nondisabling claim, based on the circumstances and medical evidence in existence at that time.

The ALJ accordingly determined that, if claimant believed his thoracic strain claim was improperly classified as a nondisabling injury, he was required under ORS 656.277[2] to request that the second claim be reclassified by the Department. The ALJ consequently dismissed claimant's request for hearing for lack of jurisdiction.

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[1] The employer interpreted claimant's request for hearing as a request for reclassification and requested the Department to make a determination on the reclassification issue pursuant to ORS 656.277(1). No such determination had issued by the time of hearing.

[2] ORS 656.277 provides in pertinent part:

"Claims for nondisabling injuries shall be processed in the same manner as claims for disabling injuries, except that:

"(1) If within one year after the injury, the worker claims a nondisabling injury originally was or has become disabling, the insurer or self-insured employer, upon receiving notice or knowledge of such a claim, shall report the claim to the Director of the Department of Consumer and Business Services for determination pursuant to ORS 656.268."

On review, claimant contends that the issue at hearing was the appropriateness of the employer's claim processing, an issue over which the ALJ had jurisdiction. Specifically, claimant argues that the employer lacked statutory authority to accept his new condition as a nondisabling component of an accepted disabling claim. Thus, as the matter before the ALJ was not the "reclassification" of the claim from the outset, but the appropriateness of the employer's claim processing, claimant asserts that the ALJ wrongly dismissed his request for hearing. We agree with claimant, reasoning as follows.

In light of subsequent changes in the law enacted by the 1997 Legislature, and the undisputed fact that claimant's thoracic strain condition was accepted after claim closure, we find that ORS 656.262(7)(c) controls.

ORS 656.262(7)(c) provides, in relevant part: "If a *condition is found compensable*[3] after claim closure, the insurer or self-insured employer *shall* reopen the claim for processing regarding that condition." (Emphasis supplied.) The provision went into effect in 1997 and retroactively applies to this claim. *See Ronald D. Smith, Sr.*, 49 Van Natta 1807, 1808 (1997).

Here, in August 1996, claimant sustained a work injury to his upper back and neck which the employer accepted as a disabling cervical strain condition. It is undisputed that claimant's additional thoracic strain condition was accepted (*i.e.*, found compensable) after the February 1997 closure of the claim. (Exs. 20, 25). Therefore, the employer is *required* to reopen claimant's claim for processing regarding the post-closure accepted thoracic strain condition. ORS 656.262(7)(c); *see Daniel I. VanWechel*, 50 Van Natta 844 (1998) (where new condition accepted after claim closure, carrier has a clear and absolute duty to reopen the claim for processing regarding the new condition). Consequently, inasmuch as the carrier is required to process claimant's "post-closure" accepted condition under ORS 656.262(7)(c), which requires reopening the claim, the appropriateness of the employer's claims processing is a matter "concerning a claim," a matter over which the Board's Hearings Division has jurisdiction. *See* ORS 656.283(1); 656.704(3).[4]

We now turn to the merits. As noted above, the employer accepted the post-closure condition as "nondisabling." Yet, the employer is statutorily required to "reopen" the 1996 disabling injury claim. The requirement that the employer "reopen the claim for processing" necessarily implies that the employer's processing duties include "reclosing" the accepted injury claim under ORS 656.268 when the conditions of that statute are met. *See* ORS 656.268(2) (a) and (4)(a).[5]

Penalties

Claimant contends that the employer's attempt to classify the thoracic strain condition as a nondisabling condition, thereby avoiding claim closure and the possible award of temporary and permanent disability, is an unreasonable resistance to the payment of compensation.

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

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[3] Claimant contends that his written request for an amended acceptance under ORS 656.262(6)(d) should be analyzed differently from a "new medical condition" claim under ORS 656.262(7)(a). For purposes of ORS 656.262(7) (c), we find nothing in the statute to support claimant's contention, as the statute clearly refers to any "condition" accepted after claim closure. Moreover, as we discussed in *Smith*, we found no distinction between a carrier voluntarily accepting a condition and that in which a condition is "found compensable" via a litigation order. 49 Van Natta at 1808 n.1.

[4] We disagree in this regard with the ALJ's conclusion that claimant was required to seek reclassification of the thoracic strain condition pursuant to ORS 656.277. By its terms, that statute applies to "nondisabling injuries." Both parties agree that claimant's August 1996 injury was properly classified as disabling from the outset. Ex. 7.

[5] This conclusion should not be interpreted as a pronouncement that claimant is, or is not, entitled to additional temporary or permanent disability benefits. Such a determination must await the closure of this claim. Instead, our decision is solely confined to a ruling that the employer is required to reopen the claim for the processing of the thoracic strain condition accepted after claim closure, which includes reclosure of the claim when statutorily warranted.

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 to the carrier. *Brown v. Argonaut Insurance Company*, 93 Or App 588, 591 (1988).

Claimant requested amendment of the Notice of Acceptance on June 26, 1997 and the employer issued the amended Notice of Acceptance on July 24, 1997, one day prior to the July 25, 1997 date that *amended* ORS 656.262(7)(c) became effective.[6] At the time the amended notice issued, *Telesmanich* was good law. Moreover, although the amended statute addresses a carrier's claim processing obligations with respect to "post-reconsideration" accepted conditions, no interpretive decision had been rendered. Finally, the present record would not support a conclusion (and claimant does not contend otherwise) that the newly accepted thoracic condition resulted in temporary disability or that there was a reasonable likelihood of permanent disability. Under these circumstances, we do not find the employer's action in accepting the "post-closure" new condition as "nondisabling" to be unreasonable. Consequently, a penalty is not warranted.

ORDER

The ALJ's order dated December 23, 1997 is reversed. Claimant's hearing request is reinstated. The self-insured employer is directed to reopen claimant's August 1996 disabling cervical injury claim for processing of the thoracic strain condition that was accepted after claim closure. Claimant's penalty request is denied. Claimant's counsel is awarded 25 percent of any temporary disability compensation resulting from this order, not to exceed $3,800, payable directly to claimant's attorney.

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[6] Section 2, ch 605, Or Laws 1997 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 the Act [July 25, 1997], regardless of the date of injury or the date a claim is presented, and this act is entended to be fully retroactive."

In the Matter of the Compensation of
MICHAEL A. BARNETT, Claimant
WCB Case No. AF-97027
ORDER ON REVIEW (REMANDING)
Robert J. Guarrasi, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Garaventa's order that declined to award an approved attorney fee for his counsel's efforts in obtaining additional temporary disability without a hearing. In his brief, claimant requests that the Board take "administrative notice" of Exhibits 1 through 5 or, alternatively, that the Board remand the case to the Hearings Division so the documents may be admitted into the record. We treat this as a motion to remand for the taking of additional evidence. *See Judy A. Britton*, 37 Van Natta 1262 (1985). On review, the issues are remand and attorney fees. We vacate and remand.

FINDINGS OF FACT

On November 20, 1997, claimant's attorney submitted a "stipulated order" (executed by claimant and his attorney) relative to his petition for attorney fees payable out of claimant's temporary disability compensation. The stipulation stated that claimant's attorney was instrumental in obtaining time loss and medical benefits for claimant and provided that claimant's attorney was entitled to an attorney fee of 25 percent of claimant's time loss compensation commencing on October 13, 1997.

Relying on *Julie A. Johnson*, 48 Van Natta 29 (1996), and *Rogelio Munoz-Martinez*, 47 Van Natta 1412 (1995), the ALJ declined to award claimant's attorney an approved fee. The ALJ found that neither the Hearings Division nor the Board had awarded or approved time loss compensation and, therefore, the Hearings Division lacked the authority to award an attorney fee.

CONCLUSIONS OF LAW AND OPINION

Remand

On review, claimant requests that the Board take "administrative notice" of Exhibits 1 through 5 or, alternatively, that the Board remand the case to the Hearings Division so the documents may be admitted into the record.

The insurer objects to the submission of exhibits because they were not in the record. The insurer asserts that because there was no litigation on the issue of time loss, there was no denial, no hearing and no record.

Because our review is limited to the record developed before the ALJ, we treat claimant's submission as a motion for remand. *See Judy A. Britton*, 37 Van Natta at 1262. For the following reasons, we grant claimant's motion to remand.

Although the ALJ relied on *Julie A. Johnson* and *Rogelio Munoz-Martinez*, we find those cases distinguishable. In those cases, the attorney fee requests were related to an action subject to the Director's authority. In *Johnson*, 48 Van Natta at 29-30, the claimant had requested a hearing on the Director's denial of reclassification. After the hearing request, the carrier voluntarily reclassified the claim as disabling. We affirmed the ALJ's order that limited the claimant's out-of-compensation fee to 25 percent of the increased temporary disability compensation. Although the claimant contended that the attorney fee should also be based on permanent disability, we found that permanent disability benefits did not flow directly from reclassification. Moreover, we reasoned that we had no authority to award an attorney fee out of compensation that neither an ALJ nor the Board had awarded or approved.

In *Munoz-Martinez*, 47 Van Natta at 1412, the ALJ declined to award an approved attorney fee, payable from future permanent disability awards, for the claimant's counsel's services rendered concerning the closure of the claim. We held that neither the Hearings Division nor the Board had authority to award an out-of-compensation attorney fee for an attorney's services in securing claim closure by the Director. *See also John Kirwin*, 50 Van Natta 379 (1998) (declining to award an approved attorney fee for the claimant's counsel's efforts in obtaining an order from the Director declaring him to be a subject worker); *Larry D. Simmons*, 50 Van Natta 107 (1998) (declining to award an attorney fee under ORS 656.386(2) for the claimant's counsel's efforts in obtaining a Determination Order finding that his nondisabling injury claim had become disabling).

Here, in contrast, the attorney fee at issue is related to claimant's attorney's services in obtaining "procedural" temporary disability compensation. The issue of temporary total disability benefits in an open claim is a matter within the authority of the Hearings Division and the Board. *See Alfredo Martinez*, 49 Van Natta 67 (1997).

Although claimant's attorney submitted a "stipulated order" relative to claimant's petition for attorney fees payable out of temporary disability compensation, the "stipulation" does not qualify as such under OAR 438-009-0001(3). Under that rule, a "settlement stipulation" refers to a written agreement in which any matter contested between the parties, other than matters resolvable in a claim disposition agreement or disputed claim settlement, are resolved by agreement of the *parties*. Here, the "stipulated order" is an agreement between claimant and his attorney. It is not a dispute "resolved by agreement of the parties."

We conclude that this matter should be addressed under OAR 438-015-0030, which provides:

> "If an attorney is instrumental in obtaining compensation for a claimant without a hearing before an Administrative Law Judge, a reasonable attorney fee may be approved or assessed. The amount of the fee shall be determined by an Administrative Law Judge or by agreement of the parties."

The agreement between claimant and his attorney indicates that claimant's attorney was instrumental in obtaining time loss and medical benefits for claimant and it provided that claimant's attorney was entitled to an attorney fee of 25 percent of claimant's time loss compensation commencing on October 13, 1997. Nonetheless, that agreement was neither agreed to by the insurer nor are claimant's and his attorney's representations supported by accompanying evidence.

We may remand a case to the ALJ for further evidence taking, correction or other necessary action if we find that the case has been improperly, incompletely or otherwise insufficiently developed or heard by the ALJ. ORS 656.295(5). Remand is appropriate on a showing of good cause or some other compelling basis. *Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986).

Here, no hearing was convened and the parties did not have the opportunity to introduce evidence as to whether claimant's attorney was instrumental in obtaining compensation for claimant without a hearing. Under such circumstances, we conclude that the record has been incompletely and insufficiently developed. Moreover, we consider these particular circumstances sufficient to constitute a compelling reason to remand for further development of the record.

Accordingly, the ALJ's order dated December 12, 1997 is vacated and this case is remanded to ALJ Garaventa with instructions to open the record for evidence from the parties regarding whether claimant's attorney was instrumental in obtaining temporary disability compensation. These proceedings may be conducted in any manner that the ALJ determines will achieve substantial justice. Thereafter, the ALJ shall issue a final, appealable order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DEBRA A. LONG, Claimant
WCB Case No. 97-04866
ORDER ON REVIEW
Bischoff, Strooband, et al, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) McWilliams' order that set aside its denial of claimant's occupational disease claim for a left foot plantar fasciitis condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant worked for the employer as a grocery receiving clerk for about nine years before the onset of left foot problems in early 1996. Her left foot condition was eventually diagnosed as plantar fasciitis.

Claimant's work involved long hours of walking and standing on hard concrete surfaces. This is the type of repetitive traumatic activity associated with the development of plantar fasciitis.

The ALJ found the claim compensable, based on the opinions of Dr. Schmidt, treating physician, and Dr. Smith, examining physician. We agree that these opinions support the claim. However, we find that the claim is not compensable, because no physician had an accurate and complete history regarding the onset of claimant's left foot problems.

Claimant first sought treatment in February 1996 for a burning sensation in her left foot. (Ex. 8AA-8). On March 8, 1996, Dr. Watt, chiropractor, referred claimant to Dr. Thompson, podiatrist, for her left foot complaints, which had existed "for past 2-3 weeks." (Ex. 8A-1, 8B-4). Dr. Thompson recorded claimant's history that her foot inflammation "poss[ibly] started [with] 4 wks of line dancing lessons [with] hoping [sic] & kicking." (Ex. 8C-1).

Claimant did not mention her line dancing activities to Dr. Schmidt, who treated her left foot beginning on April 25, 1997; or to Dr. Rex Smith, who first treated claimant on May 20, 1996; or to Dr. Anthony Smith, who examined claimant on May 30, 1997. Drs. Schmidt and the two Dr. Smiths were aware of *no* off-the-job exposures that might have contributed to her condition. (Exs. 49-7, 60-14). Claimant told Dr. Anthony Smith that her left foot problem had been going on for one month before he first examined her on May 20, 1996. (Ex. 59-27). Although claimant told Dr. Schmidt that Dr. Thompson had taken her off work for two week due to foot pain, Dr. Schmidt was under the impression that the pain began on May 20, 1996. (Ex. 42-1). Claimant apparently did not tell the two Dr. Smiths that she had seen Dr. Thompson for left foot symptoms.

At hearing, claimant denied that she had been involved in any physical activities involving her feet before her left foot symptoms started. (Tr. 29; *see* Tr. 19, 22-24).

We find that claimant's contemporaneous reporting regarding the onset of symptoms is more likely accurate than her recollection at hearing. Moreover, it is undisputed that line dancing could have contributed to her plantar fasciitis. (*See* Ex. 60-14). Accordingly, because neither of the physicians supporting the claim had an accurate and complete history concerning the onset of claimant's left foot problems or her activities at the time, we decline to rely on them. *Somers v. SAIF*, 77 Or App 259 (1986); *William D. Brizendine*, 50 Van Natta 21 (1998) (Physician's opinion unpersuasive without accurate and complete history). Under these circumstances, we conclude that the claim must fail.[1]

ORDER

The ALJ's order dated February 23, 1998 is reversed in part and affirmed in part. That portion of the order that set aside the self-insured employer' denial is reversed. The denial is reinstated and upheld. The ALJ's attorney fee award is reversed. The remainder of the order is affirmed.

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[1] In reaching this conclusion, we note evidence that claimant's obesity, cavus deformity, and preexisting degenerative changes at the midtarsal level contributed to her plantar fasciitis condition, as well as traumatic activities involving her feet (including her work activities). (Exs. 49-6, 53, 58, 59-7-14).

In the Matter of the Compensation of
DONALD J. MURRAY, Claimant
WCB Case No. 97-09400
ORDER ON REVIEW
Pozzi, Wilson, 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) Hazelett's order that dismissed his request for hearing. On review, the issue is the propriety of the ALJ's dismissal. We affirm.

FINDINGS OF FACT

On August 8, 1997, claimant signed a retainer agreement employing his then-attorney of record to represent him in connection with his workers' compensation claim. A provision of that retainer agreement stated that "[t]his is authority for [the then-attorney of record] to act in my name, and on my behalf, to file on my behalf any legal documents necessary, to appear at any hearing held thereon, and to associate other attorneys to handle any claim at their discretion."

On November 19, 1997, claimant, through his then-attorney, requested a hearing regarding a September 23, 1997 denial and raised the issue of compensability. A hearing was scheduled for February 4, 1998.

A February 2, 1998 "Docketing Action Worksheet" indicated that the hearing request had been withdrawn. On February 3, 1998, the ALJ dismissed claimant's hearing request and sent a copy of the dismissal order to claimant's then-attorney of record.

On February 18, 1998, a request for Board review of the ALJ's February 3, 1998 dismissal order was made by an attorney other than claimant's former attorney of record. No retainer agreement from that attorney was submitted to the Board.

A briefing schedule was set up, with claimant's appellant's brief due on March 26, 1998. Claimant did not submit an appellant's brief. By letter dated April 8, 1998, the SAIF Corporation notified the Board that, since claimant had not filed a appellant's brief, it would not be filing a respondent's brief.

CONCLUSIONS OF LAW AND OPINION

The ALJ dismissed claimant's hearing request. Thus, the sole issue before us is whether claimant's hearing request should have been dismissed. Based on the following reasoning, we find the ALJ's dismissal order appropriate.

Where a claimant signs a retainer agreement employing an attorney and giving that attorney authority to act on the claimant's behalf, a dismissal order issued in response to that attorney's withdrawal of the hearing request is appropriate. Robert S. Ceballos, 49 Van Natta 617 (1997); Gilberto Garcia-Ortega, 48 Van Natta 2201 (1996).

Claimant has the burden of proving that the dismissal order was not appropriate. Harris v. SAIF, 292 Or 683, 690 (1982) (burden of proof is upon the proponent of a fact or position, the party who would be unsuccessful if no evidence were introduced on either side). However, claimant makes no argument as to why the dismissal order was not appropriate.

Furthermore, the retainer agreement between claimant and his then-attorney authorized that attorney to act on claimant's behalf. Claimant does not assert that his then-attorney did not withdraw his hearing request. Nor does he assert that he was not represented by his then-attorney at the time in question. Cf. Silverio Frias, Sr., 49 Van Natta 1514 (1997) (Board vacated ALJ's dismissal order and remanded to the ALJ to determine if the attorney was authorized to withdraw the request for hearing).

Under these circumstances, we find no reason to alter the dismissal order. William A. Martin, 46 Van Natta 1704 (1994); Mike D. Sullivan, 45 Van Natta 900 (1993); Eul G. Moody, 45 Van Natta 835 (1993).

ORDER

The ALJ's order dated February 3, 1998 is affirmed.

In the Matter of the Compensation of
DONALD D. PAUL, Claimant
WCB Case No. 95-00078
ORDER ON REVIEW
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) upheld the insurer's "de facto" denial of his left knee condition; (2) upheld the insurer's "de facto" denial of his cervical spine condition; (3) declined to award temporary disability benefits; (4) declined to award travel expenses for medical and physical therapy trips; and (5) declined to award penalties for the insurer's allegedly unreasonable claims processing. In his brief, claimant requests that documents mailed on December 15, 1997 should be admitted into evidence. We treat this as a motion to remand for the taking of additional evidence. *See Judy A. Britton*, 37 Van Natta 1262 (1985). On review, the issues are remand and compensability.

We deny the motion to remand, and adopt and affirm the ALJ's order with the following supplementation.

Remand

In his brief on review, claimant requests that documents mailed to the parties on December 15, 1997 should be admitted into evidence. Because our review is limited to the record developed before the ALJ, we treat claimant's submission as a motion for remand. *See Judy A. Britton*, 37 Van Natta at 1262.

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

Here, claimant has not provided adequate reasons why the proffered evidence was unobtainable with due diligence at the time of his October 14, 1997 hearing. We note that the record already contains many of the documents submitted by claimant and the insurer on review. In any event, we conclude that the proffered evidence will not likely affect the outcome of the case. Therefore, we deny claimant's request for remand.

ORDER

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

June 16, 1998 Cite as 50 Van Natta 1134 (1998)

In the Matter of the Compensation of
SCOTT A. WHITNEY, Claimant
Own Motion No. 98-0013M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Welch, Bruun, et al, Claimant Attorneys

Claimant requests review of the insurer's January 21, 1998 Notice of Closure which closed his claim with an award of temporary disability compensation from September 22, 1997 through September 26, 1997. The insurer declared claimant medically stationary as of January 5, 1998. Claimant does not contend that the insurer's closure was premature. Rather, claimant contends that he is entitled to additional temporary partial benefits from October 2, 1997 through November 29, 1997, as he was only released to parttime work.

In an October 2, 1997 chart note, Dr. Silver, claimant's treating physician, noted that:

> "[Claimant] should stay off work at this point. However, his limitations are that he should not lift more than 5 lbs., stand for greater than an hour, sit for two hours or for four hours in a day."

According to Dr. Silver's October 2, 1997 chart note, it appears that claimant was released to four hours per day of work, with restrictions. In his October 20, 1997 chart note, Dr. Silver increased claimant's work hours to six hours per day, with restrictions and scheduled claimant for a return visit in six weeks. Claimant was seen by Dr. Silver on December 29, 1997, where claimant's "present work restrictions," were continued. However, claimant's affidavit and the work invoices submitted in support of his contentions, establish that claimant returned to full-time work by December 1, 1997.

We are persuaded that Dr. Silver approved claimant's release to modified duty with limited work hours after October 2, 1997. On this record, we find that claimant was temporarily partially disabled from October 2, 1997 through November 29, 1997. Because we have found that claimant's disability was partial, claimant is entitled to temporary partial disability (TPD) benefits during the period in question. ORS 656.212; *David L. Gooding*, 47 Van Natta 1468 (1995); *Ricardo Morales*, 47 Van Natta 1394 (1995). We have previously found that the rate of TPD must be based on a comparison of his

wages at modified duty with his at-injury wage. ORS 656.212; *Lonnie L. Dysinger*, 47 Van Natta 2282 (1995). A comparison of his wages at modified duty and the wage used to calculate temporary disability pursuant to ORS 656.210 may very well be computed as zero. In any event, that is a matter to be eventually be resolved by the parties once the insurer completes its calculation of claimant's temporary partial disability rate.[1]

Accordingly, as modified herein, the insurer's January 21, 1998 Notice of Closure is affirmed.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation, if any, 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.

[1] The record does not establish what were claimant's wages at his modified work. As previously noted, if his "modified" wages either met or exceeded his "at-injury" wages, claimant's temporary partial disability benefits would be zero. However, resolution of that question is not ripe for these proceedings. Any future dispute regarding the insurer's calculation of claimant's temporary disability benefits during the period of October 2, 1997 through November 29, 1997 may be presented for review should claimant subsequently disagree with the insurer's calculation,

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In the Matter of the Compensation of
JACK E. YONALLY, Claimant
WCB Case No. 97-07733
ORDER ON REVIEW
Robert J. Guarrasi, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Hall and Moller.

Claimant, *pro se*,[1] requests review of Administrative Law Judge (ALJ) Davis' order that: (1) upheld the SAIF Corporation's denial of his aggravation claim for a cervical condition; and (2) declined to award interim compensation. In his brief, claimant submits additional medical reports from Drs. Kane and Tuscher. We treat this as a motion to remand for the taking of additional evidence. *See Judy A. Britton*, 37 Van Natta 1262 (1985). On review, the issues are remand, aggravation and interim compensation.

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

Remand

In his brief on review, claimant submits additional medical reports from Drs. Kane and Tuscher for our consideration.[2] Because our review is limited to the record developed before the ALJ, we treat claimant's submission as a motion for remand. *See Judy A. Britton*, 37 Van Natta at 1262.

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

[1] Although claimant was represented at hearing, he is proceeding *pro se* on review.

[2] Claimant also submitted a six-page document referring to his medical treatment beginning on March 17, 1996. We have considered this as part of claimant's brief on review.

Claimant submits a chart note apparently from Dr. Tuscher dated May 12, 1997. He has offered no reasons why the evidence from Dr. Tuscher was unobtainable with due diligence at the time of his January 13, 1998 hearing. We note that the record already includes several reports from Dr. Tuscher. Furthermore, the proffered evidence from Dr. Tuscher will not likely affect the outcome of the case.

Claimant also submits chart notes and a medical report from Dr. Kane. Dr. Kane's chart notes begin on January 6, 1998 and continue after the hearing date. We are not persuaded that Dr. Kane's initial chart note dated January 6, 1998 was unobtainable with due diligence prior to the January 13, 1998 hearing. Moreover, although some of Dr. Kane's reports were not available at the time of the hearing, we would conclude that claimant has failed to sustain his burden of proof even if the proffered evidence were considered. In other words, we are not persuaded the additional documents submitted by claimant are likely to affect the outcome of this case. Consequently, we deny claimant's request for remand.

ORDER

The ALJ's order dated February 12, 1998 is affirmed.

In the Matter of the Compensation of
MODESTO M. GARCIA, Claimant
WCB Case No. 97-06800
ORDER ON REVIEW (REMANDING)
Bischoff, Strooband, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Moller and Bock.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Mongrain's order that: (1) declined its request to "reopen" the record so that additional evidence regarding the amount of an alleged overpayment could be admitted; and (2) determined that SAIF had not proved its entitlement to an offset for an alleged overpayment of temporary disability. In its briefs, SAIF requests that we remand to the ALJ for admission of additional evidence on the overpayment issue. On review, the issues are hearing procedure, remand, and offset. We vacate and remand.

FINDINGS OF FACT

On April 29, 1997, SAIF mailed claimant a letter, advising that it was deducting from unpaid current or future permanent or temporary disability awards or payments an alleged overpayment of temporary disability in the amount of $4,605.94. (Ex. 10). On May 16, 1997, SAIF sent claimant another letter explaining that, as a result of an April 18, 1997 Board Order on Review, it was deducting the overpayment from permanent disability awarded in the order. (Ex. 12).

On August 21, 1997, claimant requested a hearing, contending that SAIF had "no basis for recovering an overpayment as set forth in its letter of April 29, 1997." The hearing request further stated that SAIF had failed to assert its right to an offset of overpaid temporary disability in its hearing request regarding an Order on Reconsideration and was "barred by issue preclusion" from taking an overpayment.

CONCLUSIONS OF LAW AND OPINION

Prior to the hearing, the parties agreed to submit the issues on the basis of the documentary record and written arguments. During argument, claimant raised the issue of whether the amount of the alleged overpayment could be ascertained. SAIF responded by asserting that claimant's hearing request only raised issue preclusion as an issue and that claimant should be barred from raising the issue of the amount of the overpayment. Alternatively, SAIF requested that the record be "reopened" so that it could present testimony explaining the calculation of the overpayment.

The ALJ declined to reopen the record for presentation of additional evidence, reasoning that the issue of the amount of the overpayment was encompassed in claimant's hearing request, as to which SAIF had agreed to submit the issues on the basis of written argument. Proceeding to the merits, the ALJ determined that, while the overpayment issue was not barred by issue preclusion, SAIF had not proved the existence of the overpayment claimed in its April 29, 1997 and May 16, 1997 letters. Thus, the ALJ declined to approve the requested offset.

On review, SAIF contends that the ALJ abused his discretion in declining to grant a continuance so that it could present additional evidence regarding the existence of the overpayment. It requests that we remand the case to the ALJ for admission of further evidence regarding the calculation of the overpayment.[1] For the following reasons, we agree with SAIF's contention and grant the motion for remand.

Claimant requested a hearing, alleging that there was no basis for recovering an overpayment. In submitting this request, claimant expressly contended that SAIF was barred by "issue preclusion" from taking an overpayment. Considering claimant's express contention, we disagree with the ALJ's conclusion that the issue of the amount/existence of the alleged overpayment was encompassed within the language of the August 12, 1997 hearing request. By allowing claimant to subsequently raise the issue of the amount of the alleged overpayment, without permitting the introduction of further evidence on the issue, we find that the ALJ abused his discretion in declining to grant SAIF's motion to continue the hearing. *See Sandra L. Booker*, 48 Van Natta 2533 (1996) (Board reviews a continuance ruling for abuse of discretion) *Murray L. Johnson*, 45 Van Natta 470 (1993) (*where "occupational disese" theory of claim was found to have been properly raised before the ALJ, but the record was insufficiently developed, Board remanded for further development*). Therefore, under these particular circumstances, it follows that there is a compelling basis to remand for presentation of additional evidence. *See* ORS 656.295(5); *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986).

Accordingly, the ALJ's order dated January 21, 1998 is vacated. This matter is remanded to ALJ Mongrain for further proceedings consistent with this order. Following these further proceedings, ALJ Mongrain shall issue a final, appealable order.

IT IS SO ORDERED.

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[1] SAIF does not contest the ALJ's finding that, based on the record as developed, SAIF did not establish the existence of the overpayment asserted in the April 29, 1997 and May 16, 1997 letters.

In the Matter of the Compensation of
LORETTA GLAZE, Claimant
WCB Case No. C8-01267
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Emmons, et al, Claimant Attorneys
Zimmerman, et al, Defense Attorneys

Reviewed by Board Member Biehl and Haynes.

On June 3, 1998, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

The first page and body of the CDA provides for a total consideration of $4,000, consisting of a lump sum payment to claimant of $3,000, and an attorney fee of $1,000. Page 4, paragraph 19 provides that, due to an Order on Reconsideration reducing an award of permanent disability, an overpayment in the amount of $4,576 exists. In light of these circumstances, the parties stipulate that the carrier shall waive the overpayment as additional consideration for the CDA.

We have previously held that, where an overpayment apparently has been made pursuant to prior claims processing obligations, that overpayment cannot qualify as "proceeds" of the parties' CDA. *See Ronald Smith*, 47 Van Natta 38 (1995); *Timothy W. Moore*, 44 Van Natta 2060 (1992). Furthermore, a carrier's contractual forbearance of its right to pursue an offset cannot serve as consideration for a claimant's release of rights to workers' compensation benefits. *Id.* Consequently, the carrier's release of the $4,576 overpayment in this case does not constitute valid consideration for the CDA.[1] Nevertheless, such a provision does not automatically result in the disapproval of the proposed disposition.

In *Roy D. Welty*, 47 Van Natta 1544 (1995), we considered a CDA which provided, as consideration for the disposition, the release of the carrier's claims to an overpayment, as well as a lump sum payment. After noting that a carrier's contractual relinquishment of the right to pursue an overpayment could not serve as consideration for a CDA, we interpreted the CDA's total consideration as consisting of the lump sum payment, excluding the overpayment, and approved the CDA.

Similarly, in *Steven T. Kunz*, 48 Van Natta 2279 (1996), we considered a CDA which provided for the payment of a lump sum of $20,000, and indicated that "part of the consideration" included the carrier's agreement to waive an overpayment. Relying on *Welty* and *Margie L. Brame*, 48 Van Natta 204 (1996), we construed the consideration underlying the CDA as being limited to the $20,000 lump sum and approved the proposed CDA. *See also Georgia A. Cassle*, 49 Van Natta 1387 (1997) (Board interpreted the consideration underlying a CDA to consist only of a $16,633.68 lump sum and not the carrier's waiver of an overpayment).

Here, as we did in *Welty*, *Brame* and *Kunz*, we interpret the consideration underlying the CDA to include only the $4,000 lump sum, and not to include the carrier's waiver of the overpayment. Based on such an interpretation, we do not consider the consideration for the release of claimant's "non-medical service" benefits to be unreasonable as a matter of law. *See ORS 656.236(1)(a)(A)*. In addition, the proposed attorney fee ($1,000 from a $4,000 disposition) is consistent with the Board's applicable rule. OAR 438-015-0052(1).

Accordingly, as interpreted herein, the CDA is in accordance with the terms and conditions prescribed by the Board. Therefore, the parties' CDA 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.

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[1] Although the overpayment cannot be consideration for the CDA, the agreement nonetheless memorializes the parties' agreement that the carrier will not seek recovery of the overpayment from claimant.

In the Matter of the Compensation of
DARLENE F. REED, Claimant
WCB Case Nos. 97-07637, 97-04261 & 97-03115
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Thomas A. Andersen, Defense Attorney
Zimmerman, Nielsen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that: (1) upheld the EBI Companies' compensability and responsibility denial of claimant's occupational disease claim for a bilateral shoulder condition; (2) upheld Wausau's compensability and responsibility denial of the bilateral shoulder condition; and (3) upheld Safeco's compensability and responsibility denial of the same condition. Safeco has also moved to strike claimant's reply brief. On review, the issues are motion to strike, compensability and (potentially) responsibility.

We deny the motion to strike and adopt and affirm the ALJ's order.

Safeco objects to claimant's reply brief and contends that, because we rejected claimant's request for an extension of time in which to file her appellant's brief (and, thus, an appellant's brief was not filed), a reply brief should also be disallowed. Safeco, therefore, requests that we strike claimant's "reply" brief.

We would agree with Safeco if a respondent's brief had not been filed. Under such circumstances, there is nothing to which to reply. *See Alvin L. Woodruff*, 39 Van Natta 1161 (1987). However, Safeco chose to file a "respondent's" brief. Because Safeco chose to file a respondent's brief, claimant was entitled to file a reply. *See Virgil Brogan*, 40 Van Natta 67 (1988). Accordingly, the motion to strike claimant's reply brief is denied.

ORDER

The ALJ's order dated February 19, 1998 is affirmed.

In the Matter of the Compensation of
PATRICK L. RICE, Claimant
WCB Case No. C8-01240
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Bernt A. Hansen, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Member Biehl and Haynes.

On June 1, 1998 the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases his rights to future workers' compensation benefits, except medical services, for his compensable injury. We approve the proposed disposition.

The CDA provides that claimant has asserted a third party claim and that the carrier has asserted a lien against the proceeds of any third party settlement. In addition, the CDA provides that the consideration for the CDA is the carrier's waiver of $9,000 of its $21,925.63 third party lien.

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

Here, the CDA does not provide the amount of the third party settlement. However, attached to the proposed agreement is a "release" document providing for a $42,000 settlement to be paid to claimant. Because the "release" involves an entity other than claimant's employer or its insurer, we find that the agreement is claimant's settlement with the third party. Although the "release" is not incorporated into the CDA, it is attached to the CDA. Under these particular circumstances, we consider the "release" to be part of the CDA.

We interpret the parties' CDA as follows. The third party settlement is $42,000. The carrier's statutory third party lien is $21,925.63. Of that amount, the carrier agrees to waive $9,000 of its lien as consideration for the CDA, thereby reducing its third party lien from $21,925.63 to $12,925.63. Under these circumstances, we are able to determine the "value" of the consideration for the CDA.[1]

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

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

IT IS SO ORDERED.

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[1] After deduction from the third party settlement of statutorily allowed costs and attorney fees (absent extraordinary circumstances, not more than 1/3 of the gross third party settlement, OAR 438-015-0095) and the worker's 33-1/3 percent statutory share of the balance of the settlement, the remaining balance of the recovery would be approximately $18,666.66. *See ORS 656.593(1)(a) and (b).* From this amount, the carrier can satisfy its third party lien. *See ORS 656.593(1)(c).* Because its lien is greater than $18,666.66, the carrier would statutorily be entitled to receive all of the remaining $18,666.66 balance after deduction of costs and attorney fees and claimant's share. By reducing its lien to $12,925.63, the carrier has allowed claimant to receive at least $5,741.03 more from the third party settlement than he would otherwise have recovered had the carrier not reduced its lien. Under such circumstances, we find that the carrier's waiver of a portion of its recoverable third party lien provides valid consideration for the CDA. However, rather than the $9,000 suggested as consideration for the CDA, we find that the consideration is approximately $5,741.03. In any case, because we do not find such consideration to be unreasonable as a matter of law, the disposition is approved. *See ORS 656.236(1)(a).*

In the Matter of the Compensation of
ROBERT M. BERG, Claimant
Own Motion No. 66-0456M
OWN MOTION ORDER
Burt, Swanson, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

On June 12, 1998, the SAIF Corporation submitted its request to reopen claimant's claim under our own motion jurisdiction to provide reimbursement for the March 9, 1998 independent medical examination (IME) incurred to determine the compensability of his current condition as it relates to his compensable December 14, 1965 injury.[1]

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 for compensable injuries occurring before January 1, 1966. See ORS 656.278(1).

We have previous held that diagnostic medical services are compensable when the services are reasonable and necessary in order to establish a causal relationship between the compensable condition and the current condition. *Carl Hight*, 44 Van Natta 224 (1992) and *Cordy A. Brickey*, 44 Van Natta 220 (1992). Here, the March 9, 1998 IME occurred prior to SAIF's recommendation to deny reopening of claimant's claim. In keeping with our holdings in *Hight, supra* and *Brickey, supra,* we find that the medical report generated as result of the IME an integral part of a medical service provided to an injured worker. As such, we conclude the IME report qualifies as compensation under ORS 656.005(8) and ORS 656.625.

Accordingly, we find that the requested medical services are reasonable and necessary and are justified by special circumstances. Therefore, we authorize SAIF's request for reimbursement for the costs incurred for the March 9, 1998 IME in the amount of $619.90.

Claimant's claim is hereby reopened to provide SAIF's reimbursement for the above medical services. By this order, the claim is again closed. OAR 438-012-0055.

IT IS SO ORDERED.

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[1] Claimant underwent an IME on March 9, 1998 to determine the compensability and responsibility issues regarding his current worsening. On March 24, 1998, SAIF denied compensability of claimant's current condition. Claimant has requested a hearing regarding that denial. (WCB Case No. 98-03815) A hearing has been scheduled for August 13, 1998 before Administrative Law Judge Spangler.

In the Matter of the Compensation of
TRACIE M. BRUMLEY, Claimant
WCB Case No. 97-03395
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Hoguet's order that: (1) found that claimant filed a valid aggravation claim; and (2) set aside the insurer's denial of claimant's aggravation claim for a right shoulder condition. On review, the issues are validity of the aggravation claim and compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following exception and brief summary. We do not adopt the ultimate findings of fact.

Claimant has a compensable disabling bilateral carpal tunnel syndrome and right shoulder tendonitis claim as a result of work activities for the employer. (Ex. 5). The current aggravation claim involves only the right shoulder condition. Claimant's last arrangement of compensation was made by a May 30, 1995 Determination Order that awarded no permanent disability compensation. (Exs. 21, 26).

Claimant received no medical treatment for her right shoulder from February 1994 through June 1996. In July 1996, claimant sought medical treatment for her right shoulder due to increased symptoms. She treated with Dr. Weinman, orthopedist, for approximately two months. Dr. Weinman released her from orthopedic care and referred her to Dr. Saviers, a physical medicine and rehabilitation physician, for evaluation and treatment. After beginning treatment with Dr. Saviers, the insurer notified claimant that she could not continue treating with Dr. Saviers because he was not a member of the insurer's MCO. Claimant began treating with Dr. Galt, orthopedist, on December 17, 1996. (Ex. 32).

Dr. Galt's impression was that claimant had impingement syndrome, myofascial syndrome and derangement of the AC joint all of the right shoulder. On January 7, 1997, Dr. Galt filed an aggravation claim on claimant's behalf and proposed right shoulder surgery. (Exs. 32-3, 33).

Claimant was in a bowling league from October 1996 through April 1997. She was placed under surveillance by the insurer and was video-taped while bowling on January 19, 1997. (Ex. 33A). On May 16, 1997, Dr. Galt viewed this video tape and observed that claimant was able to bowl comfortably and extend her hands over her head in full flexion. (Ex. 37). After viewing the tape, Dr. Galt withdrew his recommendation for surgery. *Id.*

On February 6, 1997, claimant was examined by Drs. Rich, neurologist, and Donahoo, orthopedist, on behalf of the insurer. (Ex. 34).

Both Drs. Galt and Donahoo were deposed. (Exs. 39, 40).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant filed a valid aggravation claim and established a compensable aggravation claim on the merits. The insurer disputes both findings. We need not address the validity of the aggravation claim because, even if claimant filed a valid aggravation claim, the medical record does not establish a compensable aggravation claim.[1]

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[1] Regarding the validity of the aggravation claim, the insurer argues that ORS 656.273(3) requires that a claim for aggravation must be accompanied by the attending physician's report. The insurer also makes several arguments that Dr. Galt, treating physician, does not qualify as claimant's attending physician and, thus, is without authority to file an aggravation claim on claimant's behalf. Given our decision that we need not address the issue of the validity of the aggravation claim, we also find that we need not address the insurer's arguments relating to that issue, *i.e.*, Dr. Galt's status as the attending physician. *But see Arlene J. Koitzsch*, 46 Van Natta 1563, *on recon* 46 Van Natta 2265, *on recon* 46 Van Natta 2347 (1994) (where carrier failed to timely raise an objection to an apparently out-of-state physician's status as an attending physician under *former* ORS 656.005(12)(b)(A) and treated the physician as an attending physician, the carrier's failure to timely object was treated as a concession that the physician was an attending physician).

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." An "actual worsening" may be established by direct medical evidence of a pathological worsening, or for a symptomatic worsening to constitute an "actual worsening," a medical expert must conclude that the symptoms have increased to the point that it can be said that the condition has worsened. *SAIF v. Walker*, 145 Or App 294, 305 (1996). Absent such evidence, it is no longer permissible for the fact-finder "to infer from evidence of increased symptoms that those symptoms constitute a worsened condition for purposes of proving an aggravation claim." *Id.*

The question of whether claimant's right shoulder condition pathologically worsened since May 30, 1995, the date of the last arrangement of compensation, presents a complex medical question, the resolution of which turns largely on expert medical evidence. *Uris v. Compensation Department*, 247 Or 420, 426 (1967); *Kassahn v. Publishers Paper Co.*, 76 Or App 105, 109 (1985). The medical evidence regarding the question of actual worsening is provided by two physicians: Dr. Donahoo, examining orthopedist, and Dr. Galt, treating orthopedist. Furthermore, Drs. Donahoo and Galt agreed that the only objective medical evidence of worsening was claimant's reduced range of motion, which they agreed was caused by pain rather than any mechanical cause.

Dr. Donahoo examined claimant on February 6, 1997, at which time claimant reported ongoing right shoulder pain since the initial onset of pain in 1993. (Ex. 34-2). Dr. Donahoo noted that claimant demonstrated pain behavior beyond the anticipated, but did not interfere with the examination. (Ex. 34-6). Regarding any pathologic worsening, Dr. Donahoo opined that claimant's right shoulder acromioclavicular joint impingement had not been treated and it was a question of ongoing symptoms as opposed to pathologic worsening. (Ex. 34-6). Dr. Galt concurred with Dr. Donahoo's report, although he added a notation that he believed claimant was "symptomatic with impingement." (Ex. 35).

In response to questions from the insurer's attorney, Dr. Galt opined that claimant had no pathologic or objective changes in her condition. (Ex. 37). In addition, although Dr. Galt had proposed right shoulder surgery when he first examined claimant on December 17, 1996, after viewing the January 19, 1997 surveillance video showing claimant bowling comfortably and raising her hands over her head in "full flexion," he withdrew his recommendation for surgery. (*Id.*).

In response to questions from claimant's attorney, Dr. Galt opined that claimant had symptoms consistent with diagnoses of impingement syndrome, myofascial syndrome, and derangement of the AC joint of the right shoulder. (Ex. 38). He also stated that pain will reflect a level of inflammation, therefore increasing pain would most likely represent increased inflammation in the shoulder. (*Id.*). Dr. Galt offered no opinion that this represented a pathologic worsening.

In his deposition, Dr. Donahoo testified that he had reviewed all of the medical records and concluded that claimant's right shoulder condition was a continuation of symptoms from the initial onset of the condition in 1993, as opposed to a pathologic worsening. (Ex. 39-4, -7, -8, -19, -20, -22-23). Dr. Donahoo was also concerned about the functional elements claimant displayed on examination. He noted that with the presence of functional elements, you have to discount reported pain a bit and, given those functional elements, he was not willing to say that claimant's pain was strictly due to organic causes. (Ex. 39-14, -17-18, -19-20).

In his deposition, Dr. Galt stated that it was still his opinion that, based on objective medical findings, claimant sustained no material worsening since her claim was last closed on May 30, 1995. (Ex. 40-23). He also explained that, medically speaking, a pathologic change would be a permanent change in tissues and claimant had no permanent structural change. (Ex. 40-25-26). Although Dr. Galt was repeatedly asked about the likelihood of a temporary pathologic change evidenced by inflammation, pain, and/or loss of range of motion, he consistently responded in terms of the possibility of such a change. (Exs. 40-9-10, 40-13, 40-19-20, 40-23, -25-26).

On this record, we find that claimant has not met her burden of proving an "actual worsening" pursuant to ORS 656.273(1). Dr. Donahoo essentially opines that claimant's right shoulder condition remains the same as at the last closure, which does not support claimant's claim. Furthermore, we disagree with claimant's argument that Dr. Galt's opinion establishes a temporary pathologic worsening.

Dr. Galt did not determine, within reasonable medical probability, that claimant sustained a temporary pathologic worsening. Instead, he merely discussed the possibility of such a temporary

worsening. *See Gormley v. SAIF*, 52 Or App 1055 (1981) (medical opinion must be stated in terms of reasonable medical probability, not mere possibility). In addition, we disagree with claimant's interpretation of Dr. Galt's final statement regarding this matter. (Ex. 40-25-26).

In the depositions of both Drs. Donahoo and Galt there was much discussion as to the meaning of claimant's response to two injections in her right shoulder. However, this discussion focused on claimant's diagnoses rather than whether she sustained an actual/pathologic worsening of her right shoulder condition, with Dr. Donahoo opining that claimant's response was inconsistent with a diagnosis of impingement. In contrast, Dr. Galt diagnosed three conditions in claimant's right shoulder (impingement syndrome, myofascial syndrome and derangement of the AC joint). Dr. Galt opined that, because only the impingement syndrome would respond to injections, the fact that claimant did not experience long-lasting relief from shoulder pain with the injections did not weigh against those three diagnoses. (Ex. 40-13-21).

When asked to explain his opinion as to whether or not claimant sustained any pathologic worsening, Dr. Galt explained that, medically speaking, a pathologic change would be a permanent change in tissues and claimant had no permanent structural change. (Ex. 40-25-26). Dr. Galt then stated:

> "But I do feel confident that in the evaluation, my assessment was designed to identify the diagnoses, of which there are three, and to document as well as possible, and I think I would say that it is objective. They were objective findings. So I felt that she was symptomatic with an impingement syndrome at that time." (Ex. 40-26).

Contrary to claimant's argument, this statement does not mean that the impingement syndrome represented a temporary pathologic change. Instead, Dr. Galt simply repeated his conviction that claimant had three conditions in her right shoulder and his exam showed that claimant was "symptomatic with an impingement syndrome."

Accordingly, on this record, claimant failed to meet her burden of proving a compensable aggravation claim.

ORDER

The ALJ's order dated November 20, 1997 is reversed. The attorney fee award is reversed. The insurer's aggravation denial dated March 18, 1997 is reinstated and upheld.

June 18, 1998 Cite as 50 Van Natta 1144 (1998)

In the Matter of the Compensation of
RUTH L. McINTIRE (aka HOLTZ), Claimant
WCB Case Nos. 97-05025 & 97-01888
ORDER OF ABATEMENT
Robert J. Guarrasi, Claimant Attorney
Lundeen, et al, Defense Attorneys
Steven A. Wolf (Saif), Defense Attorney

On May 20, 1998, we set aside the SAIF Corporation's denial of claimant's aggravation claim for her current right shoulder condition, upheld Liberty Northwest's denial of claimant's "new injury" claim for the same condition, and found SAIF responsible for the Administrative Law Judge's (ALJ's) $3,800 carrier-paid attorney fee award. Contending that neither our decision nor the ALJ's order found that claimant's counsel "actively and meaningfully" participated at hearing as required by ORS 656.307(5) and asserting that neither our decision nor the ALJ's order applied the factors recited in OAR 438-015-0010(4), SAIF seeks reconsideration of our decision.

In order to further consider SAIF's motion, we withdraw our May 20, 1998 order. Claimant and Liberty Northwest are granted an opportunity to respond. To be considered, those responses must be filed within 14 days from the date of this order. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
DANIEL L. CARTER, Claimant
WCB Case No. 97-08126
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order which affirmed the Order on Reconsideration that awarded no permanent disability benefits for his lung condition. In his brief, claimant requests that this case be remanded to the Director for the promulgation of a temporary rule adddressing his disability. On review, the issues are extent of unscheduled permanent disability and remand.

We deny the motion to remand and, on the merits, adopt and affirm the ALJ's order, with the following supplementation.

Extent

On review, claimant contends that the ALJ erred in deferring to the opinion of the medical arbiter, Dr. Lewis, in finding that claimant has a Class 1 lung impairment. Based on the opinions of his attending physician, Dr. Corley, and the examining physician, Dr. Smith, claimant argues that he has proven a Class 2 lung impairment. We disagree.

Evaluation of a worker's disability is as of the date of issuance of the reconsideration order. ORS 656.283(7). When rating impairment, only the opinions of the attending physician and the medical arbiter(s), if any, may be considered. *See Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666 (1994); *Roseburg Forest Products v. Owen*, 129 Or App 442 (1994). The impairment findings of an independent (insurer-requested) medical examiner may be used only when the attending physician has ratified those findings. *Owen*, 129 Or App at 445; *Raymond D. Lindley*, 44 Van Natta 1217 (1992). Where a medical arbiter is used, as in this case, we do not automatically rely on the medical arbiter's opinion in evaluating impairment, but rather, rely on the most thorough, complete, and well-reasoned evaluation of impairment due to the injury/disease. *See Kenneth W. Matlack*, 46 Van Natta 1631 (1994).

In this case, we may not consider the impairment findings made by the examining physician, Dr. Smith (Exs. 13-15), because the attending physician, Dr. Corley, did not ratify those findings. *See Owen*, 129 Or App at 445. Furthermore, after considering the impairment findings made by the attending physician, Dr. Corley, and the medical arbiter, Dr. Lewis, we conclude that Dr. Lewis provided the most reliable evaluation of claimant's lung impairment as of the date of issuance of the Order on Reconsideration. The Order on Reconsideration issued on September 29, 1997. (Ex. 38). Three weeks earlier, on September 10, 1997, Dr. Lewis conducted spirometric testing and reported the following findings: claimant's FVC and FEV1 were greater than 80 percent of predicted, and his FEV1/FVC ratio was greater than 70 percent of predicted. (Ex. 37-3). Those findings would place claimant in the Class 1 (0% impairment) category of lung impairment under OAR 436-035-0385(2). *See* WCD Admin. Order 96-072 (eff. 2/15/97).

By contrast, the record shows that Dr. Corley last performed testing of claimant's pulmonary function on January 8, 1997, more than eight months before the issuance date of the reconsideration order. The record further shows that Dr. Corley did not provide specific test results on January 8, 1997, but merely commented that "there ha[d] been no significant change" since the previous testing on September 1, 1995. (Ex. 24).

The fact that the medical arbiter's examination was performed closer in time to the issuance date of the reconsideration order is not always decisive. *See, e.g., Charlene L. Vinci*, 47 Van Natta 1919 (1995). However, we have held that a medical arbiter's report may be more probative when there is a significant time gap between the closing examination and the medical arbiter's examination. *E.g., James A. Hanson*, 50 Van Natta 23, 24 (1998); *Ronald L. Tipton*, 48 Van Natta 2521, 2522 n 5 (1996); *David Gonzalez*, 48 Van Natta 376 (1996). Here, we find that the time gap between Dr. Corley's closing examination and Dr. Lewis's medical arbiter examination (*i.e.*, more than eight months) was significant. We therefore conclude that Dr. Lewis's report provided more probative evidence of claimant's disability as of September 23, 1997, the issuance date of the reconsideration order.

Claimant argues that Dr. Lewis's report is unpersuasive because he declined to measure claimant's lung volume due to concerns about claimant's "volitional splinting secondary to perceived [thoracic] pain." (Ex. 37-3). Claimant asserts that Dr. Lewis's refusal to consider his thoracic pain in rating lung impairment undermined the reliability of his impairment findings. Even assuming that Dr. Lewis's spirometric testing was incomplete, we nevertheless conclude that the objective test results obtained by Dr. Lewis placed claimant in the category of Class 1 lung impairment. Claimant, as the party bearing the burden of proof in this matter, *see* ORS 656.266, must present a preponderance of evidence to support a higher level of lung impairment. Claimant relies on Dr. Corley's report to carry his burden of proof; however, Dr. Corley did not report the specific results of the pulmonary function testing performed in January 1997. Without those test results, we are not persuaded that the results would place claimant in the Class 2 category of lung impairment. Accordingly, based on this record, we conclude that claimant has not carried his burden of proof.

Remand

Claimant next contends that this matter should be remanded to the Director for the promulgation of a temporary rule amending the standards to address his lung disability. ORS 656.726(3)(f)(C) provides in pertinent part:

> "When, upon reconsideration of a determination order or notice of closure pursuant to ORS 656.268, it is found that the worker's disability is not addressed by the standards adopted pursuant to this paragraph, notwithstanding ORS 656.268, the director shall stay further proceedings on the reconsideration of the claim and shall adopt temporary rules amending the standards to accommodate the worker's impairment."

The Board has the authority to remand a claim to the Director for the promulgation of a temporary rule amending the standards to address a worker's disability. *Gallino v. Courtesy Pontiac-Buick-GMC*, 124 Or App 538 (1993). Claimant has the burden of proving that his disability is not addressed by the standards. *See* ORS 656.266; *Susan D. Wells*, 46 Van Natta 1127 (1994).

Noting that he has been restricted to light duty due to pleuritis-related pain, claimant argues that his rating of zero percent impairment does not address his inability to perform his regular work. However, as the ALJ observed, the standards for rating disability specifically provide, in part, that "[p]ain 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." OAR 436-035-0320(3). Therefore, in order to establish his entitlement to an award for pain-related disability, claimant must show that the pain resulted in "measurable impairment"; it is not enough to show that he is medically restricted from returning to his regular job. "Measurable" lung impairment is addressed by the standards under OAR 436-035-0385(2), which sets forth four classes of impairment. Under this standard, claimant's pulmonary function was measured in the Class 1 category, resulting in no measurable impairment.

Therefore, we conclude that claimant's lung condition is addressed by the standards.[1] Under those standards, his pulmonary function test results were rated as showing no measurable impairment. Because claimant's lung condition is addressed by the standards, but function testing resulted in no measurable impairment, no unscheduled permanent disability award is allowed under the standards and claimant's request for remand must be denied.

ORDER

The ALJ's order dated January 15, 1998 is affirmed.

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[1] Our conclusion, based on *de novo* review of the record, that claimant's disability is addressed by the standards is also supported by the Director's own finding that "[claimant's] disability is addressed by the current Standards." (Ex. 38-2). *See German C. Ronquillo*, 49 Van Natta 129, 131 (1997); *Robert W. Wilmot*, 48 Van Natta 1525 (1996); *Terry J. Hockett*, 48 Van Natta 1297 (1996).

In the Matter of the Compensation of
JOHN J. DRONKERS, Claimant
WCB Case No. 97-05107
ORDER ON RECONSIDERATION
Starr & Vinson, Claimant Attorneys
William J. Blitz (Saif), Defense Attorney

On May 20, 1998, we affirmed an Administrative Law Judge's (ALJ's) order that: (1) increased claimant's scheduled permanent disability award for the loss of use or function of his right forearm from 25 percent (37.5 degrees), as granted by an Order on Reconsideration, to 27 percent (40.5 degrees); and (2) affirmed an Order on Reconsideration that awarded 25 percent (37.5 degrees) scheduled permanent disability for loss of use or function of the left forearm. Reiterating its previously asserted position that the Director lacked authority to refer the claim to a medical arbiter under ORS 656.268(7)(a), the self-insured employer seeks reconsideration of our decision.

Specifically, the employer argues that a referral under ORS 656.268(7)(a) was not appropriate because claimant did not disagree with the findings of impairment used to rate the claim when he requested reconsideration of the Notice of Closure. In support of its argument, the employer relies on the first clause of ORS 656.268(7)(a) and OAR 436-030-0165(1). Pursuant to this statutory language and rule, if the basis for objection to a notice of closure or determination order is disagreement with the impairment used in rating of the worker's disability, the director shall refer the claim to a medical arbiter.

After further consideration of this matter, we continue to agree with the ALJ's conclusion that the Director's referral to a medical arbiter was appropriate under ORS 656.268(7)(a). In addition to the statutory language cited by the employer, this provision also provides that the director shall refer the claim to a medical arbiter if the director determines that sufficient medical information is not available to estimate disability. Furthermore, OAR 436-030-0165(1)(a) mirrors this statutory language. This statutory language and administrative rule authorized the Director's referral in this case. We are not persuaded by the employer's argument that, as a result of the referral, "a new issue was interjected into the review process and no opportunity was afforded to the self-insured employer to respond." To the contrary, there is nothing in the record to indicate that the employer did not have a reasonable opportunity to respond to the medical arbiter's findings during the reconsideration process itself.

Accordingly, we withdraw our May 20, 1998 order. On reconsideration, as supplemented herein, we adhere to and republish our May 20, 1998 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
BRETT S. HUSTON, Claimant
Own Motion No. 98-0223M
OWN MOTION ORDER
Hollander, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable right shoulder tendonitis. Claimant's aggravation rights expired on December 18, 1994. SAIF opposes authorization of temporary disability compensation, contending that: (1) claimant's current condition does not require surgery or inpatient hospitalization; (2) claimant's current condition is not causally related to the accepted condition; (3) SAIF is not responsible for claimant's current condition; and (4) surgery or hospitalization is not reasonable and necessary for the compensable injury.

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

On October 6, 1997, claimant presented himself to the emergency room for an injury to his shoulder. The attending emergency room doctor diagnosed a right shoulder strain and completed a First Medical Report form with the same diagnosis. No further medical documentation is contained in the record. Thus, the record submitted to us fails to demonstrate that claimant requires surgery or hospitalization for treatment now or in the near future.

Additionally, SAIF contends that claimant has not formally requested acceptance or denial of any new medical condition. SAIF further contends that claimant's April 6, 1998 letter "simply made a 'claim for benefits'" and that his letter is insufficient to constitute as a formal written request for claim acceptance or denial. As noted above, SAIF contends claimant's current condition is not causally related to the accepted condition. Claimant has not responded to SAIF contentions.

Inasmuch as the dispute between the parties remains unresolved, we are not authorized to reopen claimant's 1989 injury claim for the payment of temporary disability benefits. *See* ORS 656.278(1)(a). Should claimant's circumstances change, and surgery is recommended and determined to be reasonable and necessary, claimant may again seek own motion relief.

Accordingly, claimant's request for temporary disability compensation is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT L. SMITH, Claimant
WCB Case Nos. 96-08046 & 96-03518
ORDER ON REMAND
W. Daniel Bates, Jr., Claimant Attorney
Reinisch, et al, Defense Attorneys
Wallace, Klor & Mann, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Pursuant to the court's June 15, 1998 order, we have been directed to consider the parties' settlement. Claimant and Kemper Insurance have submitted a proposed "Disputed Claim Settlement and Stipulation," which is designed to resolve the parties' dispute regarding the compensability of claimant's current need for treatment.

Pursuant to the settlement, claimant and Kemper agree that Kemper's denial "shall be affirmed in all respects and become final." Claimant and Kemper further stipulate that claimant's "Request for Hearing shall be dismissed with prejudice."

We have approved the proposed settlement, thereby fully and finally resolving this dispute, in lieu of all prior orders.[1] Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

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[1] Listing unpaid medical service provider billings that were in the insurer's possession on the date the settlement terms were agreed on, the agreement provides that the insurer will satisfy those accounts in addition to the settlement proceeds paid to claimant. In setting forth this provision, the parties state that "ORS 656.313(4)(d) does not apply." Page 3, line 7. We have previously ruled that a settlement containing a provision that a carrier will pay all outstanding medical service provider billings as of the "settlement date" is approvable. *Jodi G. Palmer*, 47 Van Natta 1925 (1995). However, the basis for such an approval is not that the medical service provider reimbursement formula of ORS 656.313(4)(d) is not applicable; rather, our approval is premised on an acknowledgment that the carrier is exceeding its obligation under the statutory scheme. Here, in granting our approval of the parties' settlement, we have construed the aforementioned provision in a manner consistent with the *Palmer* rationale.

In the Matter of the Compensation of
CHARLES R. WRIGHT, Claimant
WCB Case No. 96-08551
ORDER ON REVIEW
Aspell, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Hall and Bock.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that set aside its denial of claimant's occupational disease claim for pleurisy.[1] On review, the issue is compensability.

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

Claimant, age 62 at the time of hearing, worked as a fireman for approximately 10 years during the 1960's and 1970's. In 1976, he made an occupational disease claim for heart and lung problems. After protracted litigation, SAIF was directed to accept claimant's heart and lung conditions, diagnosed as pleuritis, pericarditis and coronary artery spasm.[2] (*See* Ex. 9). These conditions were found compensable under the "firefighter's presumption" of the occupational disease statute, ORS 656.802.[3] (Exs. 9, 13, 15, 16, 17).

Claimant's claim was closed pursuant to a May 3, 1979 Determination Order. In December 1981, claimant was readmitted to the hospital with recurrent chest pains. (Ex. 18, 19). Although SAIF voluntarily reopened the claim, it later issued a denial stating that its earlier reopening of the claim had been in error. After further litigation, claimant was found to have suffered an aggravation of his "compensable pleuritis condition" and his claim was remanded to SAIF for reopening. (Exs. 39, 45). *See also Charles R. Wright*, 39 Van Natta 374 (1987).

Meanwhile, a December 4, 1986 Determination Order found claimant to be permanently and totally disabled as of October 14, 1986. (Exs. 40, 41, 42).

In August 1991, SAIF denied the compensability of claimant's rheumatoid arthritis and collagen disease. (Ex. 50). This denial was not appealed and became final by operation of law.

On December 26, 1995, claimant experienced an acute inferior wall myocardial infarction. (Exs. 60, 61, 62). During the course of treatment for claimant's myocardial infarction, he was again diagnosed with pleurisy.

Dr. DeMots reviewed claimant's medical records at SAIF's request. On December 15, 1996, Dr. DeMots opined that claimant's recent pleurisy episode was not work related. On December 30, 1996, SAIF denied the compensability of pleurisy.

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[1] That part of the ALJ's order which upheld SAIF's partial denial of claimant's coronary artery disease and myocardial infarction is not contested on review.

[2] A November 13, 1978 Opinion and Order found the claim compensable. SAIF requested review, and on May 9, 1979, the Board affirmed the then-Referee's order. SAIF requested judicial review and the Court of Appeals reversed the Board, finding the claim not compensable. *Wright v. SAIF*, 43 Or App 279 (1979). The Oregon Supreme Court allowed review and reversed the Court of Appeals. *Wright v. SAIF*, 289 Or 323 (1980). On remand, the Court of Appeals held that the evidence was insufficient to overcome the statutory presumption that claimant's condition was related to his employment as a fireman. The court therefore affirmed the Board's order finding the claim compensable. *Wright v. SAIF*, 48 Or App 867 (1980).

[3] Pursuant to *former* ORS 656.802(2) (which has since been renumbered 656.802(4)), the law presumes that, under certain circumstances, a firefighter who experiences disability or impairment caused by certain enumerated conditions, including disease of the lungs, has a compensable occupational disease.

In setting aside SAIF's denial, the ALJ determined that the denied condition (pleurisy) was the same as the "pleuritis" condition that SAIF had accepted in connection with claimant's occupational disease claim. On review, SAIF contends that it accepted only "pleural pericarditis," which is not the same as "pleurisy." Alternatively, SAIF argues that even if its prior acceptance encompassed pleurisy, claimant's current pleurisy condition is separate from, and unrelated to, the accepted pleurisy condition. We disagree.

Contrary to SAIF's contention, we find that SAIF was ordered to accept "pleuritis" as part of claimant's original occupational disease claim.[4] (*See, e.g.*, Ex. 9, the Opinion and Order finding that claimant "developed pleuritis, pericarditis and coronary artery spasm" presumably related to his work as a firefighter). *See also Wright v. SAIF*, 48 Or App at 871, where the court, on remand, explained that claimant had both "pericardial (heart-related) and pleuritic (lung-related) problems," and that "his lung problems arose after he inhaled super-heated smoke while involved in extinguishing a serious fire."[5] Therefore, it is the law of the case that claimant's pleuritis condition is compensable.

Unless the evidence establishes that claimant's current pleurisy condition is different from, or unrelated to, his compensable pleuritis condition, the *res judicata* doctrine of "issue preclusion" bars SAIF from relitigating compensability.[6] *See, e.g., David R. Sills*, 48 Van Natta 1621 (1996) (in determining whether issue preclusion applies, Board will focus on whether the current denied condition is the same condition which was actually litigated and found compensable in a prior proceeding).

After considering the medical evidence, we are persuaded that claimant's current pleurisy condition is the same pleuritis condition that was found compensable in 1980 and 1987. Dr. Berven, claimant's treating doctor since 1975, explained in 1996 that, over the past 20 years, claimant has experienced two types of chest pain, substernal (characteristic of angina) and pleural. Dr. Berven noted that ever since claimant was exposed to super-heated smoke in a large fire he was fighting, he has experienced recurrent episodes of pleuritis. In addition, Dr. Berven noted that, although claimant does not currently have pericarditis, "he certainly has recurrent pleural pain that has really never gone away." Dr. Berven concluded that his examination of claimant "has been compatible with recurrent episodes of pleural inflammation." (Ex. 68).

Although Dr. DeMots determined that claimant's recent pleurisy episode is not work related (Ex. 75), we are unpersuaded by his opinion because it is conclusory and inconsistent with the law of the case. *See Kuhn v. SAIF*, 73 Or App 768 (1985). Dr. DeMots' opinion does not acknowledge that claimant's history of recurrent pleuritis is compensable as a matter of law, nor does it explain why claimant's more recent episode is unrelated to his prior episodes.

Consequently, on this record, we agree with the ALJ's decision to set aside SAIF's denial of claimant's current pleurisy condition.

Because claimant's compensation was not reduced by this 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 $1,300, 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.

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[4] Like the ALJ, we take official notice of the fact that "pleuritis" is synonymous with "pleurisy." *See* Stedman's Electronic Medical Dictionary, 1996 (based on Stedman's Medical Dictionary, 26th ed.).

[5] SAIF was also directed to accept claimant's "recurrent pleuritis" in 1987 as a part of his 1981 aggravation claim. *See Charles R. Wright*, 39 Van Natta at 375. In that case, we acknowledged that "[c]laimant suffers from a compensable pleuritis condition characterized by inflammation of the pleura." *Id.; see also* Ex. 45.

[6] Although ORS 656.262(6)(c) allows a carrier to later deny an accepted combined or consequential condition "if the otherwise compensable injury ceases to be the major contributing cause of the combined or consequential condition," that provision is inapplicable in this case because SAIF does not contend (and the medical evidence does not establish) that claimant's current pleurisy condition is a combined or consequential condition for purposes of ORS 656.005(7).

ORDER

The ALJ's order dated December 3, 1997, is affirmed. For services on review, claimant's counsel is awarded an assessed fee $1,300, payable by the SAIF Corporation.

In the Matter of the Compensation of
JANET R. CHRISTENSEN, Claimant
WCB Case No. 97-09018
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Sather, et al, Defense Attorneys

Reviewed by the Board *en banc*.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that affirmed an Order on Reconsideration that declined to award any scheduled or unscheduled permanent disability arising out of claimant's accepted lumbar strain. On review, the issues are administrative notice and extent of scheduled and unscheduled permanent disability. We affirm.

FINDINGS OF FACT

Claimant compensably injured her low back on May 16, 1996 while lifting a box of mirrors. On May 31, 1996, the employer accepted "low back pain r/o HNP."

Claimant initially treated with Dr. Yarusso, who diagnosed back pain with degenerative disc disease, spinal stenosis and herniated nucleus pulposus at L3, L4 and L5. (Exs. 5, 8, 9). Claimant also saw Dr. Tenabe, a neurosurgeon, who diagnosed chronic lumbar strain superimposed on spondylitic changes in the lumbar spine and mild to moderate lumbar stenosis. (Ex. 13). Claimant's claim was processed and benefits were paid.

Between May 1996 and January 1997, claimant's continuing low back and radicular symptoms were treated conservatively by a series of physicians, including neurosurgeons Rosenbaum and Miller and Drs. Keenen and Wong. (*See, e.g.*, Exs. 15, 18, 22, 30, 39, 40)

On January 14, 1997, Dr. Wong became claimant's attending physician. (Ex. 41). He authorized claimant's return to modified work. (Ex. 41, 42). A January 21, 1997 physical capacities evaluation (PCE) found her capable of performing sedentary-light work. (Ex. 44). On February 4, 1997, Dr. Wong concurred with the PCE and found claimant medically stationary. (Ex. 46).

On March 4, 1997, claimant was examined by Drs. Stanford and Ferris at the employer's request. They diagnosed spinal stenosis, degenerative arthritis, a history of low back strain on May 16, 1996, exogenous obesity and deconditioning. Drs. Stanford and Ferris also concluded that claimant's May 16, 1996 back strain did not cause permanent impairment. (Ex. 48-6). Dr. Wong concurred with this report. (Exs. 49-3, 50).

On March 20, 1997, Dr. Wong performed a closing evaluation and noted that claimant had a chronic condition that would tend to wax and wane. He released claimant to sedentary-light work. (Ex. 49). In a supplemental report, Dr. Wong indicated that claimant's May 16, 1996 injury resulted in a lumbar sprain/strain, which combined with her preexisting degenerative joint disease and stenosis to prolong her need for treatment. Dr. Wong further opined that, as of March 1997, claimant's low back strain had resolved and did not result in any permanent disability. (Ex. 54).

On June 4, 1997, the employer issued a denial indicating that it had accepted and processed a "lumbar strain/sprain" and denying claimant's preexisting conditions (degenerative disc and joint disease, stenosis and herniation) as well as her current condition. (Ex. 56).

Thereafter, on June 17, 1997, claimant's injury claim was closed pursuant to a Notice of Closure which awarded temporary disability only. (Ex. 57). Claimant requested reconsideration of the Notice of Closure and a medical arbiter examination.

On October 18, 1997, claimant was examined by a medical arbiter panel consisting of Drs. Ballard, Olson and Vessely. Noting that claimant's preexisting degenerative disc and joint disease, stenosis and herniations were in denied status, the medical arbiters found no impairment and limitations related to claimant's May 16, 1996 back strain/sprain. (Ex. 62).

An October 30, 1997 Order on Reconsideration affirmed the Notice of Closure in all respects, finding that claimant had "no physical or vocational limitations due to her accepted 'lumbar strain.'" (Ex. 63).

Subsequent to the issuance of the Order on Reconsideration, the Board issued an Order on Review setting aside the employer's June 4, 1997 denial and remanding the claim for processing according to law.[1] This order is subject to judicial review and is not yet final.

CONCLUSIONS OF LAW AND OPINION

Acknowledging that claimant's preexisting conditions were in denied status at the time of claim closure, the ALJ found that claimant failed to establish any permanent impairment related to her accepted lumbar strain condition. Consequently, the ALJ affirmed the Order on Reconsideration's award of no scheduled or unscheduled permanent disability for the lumbar spine.

On review, claimant first requests that we take administrative notice of our March 16, 1998 Order on Review which issued subsequent to the ALJ's order. On the merits, claimant argues that the ALJ erred in affirming the Order on Reconsideration and that (in light of the subsequent order finding her degenerative disc disease and spinal stenosis compensable) she is entitled to an award of 31 percent unscheduled permanent disability for her low back and 13 percent scheduled permanent disability for loss of use or function of her right leg. Alternatively, claimant requests remand to the ALJ for rating of her compensable conditions.

As discussed below, we find that we are authorized to take administrative notice of our March 16, 1998 Order on Review. We nevertheless conclude that, because a preponderance of the medical evidence fails to establish any ratable impairment arising from claimant's compensable lumbar strain, the October 30, 1997 Order on Reconsideration must be affirmed. In addition, because such action would be procedurally premature and inconsistent with the provisions of ORS 656.262(7)(c), we decline to rate claimant's other compensable conditions at this time.

As a general rule, the Board may take administrative notice of "any fact capable of accurate and ready determination by resort to sources whose accuracy cannot be reasonably questioned." *See Groshong v. Montgomery Ward Co.*, 73 Or App 403 (1985); *Gasper Lopez*, 48 Van Natta 1774 (1996). This includes the ability to take administrative notice of agency orders involving the same claimant. *See, e.g., Gary L. Goodeagle*, 47 Van Natta 628 (1995). In addition, for purposes of administrative efficiency, we will generally give precedential effect to a non-final litigation order. *See Elmer F. Knauss*, 47 Van Natta 826, *on recon* 47 Van Natta 1064 (1995).

On the other hand, pursuant to ORS 656.283(7), we are statutorily prohibited in "extent" cases from considering "[e]vidence on an issue regarding a notice of closure or determination order" if that evidence was not submitted on reconsideration and made a part of the reconsideration record. *See, e.g., Precision Castparts v. Plummer*, 140 Or App 227 (1996); *Joe R. Ray*, 48 Van Natta 325, *on recon* 48 Van Natta 458 (1996). Therefore, insofar as our March 16, 1998 Order on Review was not in existence at the time of the reconsideration proceeding, we may not consider it as evidence on any issue regarding the Notice of Closure in this case. ORS 656.283(7) does not, however, prohibit us from taking official notice of the fact that claimant's stenosis and degenerative disc disease conditions were found compensable subsequent to the issuance of the Order on Reconsideration.

Because taking administrative notice of our prior Order on Review has no impact on our rating of those conditions accepted at the time of closure (but is relevant to this case insofar as we discuss the procedure for processing and rating of conditions found compensable subsequent to claim closure), we grant claimant's request.

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[1] As discussed *infra*, we take official notice of this "post-reconsideration" fact.

As the ALJ noted, at the time of the issuance of the Notice of Closure, claimant's underlying stenosis and degenerative disc disease were in denied status. By its terms, the Notice of Closure did not determine any benefits regarding any conditions in denied status at that time. (Ex. 57). In fact, it is evident from the record that the only compensable condition being determined and rated by the Notice of Closure and Order on Reconsideration was the lumbar sprain/strain resulting from claimant's May 16, 1996 injury.[2] (Exs. 56, 62, 63). Because the uncontroverted medical evidence establishes that claimant has no permanent impairment caused by her compensable lumbar strain,[3] the Order on Reconsideration must be affirmed.

In *Anthony J. Telesmanich*, 49 Van Natta 49, 51 (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* ORS 656.262(7)(c); *Bernard G. Hunt*, 49 Van Natta 223 (1997). Therefore, in rating permanent disability under the current statutory scheme (particularly ORS 656.262(7)(c)[4]), the focus is on accepted conditions at the time of claim closure and reconsideration. *See James Mack*, 50 Van Natta 338 (1998) (Evaluation of a "post-closure" accepted condition must await the reopening and processing of the claim for that new condition).

We reject claimant's contention that her stenosis and degenerative disc disease do not constitute "additional conditions" because our March 16, 1998 Order on Review found that the employer's original acceptance of "low back pain r/o HNP" encompassed her underlying low back conditions. For purposes of claim processing and ORS 656.262(7)(c), the determinative factor is when the condition is found compensable. If the condition is found compensable *after* claim closure, the carrier is obligated to "reopen" the claim for processing of that condition. Consequently, in this case, by virtue of our March 16, 1998 order, claimant's stenosis and degenerative disc conditions have been remanded to the employer for processing according to law. If claimant is dissatisfied with the processing and rating of these conditions, she may request reconsideration and/or a hearing at the appropriate time. *See Patricia Dropinski*, 49 Van Natta 212 (1997).

ORDER

The ALJ's order dated March 6, 1998 is affirmed.

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[2] Although the employer had accepted "low back pain r/o HNP," claimant's underlying stenosis and degenerative disc disease were denied and therefore not accepted conditions at the time of claim closure or reconsideration.

[3] *See, e.g.*, Exs. 48 and 50 (Dr. Wong concurred with the findings of Drs. Stanford and Ferris, including their determination that claimant's "back strain" did not cause permanent impairment); Ex. 62 (the medical arbiter panel similarly reported that claimant's current findings and limitations were due to her preexisting degenerative condition rather than a strain).

[4] This section provides that "[i]f a condition has been found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition."

In the Matter of the Compensation of
WALTER LEPTIEN, Claimant
Own Motion No. 95-0183M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE

On May 7, 1998, the Board received claimant's letter dated May 4, 1998, requesting review of the self-insured employer's January 15, 1998 Notice of Closure which closed his claim with an award of temporary disability compensation from April 6, 1995 through December 3, 1997. The Notice of Closure declared claimant medically stationary as of December 3, 1997. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

Under OAR 438-012-0060(1), a request for review of the insurer's claim closure must be in writing and filed with the Board within 60 days after the mailing date of the notice of closure, or within 180 days after the mailing date if the claimant establishes good cause for the failure to file the request within 60 days after the mailing date.

Here, the 60th day following the January 15, 1998 mailing of the Notice of Closure was March 16, 1998. Claimant's letter is dated May 4, 1998, and received by the Board on May 7, 1998. Hence, claimant's filing was untimely.

Furthermore, if a request for review of the notice of closure is not timely filed, it is incumbent upon claimant to establish that there was good cause for failure to file the request within 60 days after the mailing date of the notice of closure. *See* OAR 438-012-0060(1). Claimant submitted a June 10, 1998 letter wherein he explains that he did not seek review of the closure within the 60-day appeal period because he was "trying [to] work on my knee to try and improve or being able to do normal activities, which I cannot do." We do not find that claimant's attempt to rehabilitate his knee prior to seeking review of the closure, constitutes "good cause" for failing to file within the 60-day appeal period. In fact, we conclude that claimant only sought review of the closure when his condition worsened, which was beyond the 60-day appeal period.[1] Therefore, claimant's request is untimely, and the closure is final by law.

Additionally, in his request for review, claimant raises the issue of "permanent disability." 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. 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).

Accordingly, we dismiss claimant's request for review of the employer's January 15, 1998 Notice of Closure.

IT IS SO ORDERED.

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[1] If claimant's compensable condition has worsened to the extent that surgery and/or inpatient hospitalization is eventually required, he may again request reopening of his claim for the payment of temporary disability. *See* ORS 656.278(1).

Further, it appears from claimant's request that he is unclear as to his rights and benefits under the Workers' Compensation laws. 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, since claimant is unrepresented, he 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

In the Matter of the Compensation of
DOUGLAS G. ABBOTT, Claimant
WCB Case No. 96-08127
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by the Board en banc.

Claimant requests review of Administrative Law Judge (ALJ) Myzak's order that: (1) upheld the insurer's denials of his aggravation claim for low back and left leg pain; and (2) upheld the insurer's partial denial of his claim for left-sided leg symptoms. On review, the issues are compensability and aggravation. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant, age 60 at the time of hearing, has a history of back problems dating back to the early 1970's. In April 1973, Dr. Holbert performed a laminectomy and fusion at L5-S1. (Ex. 3). On October 5, 1991, claimant slipped off a ladder and sustained a low back injury while working for another employer. (Ex. 5). He was treated conservatively. (Ex. 6).

On October 22, 1994, claimant was compensably injured when he fell while climbing into a truck. (Ex. 8). Dr. Adams diagnosed a disk herniation at L4-5 on the right. (Ex. 11). On November 14, 1994, Dr. Adams performed a total hemilamectomy of L4 on the right with exploration of the L5 nerve and decompression of the L4 nerve with a diskectomy of L4-5. (Ex. 12). On December 5, 1994, the insurer accepted "L4-5 disc herniation, right." (Ex. 14). Claimant continued to experience symptoms and Dr. Adams performed a re-exploration of the right L4-5 disk area on December 15, 1994. (Ex. 16). Claimant returned to modified work in early 1995. (Tr. 10).

Claimant developed left leg symptoms approximately four months after surgery. (Ex. 20). Dr. Adams recommended an independent medical examination. (*Id.*)

On September 29, 1995, Dr. Rich, neurologist, and Dr. Marble, orthopedic surgeon, examined claimant on behalf of the insurer. (Ex. 21). They diagnosed, among other things, "[c]hronic mechanical low back pain with leg symptoms, possibly due to postoperative fibrosis." (Ex. 21-4). Dr. Adams concurred with their report. (Ex. 22).

An MRI on November 14, 1995 showed no definite evidence of disc herniation or stenosis. (Ex. 24). The radiologist noted that "[m]ost of the soft tissue density posterior to the disc on the right at [L4-5] * * * is felt to represent fibrosis and scar tissue." (*Id.*)

Claimant's October 1994 claim was closed by a Determination Order dated November 20,1995, which awarded 22 percent unscheduled permanent disability for his low back condition. (Ex. 25). Claimant requested reconsideration. Drs. Scheinberg and Neumann performed a medical arbiter examination on March 19, 1996. (Ex. 31). An Order on Reconsideration dated April 11, 1996 awarded claimant 32 percent unscheduled permanent disability for his low back condition. (Ex. 35).

Claimant was referred to Dr. Kitchel, who diagnosed mechanical low back pain, multiple level lumbar degenerative disc disease and radiculitis at left L4 and left L5. (Ex. 26-5). He did not recommend surgery.

On April 9, 1996, Dr. Adams reported that claimant's left leg pain was becoming "incapacitating" and he discussed the possibility of surgery. (Ex. 28-1). On May 2, 1996, Dr. Adams signed a "Notice of Claim for Aggravation of Occupational Injury or Disease." (Ex. 36). Dr. Adams wrote to the insurer on May 10, 1996, referring to claimant's "significant" left leg pain. (Ex. 37).

On July 17, 1996, Dr. Rosenbaum, neurosurgeon, examined claimant on behalf of the insurer. (Exs. 38, 39). He concluded that claimant did not have structural lesion and was not a candidate for surgery. (Ex. 39-1). Dr. Rosenbaum said that claimant's left leg pain was presumed to be a residual of his prior lumbar diskectomies. (Ex. 39-4).

Dr. Gallo, neurosurgeon, examined claimant on November 18, 1996. (Ex. 44). Dr. Gallo diagnosed back and left leg pain in the S1 distribution without obvious etiology. (Ex. 44-5). She recommended a discogram, which was performed by Dr. Wilson on November 26, 1996. (Ex. 45). A CT scan was performed on the same day. After reviewing the test results, Dr. Gallo reported that the tests showed a solid fusion at L5-S1 with multilevel painful disc degeneration above that, with no evidence of disc herniation or nerve root compression. (Ex. 46).

Claimant began treating with Dr. Bert because Dr. Adams retired. (Tr. 16). On January 13, 1997, Dr. Bert diagnosed mechanical instability with a failed disc syndrome at L4-5 and recommended a "salvage procedure" that would be a fusion at L4-5. (Ex. 47). On January 15, 1997, Dr. Bert signed a "Notice of Claim for Aggravation of Occupational Injury or Disease" and a "Change of Attending Physician" form. (Exs. 48, 49).

On February 22, 1997, Dr. Bald examined claimant on behalf of the insurer. He diagnosed, among other things, "[m]oderately severe degenerative disc disease of the lumbar spine, pre-existing, progressive and unrelated." (Ex. 50-6). He concluded that the major contributing cause of the increased symptomatology was related to the natural progression of his preexisting degenerative disc disease. (*Id.*) Dr. Bald was later deposed. (Ex. 56).

In a concurrence letter from claimant's attorney signed on April 23, 1997, Dr. Bert agreed that claimant's L4-5 failed disc syndrome combined with the preexisting degenerative changes, and the October 22, 1994 injury and subsequent surgeries were more than 50 percent responsible for claimant's condition. (Ex. 55-3).

On August 8, 1996, the insurer issued a denial of claimant's aggravation claim on the basis that his condition had not objectively worsened. (Ex. 40). The insurer issued an amended denial on October 25, 1996, which included a partial denial of claimant's treatment for low back and left leg pain on the basis that his left sided symptoms were not related to the accepted lumbar strain and right L4-5 disc herniation. (Ex. 43). Claimant requested a hearing on both denials.

CONCLUSIONS OF LAW AND OPINION

The ALJ noted that claimant did not specify what legal theory he was pursuing. However, because claimant relied on the opinions of Drs. Bert and Rosenbaum, which supported a consequential condition theory, the ALJ analyzed the claim as an aggravation and consequential condition. The ALJ concluded that the medical evidence did not establish either an aggravation or compensability of the left-sided leg symptoms.

On review, claimant contends that Drs. Adams, Bert, Rich, Marble, Kitchel and Rosenbaum attributed his left-sided leg symptoms to the consequences of his October 22, 1994 injury and two subsequent surgeries. He argues that he has established compensability of his left-sided symptoms and the aggravation of his October 22, 1994 injury.

Under ORS 656.273(1), a worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings. Two elements are necessary to establish a compensable aggravation: (1) a compensable condition; and (2) an "actual worsening." *Gloria T. Olson*, 47 Van Natta 2348, 2350 (1995). If the allegedly worsened condition is not a compensable condition, compensability must first be established under ORS 656.005(7)(a). *Id.*

We begin our analysis with a determination of whether claimant's current condition is a compensable condition. As a result of the October 1994 injury, the insurer accepted "L4-5 disc herniation, right." (Ex. 14). Claimant's current left leg pain is not an accepted condition. Therefore, in order to establish a worsened condition resulting from the original injury, claimant must first establish that the left leg pain is a compensable condition. *See Gloria T. Olson*, 47 Van Natta at 2350.

Claimant asserts that he had no complaints of left leg pain at the time of the October 1994 injury and did not develop left leg symptoms until approximately four months after the second L4-5 surgery, which took place on December 14, 1994. (Exs. 11, 20). We find no medical evidence that establishes that claimant's left leg symptoms arose directly from the October 1994 injury. Rather, we agree with the ALJ that the medical evidence supporting compensability indicates that claimant's left-sided leg pain was

attributable to the consequences of the October 22, 1994 injury and two subsequent surgeries. Under these circumstances, we conclude that the compensability of claimant's left leg pain is most appropriately analyzed as a consequential condition under ORS 656.005(7)(a)(A). Therefore, in order to establish the compensability of his left leg symptoms, claimant must prove that the compensable October 1994 work injury is the major contributing cause of that condition. ORS 656.005(7)(a)(A).

For the following reasons, we agree with claimant that the preponderance of the medical evidence establishes that his left leg symptoms are compensable.

As we discussed earlier, claimant did not have left leg symptoms at the time of his October 22, 1994 injury. He had two lumbar surgeries following his injury and developed left leg complaints within four months after the second surgery. The left leg symptoms persisted and became progressively worse.

Drs. Rich, Marble, Adams, Kitchel, Rosenbaum and Bert all concluded that claimant's October 22, 1994 injury, together with mechanical instability and scarring following the two L4-5 surgeries, were responsible for claimant's left-sided complaints. Drs. Rich and Marble examined claimant on September 29, 1995, on behalf of the insurer. (Ex. 21). They diagnosed, among other things, "[c]hronic mechanical low back pain with leg symptoms, possibly due to postoperative fibrosis." (Ex. 21-4). They felt that 75 percent of claimant's impairment was due to the October 22, 1994 injury and 25 percent was due to the preexisting spinal fusion at L5-S1. (Ex. 21-6). Dr. Adams, claimant's treating physician, concurred with the opinion of Drs. Marble and Rich. (Ex. 22). A subsequent MRI showed that "[m]ost of the soft tissue density posterior to the disc on the right at [L4-5] * * * is felt to represent fibrosis and scar tissue." ((Ex. 24).

Dr. Kitchel examined claimant in December 1995. He diagnosed mechanical low back pain, multiple level lumbar degenerative disc disease and radiculitis at left L4 and left L5. (Ex. 26-5). He did not recommend surgery. Dr. Kitchel concluded that, assuming claimant's history was accurate, the current problem was a work related injury. (*Id.*)

The opinion of Dr. Rosenbaum, who examined claimant on behalf of the insurer, also supports a causal relationship between claimant's left leg symptoms and the October 1994 injury and resulting surgeries. He concluded that claimant did not have a structural lesion and was not a candidate for surgery. (Ex. 39-1). Dr. Rosenbaum noted that, in the absence of a structural lesion, it was difficult to assess the etiology of left leg pain. (*Id.*) Nevertheless, he opined that claimant's symptoms were consistent with radiating leg pain as well as the two prior operative procedures. (Ex. 39-4). He felt that claimant's subjective complaints were relatively within proportion to his objective findings. (*Id.*) Dr. Rosenbaum concluded that the major contributing cause of claimant's current symptoms was his prior work injury exposure. (*Id.*) He acknowledged that the definitive diagnosis remained "somewhat obscure" because there was no compression. However, he presumed claimant's pain was a residual of his prior lumbar diskectomies, although he could not be absolutely certain. (*Id.*)

Although Dr. Rosenbaum could not state with "absolute certainty" that claimant's left leg symptoms were a residual of his prior lumbar surgeries, 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. Rosenbaum persuasively stated his opinion in terms of reasonable medical probability.

Dr. Bert's opinion also establishes that claimant's left leg symptoms are compensable. He diagnosed mechanical instability with a failed disc syndrome at L4-5 and recommended a "salvage procedure" that would be a fusion at L4-5. (Ex. 47). He opined that claimant's pain was "directly related to an old injury and subsequent surgery." (Ex. 52). In a concurrence letter from claimant's attorney, Dr. Bert agreed with the following:

> "It is your opinion to a reasonable medical probability that [claimant's] left leg pain and numbness are directly related to his October 22, 1994 injury and the two subsequent L4-5 surgeries. It is your opinion that [claimant's] left leg pain and numbness are due to impingement and irritation of the left L5 nerve root. The sources of impingement and irritation are mechanical instability and scarring following the surgical procedures that Dr. Adams performed on November 14, 1994 and December 15, 1994. The x-rays you reviewed on January 13, 1997 confirmed the presence of fibrotic scar tissue. The scarring has extended beyond the right sided L4-5 surgical site into the area of the left nerve root." (Ex. 55-2).

Dr. Bert agreed that claimant's L4-5 failed disc syndrome combined with the preexisting degenerative condition and the October 22, 1994 injury and subsequent surgeries were more than 50 percent responsible for claimant's condition. (Ex. 55-3).

In contrast to the aforementioned medical opinions, Dr. Bald's opinion does not support compensability of claimant's left leg symptoms. He commented that claimant had considerable pain behavior and he felt there was a large psychogenic component to his pain complaints. (Ex. 50-6). Dr. Bald found no evidence of actual mechanical instability and said that the lower back symptoms could be explained by the progression of degenerative disc disease. (Ex. 50-7). He did not believe the left leg symptoms were related to the October 1994 work injury. (*Id.*) Dr. Bald concluded that the major contributing cause of claimant's increased symptomatology was related to the natural progression of his preexisting moderately severe degenerative disc disease. (Ex. 50-6).

We are not persuaded by Dr. Bald's opinion. Although Dr. Bald opined that claimant had "moderately severe" degenerative disc disease, Dr. Gallo reported that claimant had multilevel "mild" degenerative changes. (Ex. 44-5). Dr. Bert agreed that claimant suffered from "an anticipated level of natural degenerative changes." (Ex. 55-3). In light of the reports from Drs. Gallo and Bert, we are not persuaded by Dr. Bald's conclusion that claimant had "moderately severe" degenerative disc disease. Moreover, Dr. Bald is the only physician who attributed claimant's complaints to a "large psychogenic component." In contrast, Dr. Rosenbaum felt that claimant's subjective complaints were relatively within proportion to his objective findings. (Ex. 39-4).

In light of the persuasive reports from Drs. Rich, Marble, Adams, Kitchel, Rosenbaum and Bert, we are not persuaded by Dr. Bald's opinion. We conclude that claimant has established that the compensable October 1994 work injury and sequelae from the injury, including two back surgeries, are the major contributing cause of his left leg symptoms. *See* ORS 656.005(7)(a)(A).

Amended ORS 656.262(7)(c) provides, in 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, Sec. 1 (July 25, 1997). The amendments to ORS 656.262 apply 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, Sec. 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, we have concluded that claimant's left leg symptoms are compensable pursuant to ORS 656.005(7)(a)(A). Accordingly, consistent with *amended* ORS 656.262(7)(c), the insurer must "reopen" the claim for processing of the left leg symptoms.

Aggravation

In order to prove a compensable aggravation, claimant must establish an "actual worsening" of the compensable condition. 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 required to prove an aggravation and that it is no longer permissible, as it was under the former law, to infer a worsened condition from evidence of increased symptoms alone. *Id.*

Here, the insurer accepted an L4-5 disc herniation, right. (Ex. 14). An Order on Reconsideration dated April 11, 1996 awarded claimant 32 percent unscheduled permanent disability for his low back condition. (Ex. 35). In addition, as previously discussed, we have found claimant's left leg symptoms to be compensable. Claimant relies on the opinions of Drs. Adams and Bert, as well as his own testimony, to establish an "actual worsening" of his compensable condition.

Claimant testified that his pain has progressively worsened and he has fallen on occasions because his left leg has given out. (Tr. 12-15). However, claimant agrees that this matter presents a complex medical question. *See Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279 (1993). Because this case involves a complex medical question, claimant's lay testimony is of only limited persuasive value.

Claimant relies on Dr. Adams' May 10, 1996 report to support an "actual worsening." On May 10, 1996, Dr. Adams reported that claimant had significant left leg pain that was becoming incapacitating. (Ex. 37). He said that, since claimant had started complaining of the pain, it had become persistently worse. (*Id.*) However, his conclusory opinion is not sufficient to establish that claimant's symptoms had increased to the point that it can be said that the compensable *condition* has worsened. *See SAIF v. Walker*, 145 Or App at 305; *compare Edward M. January*, 49 Van Natta 1477, *on recon* 49 Van Natta 1915 (1997) (treating physician agreed that the claimant's increased symptoms represented a worsening of the compensable lumbar strain). We find that Dr. Adams' conclusory report that claimant had increased pain is not sufficient to establish an "actual worsening" of the compensable condition.

Claimant also relies on Dr. Bert's lumbar measurements in the January 13, 1997 examination (Ex. 47) and contends that they are "significantly worse" than the measurements obtained at the "March 19, 1995" arbiter examination. We presume that claimant is referring to the March 19, 1996 arbiter examination, in which the arbiter panel concluded that the measured lumbar flexion/extension findings were not valid. (Ex. 31-3, -5). Because the arbiter panel's findings were invalid, claimant's comparison of those findings is of limited probative value.

After reviewing the record, we are not persuaded that claimant has established an "actual worsening" of his compensable condition. Therefore, we conclude that claimant has not established a compensable aggravation claim under ORS 656.273(1).

Attorney Fees

Claimant's attorney is entitled to an assessed fee for services at hearing and on review concerning the partial denial 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 partial denial issue is $3,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated. Claimant is not entitled to an attorney fee for his attorney's services regarding the aggravation issue.

ORDER

The ALJ's order dated November 20, 1997 is reversed in part and affirmed in part. The portion of the ALJ's order that upheld the insurer's partial denial of claimant's left-sided leg symptoms is set aside and the claim is remanded to the insurer for processing according to law. The remainder of the ALJ's order is affirmed. For services at hearing and on review, claimant's attorney is awarded $3,000, payable by the insurer.

In the Matter of the Compensation of
ROBERT N. CLARK, Claimant
WCB Case No. 96-10350
ORDER ON RECONSIDERATION
Cole, Cary, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Claimant requests reconsideration of our April 30, 1998 order that set aside the insurer's denial of his claim for an L4-5 disc herniation and awarded a $4,000 assessed attorney fee. Specifically, claimant requests that we increase the $4,000 attorney fee to $6,500.

On May 27, 1998, we abated our April 30, 1998 order. Having received the insurer's response to claimant's motion, we proceed with our reconsideration.

Claimant argues that approximately 35 hours of attorney time were invested through the hearing level. He seeks a fee of $4,500 to $5,500 for services related to the hearing level. Claimant also asserts that approximately 10 hours of attorney time were spent on Board review and he seeks an attorney fee

of $2,000 for services at the Board review level, for a total fee for the hearing and Board review levels of $6,500. Claimant relies on the factors set out in OAR 438-015-0010(4). In particular, claimant relies on the following factors: the time devoted to the case (45 hours); the complexity of the issues involved; the value of the interest and the benefit secured for claimant (compensability of a herniated disc requiring surgery); the skill of the attorney (over 25 years in workers' compensation representation); and the risk that counsel's efforts might go uncompensated. The insurer relies on our decision in *Lois J. Schoch*, 49 Van Natta 788 (1997), to argue that our award of a $4,000 attorney fee for the Board and hearing level was reasonable.

We determine a reasonable attorney fee by applying the factors set forth in OAR 438-015-0010(4). 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.

Here, claimant's counsel spent approximately 45 hours on the case at the hearing and Board review levels. The record reveals that there were 36 exhibits admitted at hearing. At least four of the exhibits were medical reports obtained by claimant's attorney. In addition, there was one deposition of a physician. The hearing lasted approximately two hours and forty five minutes. Two witnesses testified and the hearing transcript was 56 pages long. On Board review, claimant's counsel submitted an 8-page appellant's brief and 5-page reply in support of claimant's contention that the claim was compensable.

The issue in the case was compensability of a disc herniation requiring surgery. Considering claimant's prior medical history and previous surgeries, the compensability issue was of a complexity level beyond those compensability/medical disputes that are typically tried before the Hearings Division and Board. The value of the interest involved and the benefits secured for claimant were significant in that the disc condition required surgery and claimant will now receive medical and other benefits for that condition. Both attorneys were skilled and experienced in the area of workers' compensation law and presented their arguments in a thorough and well-reasoned manner. Because there was divided medical evidence and a vigorous defense, we find that there was a risk that claimant's counsel's efforts might have gone uncompensated. No frivolous issues or defenses were asserted.

After reconsidering this matter in light of claimant's motion and having considered the insurer's objection, we find, after applying the factors discussed above, that the attorney fee award should be increased to $6,500 as a reasonable attorney fee for claimant's counsel's services at hearing and on Board review.[1] In awarding a greater fee, we have particularly relied on the medical complexity of the compensability issue, the time devoted to the compensability issue (as represented by the record and claimant's appellate briefs), the value of the interest involved, the benefits secured, and the risk that counsel might go uncompensated.

As modified and supplemented herein, we republish our April 30, 1998 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] As we noted above, the insurer has cited our decision in *Lois J. Schoch* to argue that the $4,000 attorney fee awarded by our April 30, 1998 order was reasonable. The insurer notes that although *Schoch* was a complicated case, we awarded $3,000 as a reasonable attorney fee for the hearing and Board levels. *Schoch* was a procedurally complex case involving a denial of low back surgery. There, in determining the amount of a reasonable fee, we took into account the fact that claimant's counsel had already received a $5,750 attorney fee in a collateral proceeding involving the same surgery. In the present case, claimant's attorney has not received any other attorney fees related to the L4-5 disc condition. Given the differences between this case and *Schoch*, we do not find the amount of the fee awarded in *Schoch* to be helpful in determining a reasonable fee in this case, although we consider *Schoch* to be generally helpful in its analysis of the factors to be considered in awarding a reasonable fee.

In the Matter of the Compensation of
JOHN HOFFMAN, Claimant
WCB Case No. 97-01303
ORDER ON REVIEW
Schneider, Hooton, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Bethlahmy'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 with the exception of the last two sentences.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that ORS 656.005(7)(a)(B) was not applicable, but nevertheless concluded that claimant's work activities were the major contributing cause of claimant's disability and need for treatment. On this basis, the ALJ set aside the employer's denial.

On review, the employer argues that claimant's claim should be analyzed as an occupational disease claim. In the alternative, the employer argues that ORS 656.005(7)(a)(B) applies and that claimant failed to meet his burden of proof under that statute. Claimant argues that the employer is raising the occupational disease theory for the first time on Board review and seeks to have that portion of the employer's brief stricken. Claimant further argues that the persuasive medical evidence does not establish that there has been a combination of the injury and claimant's preexisting condition. On this basis, claimant argues that ORS 656.005(7)(a)(B) does not apply and that the material contributing cause standard is applicable.

Where a new theory or issue is raised for the first time on review, we are inclined not to address it. *See Gunther H. Jacobi*, 41 Van Natta 1031 (1989) (fundamental fairness dictates that parties have a reasonable opportunity to present evidence on an issue). On the other hand, we are obligated to apply the appropriate legal standards to determine the compensability of a worker's claim. *Dibrito v. SAIF*, 319 Or 244, 248 (1994). Here, we need not resolve the question of whether claimant is precluded from raising an "occupational disease" theory because, for the reasons which follow, we find that whether the claim is analyzed as an injury or an occupational disease, claimant has not met his burden of proof.

There are three medical opinions addressing the nature and cause of claimant's condition in April 1996. Dr. Gambee examined claimant on behalf of the employer. Dr. Gambee diagnosed Grade 1 spondylolisthesis, unrelated to claimant's work, as well as morbid obesity. He opined that claimant's preexisting conditions are "in the order of 99 percent of his need for treatment" and that claimant's "work exposure was relatively trivial as compared to the obesity and preexisting problems."

Claimant was treated for his back condition by Dr. Wyles. Dr. Wyles indicated that she found no objective medical evidence of injury but diagnosed a sacroiliac strain. However, Dr. Wyles was unable to state that claimant's sacroiliac strain was the result of either on-the-job or off-the-job activities. Dr. Wyles was asked whether it was reasonably medically probable that the work activity in April 1996 combined with the preexisting spondylolisthesis to cause disability or a need for treatment. Dr. Wyles responded that the question was "unclear." She also stated that because she did not see claimant until several months after April 1996, she could not address his status in April 1996. Dr. Wyles also indicated that it was not reasonably medically probable that claimant's work activity was the major cause of claimant's lumbosacral strain, disability and need for treatment. At her deposition, Dr. Wyles indicated that if claimant's history was correct, claimant's work was a "contributing factor."

Dr. Megyesi, a chiropractor who initially treated claimant, also gave an opinion. Dr. Megyesi indicated that it was reasonably medically probable that the work activity combined with the preexisting spondylolisthesis and obesity to cause disability or a need for treatment. Dr. Megyesi also opined that it was reasonably medically probable that claimant's work activities were the major cause of claimant's lumbosacral strain, disability and need for treatment. He based his opinion on the relationship of the onset of claimant's symptoms to his heavy work activities in April 1996.

The opinions of Dr. Megyesi and Dr. Gambee support a conclusion that claimant's April 1996 work activities combined with his preexisting condition to cause disability or a need for treatment. Dr. Wyles indicated it was "unclear" whether the preexisting condition and the work activities combined to cause disability or a need for treatment. Based on the preponderance of the medical evidence (the opinions of Drs. Megyesi and Gambee), we are persuaded that the claim should be analyzed either as an occupational disease under ORS 656.802 or under ORS 656.005(7)(a)(B) as a "combined condition" claim. Whether analyzed as an injury or an occupational disease, claimant must meet the "major contributing cause" standard in order to establish compensability of his claim. *See* ORS 656.802(2), 656.005(7)(a)(B).

After our review of the medical evidence, we find that Dr. Wyles' opinion does not support compensability under the major contributing cause standard. In this regard, although Dr. Wyles indicated at her deposition that claimant's work was "a contributing factor," she also indicated that she could not say whether claimant's sacroiliac strain was the result of either on-the-job or off-the-job activities. In addition, Dr. Wyles indicated that she could not address claimant's "status" at the time of the April 1996 back symptoms, because she did not see claimant at that time. Under these circumstances, we do not find that Dr. Wyles' opinion establishes that claimant's April 1996 work exposure was the major contributing cause of his disability or need for treatment.

We likewise do not find Dr. Megyesi's opinion to be sufficient to meet claimant's burden of proof. In this regard, Dr. Megyesi's opinions are conclusory and are based on the temporal relationship with claimant's symptoms to his job activities. *See Allie v. SAIF*, 79 Or App 284 (1986) (causation cannot be inferred from temporal relationship alone). Consequently, we do not find Dr. Megyesi's opinion persuasive.

Dr. Gambee's opinion, although also conclusory, does not support compensability.

Based on this record, we do not find that claimant has met his burden of proof to establish compensability by a preponderance of the evidence, under either an injury or an occupational disease analysis.

ORDER

The ALJ's order dated December 19, 1997 is reversed. The employer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

June 23, 1998 Cite as 50 Van Natta 1163 (1998)

In the Matter of the Compensation of
JOE M. MANN, Claimant
WCB Case Nos. 97-02500, 97-00383 & 97-00044
ORDER ON RECONSIDERATION
Floyd H. Shebley, Claimant Attorney
Gilroy Law Firm, Defense Attorneys

On May 5, 1998, we abated our April 8, 1998 order that adopted and affirmed the Administrative Law Judge's (ALJ's) order that: (1) upheld the self-insured employer's denials of compensability for a seizure disorder, post-traumatic headache condition, and post-traumatic vestibular disorder; and (2) declined to award a penalty and attorney fee. We took this action to consider claimant's motion for reconsideration. Having received the employer's response, we proceed with our reconsideration.

In requesting reconsideration, claimant challenges only those portions of the order concerning claimant's headache and disequilibrium conditions. Claimant argues that he proved compensability for such conditions at minimum from the date of the compensable injury, January 13, 1995, through August 23, 1996, when claimant sustained a nonwork-related hematoma. Claimant also asserts that he is entitled to a penalty based on unreasonable denials.

The employer responds that compensability must be analyzed as of December 23, 1996, the date the employer issued its denial. According to the employer, because claimant did not establish that his conditions were compensable at that time, he did not carry his burden of proof. The employer further contends that, until reconsideration, claimant has not requested acceptance of a "disequilibrium" condition and that the ALJ and Board correctly concluded that he did not prove he has a "post-traumatic vestibular condition." Finally, the employer argues that the symptoms of headache and disequilibrium occurring during the period between the compensable injury and August 1996 hematoma were "encompassed" within the accepted closed head injury claim and, because claimant did not prove an aggravation, his claim qualifies as one for medical services that is within the Director's jurisdiction.

We first reject the employer's argument that the Director has jurisdiction. Claimant requested that the employer amend its acceptance to include additional conditions. The employer denied such conditions on the basis that the compensable injury was not the major contributing cause. (Ex. 67). Thus, because the litigation has not been merely for medical services for the compensable condition but concerns establishing compensability of "new" conditions, we find that it relates to "underlying" claims and we have jurisdiction. *See, e.g., James L. Anderson,* 50 Van Natta 201 (1998).

We also disagree with the employer's argument that a worker's entire claim fails if compensability is not established as of the date of the denial. *See Susan Vega,* 49 Van Natta 805 (1997) (the claimant proved compensability of her "combined condition" during a discrete period of time and denial set aside for the time period). Here, after again reviewing the record, we agree with claimant that he proved compensability of his headache condition for the discrete period of time between his compensable January 1995 injury and August 1996 hematoma; *i.e.,* the preponderance of medical evidence establishes that his work injury was a material contributing cause of his need for treatment or disability for his headache condition. ORS 656.005(7)(a). In particular, we continue to find that examining physician, Dr. Brown, provided the most persuasive opinion. According to Dr. Brown, the compensable injury caused his headaches up to the date of the hematoma; because the hematoma also could cause headaches, Dr. Brown could not state the major contributing cause of the headaches after the hematoma. (Ex. 83-16, 83-17, 83-27, 83-34). Based on such evidence, we agree with claimant that he proved the compensability of his headache condition from the date of the compensable injury until he sustained a hematoma.

With regard to the disequilibrium condition, claimant asks us to find compensable his claim for "post-traumatic vestibular dysfunction or post-traumatic concussion syndrome, whichever label the Board feels most accurately describes claimant's post-traumatic disequilibrium and imbalance." We continue to adhere to our conclusion that claimant did not prove that he has a "post-traumatic vestibular dysfunction" condition. Thus, we continue to conclude that the employer's denial of such condition should be upheld.

Furthermore, as noted by the employer, claimant did not request that the employer amend its acceptance to include either a disequilibrium condition or a post-traumatic concussion syndrome.[1] *See* ORS 656.262(6)(d). Consequently, we find claimant currently precluded from asserting compensability of such conditions. *Id.*

Finally, we continue to adhere to our conclusion that the employer had a legitimate doubt concerning its liability for the headache condition and, thus, claimant is not entitled to a penalty. *See* ORS 656.262(11)(a).

Claimant's attorney is entitled to an assessed fee for services at hearing and on review concerning the post-traumatic headache 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, on review, and on reconsideration is $1,000, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by 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.

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[1] In his brief, claimant disputed the ALJ's statement that a post-concussion syndrome was encompassed within the closed head injury claim, arguing that the employer never indicated that such condition was part of its acceptance. We understood the ALJ's statement as reflecting a comment from Dr. Brown (*see* Ex. 81), rather than any legal conclusion by the ALJ that a post-concussion syndrome condition was part of the accepted claim.

On reconsideration, as supplemented herein, we adhere to and republish our April 8, 1998 order except for that portion concerning claimant's post-traumatic headache condition. The relevant portion of the ALJ's order is reversed. The self-insured employer's denial is set aside to the extent it denied claimant's headache condition from January 13, 1995 up to August 23, 1996. For services at hearing and on review regarding this issue, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the self-insured employer. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
TERESA MARION, Claimant
WCB Case No. 97-07463
ORDER ON REVIEW (REMANDING)
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Peterson's order that dismissed her request for hearing. On review, the issue is the propriety of the dismissal order. We vacate the ALJ's order and remand.

FINDINGS OF FACT

Claimant filed a request for hearing on September 15, 1997. Neither claimant nor an attorney representing her was present when the hearing convened as scheduled on December 10, 1997. The self-insured employer then moved to dismiss claimant's hearing request based on her failure to appear. The ALJ granted the motion.

On January 5, 1998, the ALJ issued an Order of Dismissal which stated that claimant did not appear and that "no extraordinary circumstance beyond claimant's control justifying postponement of the hearing * * * has been shown, and claimant is deemed to have waived appearance at the hearing and abandoned the claim." However, the ALJ's order also stated that claimant could request reconsideration within 30 days, and that, if she could show good cause for her failure to appear, the Order of Dismissal would be set aside.

On February 4, 1998, claimant mailed a certified letter to the Board. Stating that she was out of the United States on unexpected family business on the date of hearing, claimant requested a "reconsideration on this matter by the review Board." Claimant subsequently provided more information regarding her failure to appear in her appellant and reply briefs.

CONCLUSIONS OF LAW AND OPINION

An ALJ shall dismiss a request for hearing if claimant or her attorney fail to attend a scheduled hearing, unless "extraordinary circumstances" justify postponement or continuance of the hearing. OAR 438-006-0071(2). Here, claimant failed to appear without notice to the Hearings Division. The employer moved for dismissal of claimant's request for hearing, and the ALJ dismissed the hearing request, stating that claimant had failed to show any extraordinary circumstance beyond her control that would justify postponement of the hearing. However, claimant was given 30 days in which to request reconsideration of the dismissal order to show good cause for her failure to appear at hearing.

Within 30 days of the ALJ's order, claimant requested "reconsideration on this matter by the review Board." In so doing, she explained that she was out of the United States on unexpected family business on the date of hearing. We interpret claimant's communication as a motion for postponement. *William E. Bent II*, 48 Van Natta 1560, 1561 (1996). We have previously held an ALJ must consider a motion for postponement of a hearing even after an order of dismissal has been issued. *Olga G. Semeniuk*, 46 Van Natta 152 (1994); *Mark R. Luthy*, 41 Van Natta 2132 (1989).

Moreover, we may remand to the ALJ for the taking of additional evidence if we determine that the record has been improperly, incompletely or otherwise insufficiently developed. *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. *Terrell G. Lee*, 49 Van Natta 2041 (1997).

Because the employer has challenged the representations contained in claimant's postponement request, we examine the record to determine whether it is sufficiently developed to resolve the "postponement" issue. After conducting our review, we conclude that the record is insufficiently developed. *See* ORS 656.295(5).[1] Furthermore, because claimant provided an explanation for her non-appearance within the time parameters prescribed in the ALJ's order, we find a compelling reason to remand this case for further development of the record regarding claimant's postponement request.[2] *Brent Harper*, 50 Van Natta at 500; *cf. Fred T. Hardy* 50 Van Natta 1076 (1998) (*Harper* discussed; case remanded to ALJ for determination of postponement request where no "combined" dismissal order used).

Accordingly, following further development of claimant's explanations for failing to appear at the scheduled hearing, the ALJ shall determine whether claimant's non-appearance was justified and constituted extraordinary circumstances beyond her control. The development of the record may be made in any manner that the ALJ deems appropriate. If the ALJ finds that claimant's explanation satisfies the "extraordinary circumstances" standard, a hearing will then be scheduled for the parties to present evidence on the issues raised by claimant's hearing request.

The ALJ's order dated January 5, 1998 is, therefore, vacated. This matter is remanded to ALJ Peterson for further proceedings consistent with this order. 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 record of all exhibits and testimony. If the ALJ finds that a postponement of the hearing is justified, the case will proceed to a hearing on the merits at an appropriate time as determined by the ALJ. If the ALJ finds that a postponement is not justified, the ALJ shall proceed with the issuance of a dismissal order.

IT IS SO ORDERED.

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[1] In reaching this conclusion, we note that the record does not establish the nature of the "unexpected family business" that prevented claimant's return in time for the scheduled hearing. If she had family business that arose shortly before the hearing, alternative arrangements may not have been available to claimant. On the other hand, if the family business arose some time before the hearing, then alternative arrangements to enable her to attend the hearing may well have been possible.

We also note that the ALJ's "combined order" ("show cause" and "dismissal") was appropriate here, where claimant did not appear at a scheduled hearing and no communication regarding the non-appearance was received. Nevertheless, the "show cause" period should probably have been reduced from 30 to 15 days to avoid confusion and conflict with the 30 day appeal period. *See Brent Harper*, 50 Van Natta 499, 500 n. 2 (1998).

[2] The employer argues that this claim should not be remanded to the Hearings Division because claimant has not made a showing that additional evidence is likely to affect the outcome of this case, based on the representations made in claimant's briefs on review. However, it is the Board's often-stated policy that the ALJ is the most appropriate adjudicator to consider a claimant's explanation for failure to appear at hearing and to determine whether a "postponement" is warranted. *E.g. Randy L. Nott*, 48 Van Natta 1 (1996). As we explained in *Nott* and similar cases, to do otherwise could result in our making a determination of a motion for postponement on less than all relevant facts.

In the Matter of the Compensation of
MARGO E. McMURRIN, Claimant
WCB Case No. 97-06466
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Alice M. Bartelt (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 occupational disease claim for a cervical condition. In her brief on review, claimant contests that portion of the ALJ's order that declined to assess a penalty for SAIF's allegedly unreasonable denial. On review, the issues are compensability and penalties. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings, and we also find that Dr. Verzosa's treatment of claimant was directed at multiple symptoms, including the following: cervicothoracic and right shoulder pain radiating into the right arm; cervical spasm; right shoulder spasm and swelling; numbness and tingling in the right hand; and left shoulder pain.

CONCLUSIONS OF LAW AND OPINION

We adopt and affirm the ALJ's decision with the following alternative rationale on the compensability issue.

The ALJ concluded that claimant had established a compensable occupational disease claim under ORS 656.802(2)(a), which requires claimant to prove that it is more probable than not that her employment conditions were the major contributing cause of the claimed disease. In so ruling, the ALJ deferred to the opinions of Drs. Baker and Verzosa and rejected the contrary opinion of Dr. Tsai.

While we agree with the ALJ's rejection of Dr. Tsai's opinion, we also reject Dr. Baker's opinion, which we find to be poorly-reasoned. We, instead, conclude that compensability of claimant's occupational disease claim is established based solely on the opinion of Dr. Verzosa, which we find persuasive for the reasons given by the ALJ.

In so ruling, we reject SAIF's suggested analysis of this claim under ORS 656.802(2)(b). Under that provision, 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.

We do not agree with the ALJ's rationale that ORS 656.802(2)(b) is not applicable because there is no persuasive evidence that the preexisting condition combined with the effect of claimant's alleged work injury. To the contrary, Dr. Verzosa persuasively opined that claimant's symptoms are attributable to a work-related cervicothoracic strain and nerve compression due to her preexisting degenerative disk condition and swelling, inflammation and spasmodic activity associated with the strain.

We, instead, conclude that ORS 656.802(2)(b) is not applicable because, while claimant has a "combined condition," her theory of compensability is not based on a worsening of her preexisting disk degeneration. Rather, claimant contends that her current symptoms are due in major part to the effects of her work activity. *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).

Claimant's theory of compensability is supported by Dr. Verzosa's persuasive opinion that the condition he treated is due in major part to claimant's work activity rather than the preexisting disk degeneration. Consistent with that opinion, we conclude that ORS 656.802(2)(b) is not applicable, and that claimant has established a compensable occupational disease claim under ORS 656.802(2)(a).

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 regarding the compensability issue is $1,200, to be paid 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 November 24, 1997 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,200, payable by the SAIF Corporation.

In the Matter of the Compensation of
RACHELLE M. ROCK, Claimant
WCB Case No. 97-06788
ORDER ON REVIEW
Lauren Paulson, Claimant Attorney
Thaddeus J. Hettle, Defense Attorney

Reviewed by Board Members Biehl and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that dismissed her hearing request. With her request for review, claimant submits several documents and requests that the Board remand the case to the ALJ for presentation of evidence on the merits. On review, the issues are the propriety of the ALJ's dismissal order and remand. We affirm.

FINDINGS OF FACT

On August 13, 1997, claimant signed a retainer agreement employing her then-attorney of record to represent her in connection with her workers' compensation claim. This retainer agreement stated that it provided "authority for [claimant's then-attorney of record] to file on [claimant's] behalf any legal documents necessary, and appear at any hearing held thereon."

On August 19, 1997, claimant, through her then-attorney of record, requested a hearing raising the issues of aggravation, an August 7, 1997 denial of an aggravation claim, and attorney fees. A hearing was eventually scheduled for November 18, 1997. (WCB Case No. 97-06788).

By letter dated November 17, 1997, claimant's then-attorney of record withdrew claimant's hearing request regarding WCB Case No. 97-06788. On November 25, 1997, the ALJ dismissed claimant's hearing request.

Subsequently, claimant apparently obtained another attorney, although the Board did not receive a copy of a retainer agreement from claimant's current attorney. On December 15, 1997, claimant, through her current attorney, requested review of the ALJ's dismissal order.

On March 4, 1998, claimant, through her current attorney, submitted a motion for remand to the ALJ for reinstatement of claimant's hearing request and development of the record on the merits of her claim. With that motion, claimant submitted several documents.

CONCLUSIONS OF LAW AND OPINION

The issue before us is whether claimant's hearing request should have been dismissed. Based on the following reasoning, we find the ALJ's dismissal order was appropriate.

In her request for review of the dismissal order, claimant contends that her former attorney "withdrew her Request for Hearing without [c]laimant's full understanding of the transaction and the effect such withdrawal would have on her claim." However, we have held that the dispositive issue is not a claimant's state of mind at the time a hearing request is withdrawn but whether the claimant's attorney represented her at hearing and whether the attorney withdrew the hearing request. *See Gilberto Garcia-Ortega*, 48 Van Natta 2201 (1996); *Jerry R. Testerman*, 46 Van Natta 1114 (1994).

Here, claimant signed a retainer agreement employing her former attorney and granting him authority to act on her behalf regarding her workers' compensation claim. In addition, by letter dated November 17, 1997, claimant's then-attorney of record withdrew claimant's hearing request regarding WCB Case No. 97-06788. Thus, the record establishes that claimant, through her former attorney, withdrew her request for hearing. Claimant does not dispute her former attorney's authority to act on her behalf, nor does she dispute the fact that the ALJ dismissed her request for hearing on this claim in response to her former attorney's withdrawal of the hearing request. Under these circumstances, we find no reason to alter the dismissal order. *Robert S. Ceballos*, 49 Van Natta 617 (1997); *William A. Martin*, 46 Van Natta 1704 (1994).

Furthermore, because we find the ALJ's dismissal order proper, claimant's request for remand to develop the record on the merits of her claim is rendered moot. *Compare Silverio Frias, Sr.*, 49 Van Natta 1514 (1997) (remand allowed for development of record on issue of whether the claimant's former attorney had authority to act on the claimant's behalf at the time the former attorney withdrew the claimant's hearing request).

ORDER

The ALJ's order dated November 25, 1997 is affirmed.

In the Matter of the Compensation of
LARRY M. SEARS, Claimant
WCB Case No. 97-02819
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

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

FINDINGS OF FACT

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

Claimant was diagnosed with congestive heart failure in 1995, rather than 1987. (*See* Ex. 17).

CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the relevant facts. Claimant has worked as a "bottle sorter" for the employer for over ten years. He works 4 hours per day, 5 days per week. His work duties involve counting and sorting cans and bottles into carts or bins. He often works rapidly (especially when there is a backlog or customers are waiting), using both hands, grasping three cans at a time in each hand, then reaching and twisting his wrists to deposit the cans into carts. (Tr. 9-14). When he is not busy with bottles and cans, claimant stocks the milk coolers or bales cardboard; he also has occasional "breathers," or down time, when there is no work to do. However, claimant's regular sorting work has increased over time, so that he spends less work time doing other jobs or not working.

Claimant first noticed bilateral hand pain and weakness three or four years before the 1997 hearing. He also had hand tingling, which went away off work. The busier he was at work, the more his hands hurt.

On December 10, 1996, Dr. Snider performed left carpal tunnel release surgery and claimant's left-sided symptoms resolved thereafter. (Tr. 20). Claimant returned to full duty work by February 15, 1997, and his right hand symptoms persisted. (See Tr. 17-18). Claimant does not perform hand or wrist intensive activities off work.

Claimant has diabetes and peripheral neuropathy, nonwork related conditions, which may contribute to or overlap with his bilateral CTS. He was also diagnosed with congestive heart failure and associated fluid retention and weight gain. The medical evidence is divided regarding the relative contributions by work and nonwork related factors. Drs. Snider and Stigler opined that repetitive work activities were the major contributing cause of claimant's CTS; Drs. Jewell and Peterson opined that predispositions or preexisting conditions caused the CTS.

The ALJ found the opinions of Drs. Jewell and Peterson to be the most persuasive, because claimant's medical history (specifically, peripheral neuropathy and congestive heart failure) puts him at risk of CTS; he only worked part time; and his bilateral hand symptoms continued after he stopped working. We disagree.

Dr. Snider, treating physician, acknowledged that claimant's diabetes and congestive heart failure may contribute to his CTS. He also acknowledged that it was difficult to distinguish between peripheral neuropathy (probably related to diabetes) and compressive neuropathy. (*See* Ex. 28). However, claimant does have CTS (based on bilateral electrical studies and surgical findings on the left) and Dr. Snider was able to distinguish between the neuropathy and the CTS. (*See* Ex. 38A). He also explained why he discounted nonwork factors[1] as significant contributors and noted that claimant's repetitive hand intensive work "places the kind of stress on his hands and wrists consistent with activity-induced carpal tunnel syndrome." (*Id.*, Ex. 40-3). Dr. Snider reasoned that claimant's diabetes probably did cause his neuropathy and combined with his work activities to cause the CTS. However, he noted that the dense fibrosis (scarring) which he discovered beneath claimant's left transverse carpal ligament during surgery was consistent with compressive neuropathy (CTS), *not* diabetic or other peripheral neuropathy. (Exs. 40-2). He noted that CTS could coexist with tendonitis or tenosynovitis and fibrosis, but that CTS (and fibrosis) could also occur without tendonitis or tenosynovitis. (Ex. 47-1). Dr. Snider also explained that CTS symptoms often persist after cessation of hand-intensive activity. (Ex. 40-3). He concluded that claimant's sorting activity at work was the major cause of claimant's bilateral CTS. Dr. Snider's reasoning and conclusions are supported by Dr. Stigler. (Ex. 44).

Dr. Jewell opined that claimant's CTS is diabetes related, because the incidence of CTS is higher among people with diabetes. He opined that claimant's work was not of the type that would cause CTS and that claimant's part time sorting would be insufficient repetitive activity in any event. He also stated that claimant's symptoms should have abated when he was not working, if they were work-related. (Exs. 38, 42, 46). We find Dr. Jewell's reasoning unpersuasive, because it is specifically rebutted by Dr. Snider. Moreover, Dr. Jewell does not explain why claimant's left CTS problems resolved after Dr. Snider performed left carpal tunnel release surgery.[2] (*See* Tr. 18, 20; Exs. 39A, 45-2).

Dr. Peterson generally agreed with Dr. Jewell. She predicted that claimant's CTS symptoms would only be partially cured by decompression surgery (based on previous evidence of "small nerve fiber involvement."). (Ex. 45-9). We find Dr. Peterson's opinion unpersuasive for the same reasons that we find Dr. Jewell's opinion unpersuasive. In reaching this conclusion, we specifically reiterate that claimant's left CTS problems *resolved* after his compression release surgery.

We rely on the opinions of Drs. Snider and Stigler, because we find them to be the most well-reasoned and consistent with claimant's particular circumstances. *See Somers v. SAIF*, 77 Or App 259 (1986); *see also Argonaut Insurance Company v. Mageske*, 93 Or App 698 (1988). Accordingly, based on these opinions, we conclude that claimant has established that his work activities were the major contributing cause of his bilateral CTS condition and his claim is compensable. *See ORS 656.802(2).*

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[1] Dr. Snider discounted claimant's diabetes, because the neuropathy symptoms preexisted the December 1995 diabetes diagnosis and he did not believe claimant had diabetes before that time. (Ex. 47-2). He similarly discounted claimant's congestive heart failure, noting that claimant's case was very mild and well-controlled with only a diuretic. (*Id*).

[2] If claimant had primarily a "peripheral" neuropathy, rather than a compressive neuropathy, one would expect his left-sided neuropathic symptoms to continue after the compression release surgery. (*See e.g.*, Ex. 45-9).

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 January 20, 1998 is reversed. The self-insured employer's denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on review, claimant is awarded a $5,000 attorney fee, to be paid by the self-insured employer.

In the Matter of the Compensation of
CARL E. SETZER, Claimant
Own Motion No. 98-0211M
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 claimant's compensable disc herniation L4-5. Claimant's aggravation rights expired on November 27, 1986. 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.

Claimant underwent a decompressive laminectomy and foraminotomy, L4-5 level on February 17, 1998. Thus, we are persuaded claimant's condition worsened requiring surgery. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, and is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

SAIF contends that claimant was not in the work force at the time of the current disability. In response, claimant submits copies of receipts of payment for work he did for various people between November 13, 1997 through January 13, 1998.

We have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction,[1] is the date he enters the hospital for the proposed surgery. Fred Vioen, 48 Van Natta 2110 (1996); John R. Johanson, 46 Van Natta 2463 (1994). The relevant time period for which claimant must establish he was in the work force is the time prior to his February 17, 1998 surgery, when his condition worsened requiring that surgery. See generally Wausau Ins. Companies v. Morris, 103 Or App at 273; Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990); Jeffrey A. Kyle, 49 Van Natta 1331 (1997); Michael C. Batori, 49 Van Natta 535 (1997); Kenneth C. Felton, 48 Van Natta 725 (1996).

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[1] The Board in its own motion jurisdiction can only authorize temporary disability from the time of surgery or hospitalization. See ORS 656.278(1)(a).

Claimant contends that the receipts he submitted demonstrate that he was in the work force at the time his condition worsened. Although SAIF has requested from claimant more information regarding the people who signed the receipts and copies of his 1997 W-2, it has not submitted its response to claimant's recent submission. Under such circumstances, we are persuaded that claimant was in the work force at the time of his current worsening which required surgery.

Accordingly, we authorize the reopening of claimant's claim for SAIF to pay temporary disability compensation beginning February 17, 1998, the date he was hospitalized for surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
NORMA J. WALLACE, Claimant
WCB Case No. 97-01428
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's claim for a shoulder, back and knee injury. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant is a registered nurse at a hospital. She generally works from 7 a.m. to 7:30 p.m. with two 15-minute paid breaks and a 30-minute unpaid lunch break. Claimant and other nurses are provided with pagers by the employer. The nurses are expected to respond to emergencies during their regular working hours and during their paid breaks. However, they are not expected to remain on the premises during their 30-minute unpaid lunch breaks. Nurses may choose to keep their pagers and take their 30-minute lunch break on the premises in order to respond to emergencies during their lunch breaks. However, the employer does not require them to do so.

The employer maintains an on-site fitness center at the hospital which it encourages its employees to use. Employees pay a monthly fee in order to use the fitness facility. On November 12, 1996, claimant decided to combine her first paid break with her lunch break and to spend at least a portion of that time in the fitness center on the treadmill. At approximately noon, she stepped onto the treadmill not realizing that it was operating at full speed. She fell onto her right side injuring her right shoulder, right arm, right knee and low back. She sought medical treatment and filed an 801 claim form on November 18, 1996.

The employer denied compensability on January 31, 1997 on the ground that claimant was not in the course and scope of her employment at the time of the injury.

CONCLUSIONS OF LAW AND OPINION

Finding that claimant's activities were not primarily for her personal pleasure, the ALJ concluded that ORS 656.005(7)(b)(B) was inapplicable. After finding that claimant's injury was not statutorily excluded from coverage under ORS 656.005(7)(b)(B), the ALJ found that the injury arose in the course and scope of claimant's employment and set aside the employer's denial.

On review, the employer argues that, because the injury occurred in the employer's fitness room during claimant's paid break, the injury was the result of a recreational or social activity primarily for claimant's personal pleasure under ORS 656.005(7)(b)(B). For the following reasons, we agree.

ORS 656.005(7) defines a "compensable injury" as an accidental injury arising out of and in the course of employment. It does not include, however, any injury incurred while engaging in recreational or social activities primarily for the worker's personal pleasure. ORS 656.005(7)(b)(B); *Michael W. Hardenbrook*, 44 Van Natta 529, *aff'd mem Hardenbrook v. Liberty Northwest Ins. Corp.*, 117 Or App 543 (1992). Thus, the statute excludes certain activities from the definition of compensable injury. Moreover, "[t]he proper inquiry under ORS 656.005(7)(b)(B) is, what is the primary purpose of the activity [at the time of injury]?" *Kaiel v. Cultural Homestay Institute*, 129 Or App 471, 478, rev den 320 Or 453 (1994).

Therefore, by its express terms, the focus of the inquiry under the statutory exception is the primary purpose of the activity that causes the worker's injury, i.e. whether that purpose is work-related or personal. Inquiries that are relevant to the "arising out of and in the course of employment" question -- such as whether the claimant is being paid at the time of injury; whether the injury occurs during regular work or off-work hours; whether the claimant can discontinue the activity and otherwise perform work duties if needed; whether the activity takes place on or off the employer's premises -- are relevant only insofar as they may reflect on the primary purpose of the injury-causing activity. *See Ester E. Edwards*, 44 Van Natta 1065 (1992), *aff'd mem Liberty Northwest Ins. Corp. v. Edwards*, 118 Or App 748 (1993) (knee injury incurred during an employer-sponsored volleyball game found compensable, where primary purpose of recreational activity was to enhance interoffice working relationships).

Here, claimant acknowledged that she used the fitness center because she had been advised to walk following her heart surgery in 1988. (Tr. 14). The fact that claimant had her pager with her in the fitness room does not convince us that the primary purpose of the activity of using the treadmill was to benefit the employer. In this regard, the fact that claimant would ordinarily have been required to remain on the premises during her break to respond to emergencies in the hospital -- while possibly relevant to an "arising out of and in the course of" inquiry -- does not detract from the personal reasons for her use of the exercise equipment. Based on this record, we find that claimant was injured while performing a recreational activity primarily for her own personal pleasure. On this basis, we conclude that claimant's injuries are excluded from coverage under ORS 656.005(7)(b)(B).[1] Therefore, we do not address the question whether claimant's injuries otherwise arose out of and in the course of her employment.

ORDER

The ALJ's order dated November 21, 1997 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's award of an attorney fee is also reversed.

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[1] Claimant cites *Jack K. Kyle*, 40 Van Natta 1230 (1988), for the proposition that "the Board found that the recreational or social activity exclusion did not apply because claimant was on-call and found that there was sufficient work connection to make the claim compensable." (Resp. Br. at 4-5). *Kyle* did not address the statutory exclusion for recreational or social activities, which was first adopted in 1987 and, as originally adopted, excluded only those injuries resulting from recreational or social activities solely for the worker's personal pleasure. In any event, the case was subsequently reversed by the court. *Timberline Lodge v. Kyle*, 97 Or App 239 (1989). The Board, on remand, found that the claimant's injuries did not arise in the course and scope of employment and the court affirmed without opinion. *Jack K. Kyle*, 42 Van Natta 10 (1990), *aff'd mem Kyle v. Timberline Lodge*, 104 Or App 218 (1990).

In the Matter of the Compensation of
SUSAN LAUGHLIN, Claimant
Own Motion No. 97-0536M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Linerud Law Firm, Claimant Attorneys

Claimant requests review of the self-insured employer's April 14, 1998 Notice of Closure which closed her claim with an award of temporary disability compensation from October 7, 1997 through March 23, 1998. The employer declared claimant medically stationary as of March 24, 1998. 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 April 14, 1998 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).

Dr. Berselli, claimant's treating surgeon, has treated claimant since her initial injury in 1982. He performed the first two surgeries in 1982 and 1984. He performed the most recent surgery in October of 1997. Subsequent to claimant's October 1997 surgery, Dr. Berselli treated claimant conservatively and prescribed physical therapy. On January 16, 1998, Dr. Berselli opined that claimant was slowly improving but not ready to work. Dr. Berselli last saw claimant on March 31, 1998, at which time claimant was advised to continue physical therapy and released to modified duty with severe restrictions on her left shoulder movements. Dr. Berselli planned to see claimant again in one month's time.

Drs. Dineen and Platt conducted an insurer-arranged medical examination (IME) on March 24, 1998. They concluded that claimant was "objectively medically stationary for any further treatment at this time." On April 10, 1998, Dr. Berselli concurred, without comment, with the IME's conclusions.

On April 14, 1998, the date of closure, claimant was examined by Dr. Puziss. After conducting a thorough examination of claimant, taking a detailed history and reviewing her x-rays, Dr. Puziss concluded that claimant remained partially disabled "by the fact that she has developed an adhesive capsulitis after her last surgery." Recommending an arthroscopy, removal of scar tissue and depending on the surgical findings, repair or debridement of the rotator cuff, Dr. Puziss determined that claimant was unable to due any kind of repetitive work.

On May 5, 1998, Dr. Puziss submitted a rebuttal to the March 24, 1998 IME report. In addition to pointing out significant deficiencies in the manner in which Drs. Dineen and Platt conducted the IME, Dr. Puziss outlined all the objective findings that supported his opinion that claimant was not medically stationary at the time of their examination nor was she presently medically stationary. Dr. Puziss noted loss of strength in her left shoulder, positive impingement signs, significantly positive biceps stress tests, crepitation in claimant's acromioclavicular joint area and significant tenderness. Dr. Puziss concluded that claimant needed further surgery or "she is doomed to have poor function of the shoulder."

We generally defer to the opinion of claimant's treating physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983). In addition, we give the most weight to opinions that are both well-reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259 (1986). In this case, we find Dr. Puziss' opinion more persuasive. Although Dr. Berselli was claimant's treating surgeon throughout the history of her claim, he does not offer an explanation as to why he concurred with the IME report when, just seven days after the IME was conducted, he released claimant to modified duty with severe restrictions, continued her course of physical therapy and expected to see her again within one month's time.

Dr. Puziss examined claimant on the date of closure at which time he did not believe her to be medically stationary. He offered a well-reasoned, based on accurate information, opinion. He recommended a course of treatment that was designed to materially improve claimant's current

condition. Based on Dr. Puziss' persuasive opinion, we conclude that claimant was not medically stationary on the date her claim was closed.

Accordingly, we set aside the April 14, 1998 Notice of Closure as premature. When appropriate, the claim shall be closed by the employer pursuant to OAR 438-012-0055.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
MARYANN B. BRAY, Claimant
WCB Case No. 97-05527
ORDER ON REVIEW
Black, Chapman, Webber & Stevens, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Herman's order that upheld the self-insured employer's denial of claimant's injury/occupational disease claim for left lateral epicondylitis. On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

Claimant began working for the employer's fruit packing operation in 1993. She alternates between production line work requiring rapid, repetitive arm motion and less repetitive supervisory work. In late November 1995, claimant developed right lateral epicondylitis as a result of an accepted injury with the employer. Dr. Webb, orthopedist, became the treating physician in early March 1996, at which time he placed claimant's right arm in a sling for two weeks. Shortly thereafter, claimant developed left elbow pain as she continued performing production line work with her left arm on a full-time basis through mid-March 1996, and then on a half-time basis through April 1996. Claimant's left elbow pain subsided when she resumed full-time supervisory responsibilities in early May 1996. She then began a seasonal lay-off in mid-May 1996, at which time she was not experiencing significant pain in either elbow.

Claimant subsequently experienced a flare-up of left elbow pain while packing for a household move in late May and early June 1996. She sought treatment for her left elbow pain from Dr. Webb on June 6, 1996, and he diagnosed left elbow lateral epicondylitis and treated claimant with a cortisone shot. Claimant's left elbow pain markedly improved with this treatment, but she experienced progressively worsening right elbow pain throughout the remainder of the summer. As a result of her worsening right elbow condition, claimant was unable to use that arm for any activity other than writing when she returned to work in a supervisory capacity in late September 1996. Thus, claimant primarily used her left arm to perform her supervisory responsibilities, which included moving heavy tables, taping machines and boxes. Claimant experienced a recurrence of significant left elbow pain with these activities.

Claimant continued working as a supervisor for the employer through mid-December 1996, at which time she began a seasonal lay-off. Dr. Webb performed surgery on claimant's right arm in late December 1996. Following this surgery, claimant continued to experience left elbow pain, which she reported to Dr. Webb in January 1996. At that time, Dr. Webb's office staff instructed claimant to file a worker's compensation claim for the left elbow condition, which claimant did on January 14, 1997. Dr. Webb diagnosed chronic left elbow lateral epicondylitis in March 1997.

Dr. Radecki, neurologist, examined claimant for the employer on April 24, 1997.

The employer issued a denial of claimant's left arm claim on May 19, 1997.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant's left lateral epicondylitis was not compensable as a consequential condition under ORS 656.005(7)(a)(A) and/or an occupational disease under ORS 656.802. To establish a compensable claim under either provision, claimant must prove that the left lateral epicondylitis is due in major part to claimant's repetitive use of her left arm at work and/or off-work use of that arm to compensate for her injured right arm. Resolution of this causation issue 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). 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).

In concluding that claimant had not carried her burden of proving causation, the ALJ rejected the opinion of the treating physician, Dr. Webb, that claimant's left lateral epicondylitis was due in major part to overuse of her left arm due to her work activity and her accepted right elbow condition. On review, claimant argues that the ALJ erred in rejecting Dr. Webb's opinion. We agree.

The ALJ concluded that Dr. Webb's overuse theory was based on an unreliable history of the onset and recurrence of left elbow symptoms during periods of repetitive and/or strenuous use of the left arm at work. In particular, the ALJ found that, when claimant first reported left elbow pain in June 1996, her right arm was not restricted and she had not been performing repetitive production work. We disagree that this finding is a basis for discounting Dr. Webb's opinion. While it is true that claimant did not seek treatment for left elbow pain until June 1996, she testified that she first began experiencing these symptoms in March 1996, when her right arm was restricted and she was primarily using her left arm to perform production line work. This testimony is consistent with the histories reported by Drs. Radecki and Fuller. Furthermore, claimant also testified that her left elbow pain markedly decreased in early May 1996 when she returned to full-time supervisory work, but flared-up again after her mid-May 1996 lay-off when she engaged in packing activity for a household move. This testimony is consistent with Dr. Webb's June 6, 1996 report of the development of left elbow pain over the last several weeks.

We also disagree with the ALJ's finding that claimant did not report further left elbow pain until March 1997, when she was performing supervisory work that did not involve overuse of the left arm. While it is true that claimant did not receive further treatment for left elbow pain until March 1997, she testified that the problem recurred shortly after she returned to work in late September 1996. This testimony is consistent with the history reported by Dr. Radecki, as well as Dr. Webb's March 28, 1997 chart note referencing increasing left elbow pain over the past several months. While Dr. Webb's chart notes from December 1996 thru February 1997 do not report left arm complaints, neither do they state that claimant had no such complaints; and the focus on claimant's right arm complaints is understandable, given the fact that claimant underwent right arm surgery in late December 1996. Also, claimant testified that she reported her recurrent left arm complaints to Dr. Webb in January 1997 and was instructed by his staff to file a separate worker's compensation claim for that complaint. This testimony is consistent with the fact that claimant did, in fact, file a workers' compensation claim for the left elbow on January 14, 1997.

Moreover, while claimant did not return to production line work in September 1996, she testified that her supervisory responsibilities did require her to move heavy tables, taping machines and boxes using only her left arm. This testimony is consistent with medical records establishing claimant's restricted right arm use at this time. Furthermore, while claimant's manager testified that she could have instructed another worker to move these heavy items, the manager did not contend that claimant did not, in fact, engage in this activity. Also, claimant explained in her testimony that she was under tight time constraints and moved these heavy items herself because she could set them up faster than other workers.

Finally, we acknowledge that claimant gave confusing testimony regarding the extent of her left arm complaints during the summer of 1996. Nevertheless, we otherwise defer to her testimony, which we find to be generally consistent and supported by the record as a whole. Thus, we conclude that Dr. Webb's overuse theory is well-reasoned and consistent with claimant's symptomatic and work history.

Furthermore, we are not persuaded by the contrary opinion of Dr. Radecki that claimant's left elbow complaints were attributable to a regional pain syndrome that is nonorganic in nature and not related to her work activities. We find Dr. Radecki's opinion less persuasive because it is based on general medical studies rather than claimant's specific work activities, symptomatic history and reproducible pain complaints. Accordingly, we defer to Dr. Webb and conclude that his opinion satisfies claimant's burden of proving compensability of her left lateral epicondylitis. See ORS 656.005(7)(a)(A), 656.802.

Claimant is entitled to an assessed attorney fee for prevailing over the employer'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 $4,500, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the hearing record and claimant's appellate briefs), the complexity of this issue, the risk that claimant's counsel might go uncompensated, and the value of the interest involved.

ORDER

The ALJ's order dated January 21, 1998 is reversed. The self-insured employer's denial of claimant's left lateral epicondylitis is set aside, and the claim is remanded to the self-insured employer for further processing according to law. For services at hearing and on review, claimant is awarded an assessed fee of $4,500, to be paid by the employer.

June 25, 1998 Cite as 50 Van Natta 1177 (1998)

In the Matter of the Compensation of
RICHARD O. BURKE, Claimant
WCB Case No. 97-06458
ORDER ON REVIEW
Thomas J. Dzieman, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Bock and Moller.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that vacated an Order on Reconsideration and remanded the claim to the Director for adoption of a temporary rule. On review, the issues are whether the ALJ properly remanded the claim to the Director and, alternatively, extent of scheduled and unscheduled permanent disability. We reverse.

FINDINGS OF FACT

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

Claimant, age 52 at the time of hearing, was compensably injured on February 9, 1995 when a tree fell on him while he was working as a tree faller. The employer accepted a left subcondylar fracture with displacement of the condyle out of the glenoid fossa, mildly displaced scapular neck fracture, rib fractures and multiple bruises. The acceptance was subsequently amended to include a C4-5 disc herniation.

Dr. Kirkpatrick surgically repaired claimant's cervical disc herniation and Dr. Gilsdorf treated his shoulder injury. Dr. Gilsdorf declared claimant medically stationary on November 21, 1995, noting "marked mechanical dysfunction of scapulothoracic joint secondary to extensive fracturing and soft tissue injury with secondary atrophy of supra and infraspinatus."

In January 1996, Dr. Merrill, an oral and maxillofacial surgeon, repaired claimant's malunited left tempromandibular joint with arthroplasty. Dr. Merrill declared claimant's jaw condition medically stationary on October 23, 1996, noting that claimant had permanent impairment including an inability to chew food and decreased motion of the jaw.

On March 11, 1997, claimant was examined by Dr. TenHulzen, a maxillofacial surgeon, at the employer's request. Dr. TenHulzen found claimant had no disability due to his slight altered sensation but "some inherent weakness" due to his surgery which limited him from eating hard foods and those requiring lengthy mastication. (Ex. 11). Dr. Merrill concurred with Dr. TenHulzen's assessment. (Ex. 15).

Claimant was also examined by Dr. Rich, a neurologist, and Dr. Marble, an orthopedic surgeon, at the employer's request. They found, among other things, decreased cervical and left shoulder motion and a prominent A-C joint on the left, probably indicating a third-degree A-C separation with mild atrophy of the supraspinatus muscle. The doctors recommended no overhead work with the left arm and restricted claimant's left arm pushing, pulling and lifting to 30 pounds. (Ex. 12-7). Dr. Kirkpatrick concurred. (Ex. 13).

The claim was closed pursuant to an April 11, 1997 Notice of Closure, which awarded temporary disability and a total of 40 percent unscheduled permanent disability for the neck, left shoulder and jaw. The unscheduled permanent disability award was comprised of a value of 8 percent for cervical surgery, 7 percent for reduced cervical range of motion, 5 percent for chronic loss of use of the left shoulder and 8 percent for loss of mastication (for a combined value of 25 percent for impairment) plus 15 percent for social and vocational factors.

Claimant requested reconsideration and a medical arbiter examination, including an examination by an oral and maxillofacial surgeon. Claimant was examined by Dr. Beatty, a DMD, who found no TMJ impairment but agreed that claimant was limited to eating soft foods. Claimant was also examined by Dr. Schilperoort, an orthopedic doctor and Dr. Yerby, a neurologist, who performed a cranial nerve examination.

An Order on Reconsideration, issued July 18, 1997, reduced claimant's unscheduled permanent disability award to 39 percent based on the arbiters' impairment findings. The total unscheduled permanent disability award consisted of a value of 2 percent for loss of cervical motion, 8 percent for cervical surgery, 3 percent for left shoulder loss of motion, 6 percent for cranial nerve impairment, 8 percent for loss of mastication (for a combined value of 24 percent) plus 15 percent for social and vocational factors. The Order on Reconsideration further found that claimant's disability was addressed by the current standards.

CONCLUSIONS OF LAW AND OPINION

The ALJ determined that claimant's TMJ condition was not adequately rated under the standards and remanded the claim to the Director for adoption of a temporary rule. On review, the employer argues that the current administrative rules are adequate for rating claimant's injury-related disability and challenges the ALJ's decision to vacate the Order on Reconsideration and remand. We agree with the employer's contention.

As a preliminary matter, we note that, under the circumstances of this case, the ALJ's remand order is a final appealable order. *See, e.g. Leroy A. Friend*, 44 Van Natta 775 (1992) (holding that an ALJ's order that set aside an Order on Reconsideration and remanded to the Appellate Unit for consideration of a medical arbiter's report was an appealable final order, because it potentially impacted the claimant's entitlement to temporary and permanent disability benefits); *see also Terry J. Hockett*, 48 Van Natta 1297 (1996) (Board reviewed and reversed ALJ's order that vacated an Order on Reconsideration and remanded the claim to the Director for promulgation of a temporary rule).

Having determined that we have jurisdiction to review the ALJ's order (in light of the employer's timely request for Board review), we next address whether remand to the Director is warranted. ORS 656.726(3)(f)(C) provides that, during reconsideration before the Director, when "it is found that the worker's disability is not addressed by the standards," the Director must stay the proceeding and "adopt temporary rules amending the standards to accommodate the worker's impairment." The Board may remand a claim to the Director for promulgation of a temporary rule when a disability is not addressed by the existing standards. *Gallino v. Pontiac-Buick-GMC*, 124 Or App 538, 541-42 (1993). Claimant has the burden of proving that his disability is not addressed by the standards. See ORS 656.266; *Robert W. Wilmot*, 48 Van Natta 1525 (1996); *Terry J. Hockett*, 48 Van Natta at 1298.

Here, claimant contends that the current standards do not adequately deal with impairment related to his tempromandibular joint. We disagree. The Order on Reconsideration awarded a value of 8 percent for claimant's inability to masticate firm foods. The appellate reviewer made this award based upon the preponderance of the evidence in the file, including the closing report of Dr. TenHulzen (with Dr. Merrill's concurrence) and the medical arbiter's findings.

Although Dr. Merrill opined in October 1996 that claimant had permanent impairment including decreased motion of the jaw and an inability to chew firm food, he later concurred with Dr. TenHulzen's findings that claimant exhibited a normal maximal opening and that his only permanent limitation was "some inherent weakness" due to the surgery, which prevented him from eating hard foods. Similarly, the medical arbiter, Dr. Beatty, found "no TMJ impairment" but agreed that claimant was limited to eating soft foods. The Director expressly found that claimant's disability is addressed by the current standards. The persuasive medical evidence establishes that claimant's only TMJ impairment is an inability to chew firm foods (a disability for which he has been compensated). We conclude, therefore, that remand to the Director for adoption of a temporary rule is not warranted. *See Terry J. Hockett*, 48 Van Natta at 1298.

With regard to the rating of his other compensable conditions (i.e., the C4-5 disc herniation and left shoulder/scapula injury), claimant argues that: (1) all of his cervical range of motion measurements should be considered valid; (2) the appellate reviewer erred in relying on the arbiter's report and apportioning only half (50 percent) of his range of motion loss to the compensable injury; (3) he is entitled to an award for a chronic A/C dislocation in his left shoulder; and (4) he is also entitled to a 5 percent scheduled permanent disability award for a chronic condition limiting the repetitive use of his left arm.[1] We address each issue in turn.

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. OAR 436-035-0007(13). This "preponderance of the evidence" must come from the findings of the attending physician or other physicians with whom the attending physician concurs. *See Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, 670 (1994). The Board will 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, claimant's attending physician, Dr. Kirkpatrick, concurred with the March 11, 1997 findings of Drs. Rich and Marble. Drs. Rich and Marble recorded the following cervical range of motion measurements: Flexion - 48 degrees; extension - 50 degrees; lateral bend right - 28 degrees; lateral bend left - 40 degrees; rotation right - 60 degrees; and rotation left - 48 degrees. The doctors did not indicate that their cervical findings were invalid and, in fact, noted that claimant's neck range of motion was "surprisingly good." (Ex. 12-6).

The medical arbiter, Dr. Schilperoort, measured forward flexion at 48 degrees, extension at 56 degrees, right lateral flexion at 36 degrees, left lateral flexion at 42 degrees, right rotation at 54 degrees and left rotation at 62 degrees. Unlike Drs. Rich, Marble and Kirkpatrick, however, Dr. Schilperoort considered claimant's cervical flexion and right rotation measurements invalid. In addition, Dr. Schilperoort apportioned 50 percent of claimant's cervical range of motion impairment to the accepted disc condition and the remainder to "joint disease as identified on previous independent medical evaluations." (Ex. 18).

OAR 436-035-0007(27) provides that a physician's determination that impairment findings are invalid must include a "written opinion, based on sound medical principles, explaining why the findings are invalid." Otherwise, all ratable impairment shall be rated. *See Justeen L. Parker*, 49 Van Natta 334 (1997) (arbiter's range of motion measurements rated as impairment when arbiter did not identify the validity standards that were not satisfied, nor did he provide a written explanation of why the range of motion measurements did not meet validity standards). Here, the arbiter did not explain why he considered claimant's cervical flexion and right rotation measurements invalid. Because the arbiter did not identify the validity standards that were not satisfied nor provide a written explanation of why certain measurements did not meet validity standards, we conclude that claimant is entitled to impairment ratings based on all of his cervical spine range of motion measurements. *See id.*

Accordingly, pursuant to OAR 436-035-0360(13) through (16), claimant is entitled to 6 percent cervical impairment, based on the arbiters' range of motion measurements. Furthermore, although the arbiter apportioned only 50 percent of this impairment to the accepted condition, we conclude that

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[1] On review, neither party disputes that claimant is entitled to a value of 8 percent for his cervical surgery, 3 percent for loss of shoulder motion and 6 percent for cranial nerve impairment.

apportionment is not appropriate in this case. The administrative rules provide that apportionment is appropriate "where a worker has a superimposed condition." OAR 436-035-0007(2). Here, however, the evidence fails to establish that claimant's accepted cervical disc herniation involves a superimposed condition. Indeed, although Drs. Rich and Marble noted that claimant's imaging studies showed degenerative changes in the low back, and Dr. Kirkpatrick diagnosed lumbar stenosis, the medical record does not show any preexisting cervical condition. Therefore, we find that all of claimant's cervical range of motion impairment is due to her compensable condition.

As noted above, claimant also asserts that he is entitled to an additional 15 percent for chronic dislocations of his left shoulder. We find no persuasive evidence of such a chronic condition related to claimant's compensable shoulder condition. Drs. Rich and Marble found no evidence of instability of the left shoulder. Similarly, Dr. Schilperoort found no chronic shoulder dislocation during his arbiter examination. We therefore decline to award claimant a value under OAR 436-035-0330(16).

Finally, claimant contends that he is entitled to a scheduled award for loss of use or function of his left arm. 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 his left scapula and shoulder. The medical arbiter found that, because of this condition, claimant sustained a partial loss in ability to repetitively use his left shoulder. (Ex. 18-3). The arbiter also determined that claimant should not work at or above shoulder level and that he was permanently precluded from frequently reaching, pushing or pulling more than 30 pounds with his left upper extremity. (Ex. 18-4). Drs. Rich and Marble similarly restricted claimant to no overhead work with his left arm and recommended that he limit his pushing, pulling and lifting with the left arm to 30 pounds. (Ex. 12-7).

Although claimant has established a permanent partial inability to repetitively use his left shoulder and restrictions on the use of his left upper extremity, the medical evidence does not identify any symptoms causing loss of function to claimant's left arm or a chronic condition of the left arm, as distinguished from the left shoulder. Consequently, claimant is not entitled to a separate scheduled permanent disability award for his left arm. *See, e.g. Kim S. Anderson*, 48 Van Natta 1876, 1876 (1996) (medical evidence failed to establish inability to repetitively use the claimant's arm, as distinguished from shoulder); *William L. Fischbach*, 48 Van Natta 1233 (1996).

In summary, we find that claimant is entitled to a total unscheduled permanent disability award of 43 percent, consisting of 6 percent for loss of cervical range of motion, 8 percent for cervical surgery, 3 percent for loss of left shoulder range of motion,[2] 6 percent for cranial nerve impairment and 8 percent for loss of mastication (for a combined total of 28 percent), plus 15 percent for social and vocational factors.[3]

Because our order results in increased compensation, claimant's counsel is entitled to an out-of-compensation attorney fee equal to 25 percent of the increased compensation (4 percent unscheduled permanent disability) created by this order, not to exceed $3,800. ORS 656.386(2); OAR 438-015-0055.

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[2] Although the medical evidence establishes that claimant has a chronic condition in his left shoulder, he is not entitled to an additional unscheduled chronic condition award under the disability rating standards because his total unscheduled impairment within the cervical/shoulder "body area" exceeds 5 percent. *See* OAR 436-035-0320(5)(a); *see also Linda M. Lackey*, 48 Van Natta 715 (1996) (where the claimant's other unscheduled values for the shoulder and cervical area exceeded 5 percent, she was not entitled to an additional 5 percent chronic condition award for her left shoulder).

[3] The parties do not contest claimant's social and vocational values on review.

ORDER

The ALJ's order dated December 5, 1997 is reversed. In addition to the Order on Reconsideration's award of 39 percent (124.8 degrees) unscheduled permanent disability, claimant is awarded 4 percent (12.8 degrees), giving her a total award of 43 percent (137.6 degrees) unscheduled permanent disability. Claimant's attorney is awarded an attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney.

In the Matter of the Compensation of
DAVID D. COUTURE, Claimant
WCB Case No. 97-07338
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that affirmed an Order on Reconsideration awarding 5 percent (16 degrees) unscheduled permanent disability for a low back condition. On review, the issue is extent of unscheduled permanent disability.

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

Claimant has an accepted claim for "lumbar strain." The medical arbiter measured range of motion in both the lumbar and cervical areas. Relying on *SAIF v. Danboise*, 147 Or App 550 (1997), claimant asserts that, because the medical arbiter rated range of motion in the cervical area, he is entitled to a value for such findings. In *Danboise*, the court affirmed the Board's reasoning that, when the record discloses no other possible source of impairment, medical evidence that rates the impairment and describes it as "consistent with" the compensable injury supports a finding that the impairment is due to the compensable injury. 147 Or App at 553.

We agree with the ALJ that, in the absence of any evidence that loss of cervical range of motion is "consistent with" a low back injury, *Danboise* does not aid claimant. More importantly, because claimant's accepted injury is limited to a lumbar strain, we find that claimant must satisfy ORS 656.268(16)[1] in order to be entitled to a rating for any cervical condition. Because the record also fails to show that any cervical condition is a "direct medical sequela" of the original accepted lumbar strain condition, we find that claimant is not entitled to a rating for any cervical lost range of motion.

ORDER

The ALJ's order dated February 23, 1998 is affirmed.

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[1] ORS 656.268(16) provides:

"Conditions that are direct medical sequela to the original accepted condition shall be included in rating permanent disability of the claim unless they have been specifically denied."

In the Matter of the Compensation of
JASON J. LaFOYA, Claimant
WCB Case No. 96-07965
ORDER ON REMAND
Parker, Bush & Lane, Claimant Attorneys
Lundeen, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. *Lafoya v. An Advanced Interior*, 152 Or App 400 (1998). The court has reversed our prior order, *Jason J. Lafoya*, 49 Van Natta 541 (1997), which held that, based on an interstate agreement between Oregon and Washington, claimant was not working for an Oregon employer at a "temporary [out-of-state] workplace" when injured in Washington and, as such, was not an Oregon subject worker. Citing *Carothers v. Robert Westlund Construction*, 149 Or App 457 (1997), the court has reversed and remanded for reconsideration. In accordance with the court's mandate, we now proceed with our reconsideration.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We begin by briefly recounting the factual background of the claim. The employer began work at a church in Washington in March 1996. It maintained both Oregon and Washington workers' compensation coverage. (Tr. 18, 19). Claimant, a drywall hanger, was hired by the employer in June 1996 and worked both in Oregon and Washington.

On June 14, 1996, claimant injured his back while in the course and scope of his employment at the church work site in Washington. Claimant filed claims in both Oregon and Washington. The insurer denied the Oregon claim on the ground that claimant was not an Oregon subject worker. Claimant requested a hearing.

The ALJ set aside the insurer's denial, reasoning that claimant was an Oregon subject worker temporarily in Washington when injured and, thus, entitled to benefits as though he were injured in Oregon. *See* ORS 656.126(1);[1] *Kolar v. B&C Contractors*, 36 Or App 65 (1978). In reaching this conclusion, the ALJ acknowledged the existence of an interstate reciprocity agreement between Oregon and Washington pertaining to jurisdiction over out-of-state injuries, but determined that it did not apply to this case because the work site where claimant was injured was not a "temporary workplace."[2] The ALJ also found the insurer's denial to have been unreasonably issued, thereby requiring the assessment of a 25 percent penalty pursuant to ORS 656.262(11). The insurer requested review.

We reversed. In light of the Washington-Oregon interstate agreement executed under ORS 656.126(5),[3] as interpreted in *Rodney W. Carothers*, 48 Van Natta 2372 (1996), we concluded that the

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[1] ORS 656.126(1) provides:

"If a worker employed in this state and subject to this chapter temporarily leaves the state incidental to that employment and receives an accidental injury arising out of and in the course of employment, the worker, or beneficiaries of the worker if the injury results in death, is entitled to the benefits of this chapter as though the worker were injured within this state."

[2] The interstate agreement provides, in part, that Oregon workers' compensation law will be extended to provide coverage of any Oregon workers injured in the course of employment in Washington while the employer has a "temporary workplace" in Washington. The agreement defines "temporary workplace" as not including a specific location within the state where the employer's work is performed for more than 30 days in a calendar year.

[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."

claimant was not entitled to Oregon workers' compensation coverage. *Jason J. Lafoya*, 49 Van Natta at 542-43. Claimant appealed to the Court of Appeals.

While this case was pending appellate review, the court reversed our order in *Carothers* and held that we must apply the "permanent employment relation" test in order to determine whether a claimant, who was injured at a "non-temporary" worksite in Washington, was an Oregon subject worker when injured. *Carothers*, 149 Or App at 462. Inasmuch as claimant in this case, like the claimant in *Carothers*, was injured at a "non-temporary" worksite in Washington, we conclude in accordance with the court's *Carothers* decision that the interstate agreement is inapplicable. Thus, we apply the "permanent employment relation" test to determine the subjectivity issue.

In *NorthWest Greentree v. Cervantes-Ochoa*, 113 Or App 186 (1992), the court stated that the following circumstances must be evaluated regarding the particular employee: the intent of the employer; the understanding of the employee; the location of the employer and its facilities; the circumstances surrounding the employee's work assignment; the state laws and regulations to which the employer otherwise was subject; and the residence of the employee. 113 Or App at 189-90.

Under the test, the key inquiry is the extent to which claimant's work outside the state is temporary. *Power Master Inc. v. Blanchard*, 103 Or App 467, 471 (1990);*Hobson v. Oregon Dressing, Inc.*, 87 Or App 397, 400, *rev den* 304 Or 437 (1987); *Phelan v. H.S.C. Logging, Inc.*, 84 Or App 632, 635, *rev den* 303 Or 590 (1987). The out-of-state work must be incidental to work performed in Oregon for an Oregon employer and there must be proof of an established employment relationship between the worker and this employer in Oregon before the out of state injury occurs. *Steven A. Dancer*, 40 Van Natta 1750 (1988); *aff'd mem* 99 Or App 488 (1989). In addition, the worker must have a reasonable expectation of returning to work for the employer in Oregon. *Roy L. Center*, 44 Van Natta 365, 367 (1992); *Lyle E. Estes*, 43 Van Natta 62, 63 (1991) .

With these standards in mind, the record reveals the following. Claimant resided in Oregon for over a year before his injury. (Tr. 6). Claimant was hired in Oregon by the employer, whose only office is in this state. (Trs. 7, 10). Claimant's understanding was that he would only be working in Oregon, and his first job assignment was in Oregon. (Trs. 8, 12). However, prior to his injury at the Washington job site, claimant worked at both Oregon and Washington locations. (Tr. 10). The majority of the employer's work was conducted in Oregon. The employer testified that there were only two jobs in Washington, while there were perhaps six in Oregon. (Tr. 20). Claimant testified that he and fellow employees were sent to the church job site in Washington in order to "get our 40 hours" or when there was no other place to be sent. (Tr. 14). Claimant and other employees met each Monday at the employer's Oregon office to obtain job assignments. (Tr. 13). Oregon taxes were withheld from claimant's paychecks, but claimant and the employer testified that Washington "L&I" taxes were also withheld when employees performed work in Washington. (Tr. 14, 21).

Based on the above facts, we find that claimant's Washington employment was incidental to his Oregon employment and that there was an established employment relationship between the worker and this employer in Oregon before the out of state injury occured. Moreover, because the majority of the employer's work was in Oregon, and because of the temporary nature of claimant's assignment to the Washington job site, we further conclude that claimant had a reasonable expectation of returning to work in Oregon. Thus, we determine that claimant's work outside Oregon was temporary. Under the "permanent employment relations" test, claimant was an Oregon subject worker at the time he was injured on June 14, 1996 in Washington and, therefore, entitled to Oregon workers' compensation benefits. Accordingly, on remand, we affirm the ALJ's decision to set aside the insurer's denial.

We now turn to the penalty issue. The ALJ assessed a 25 percent penalty, finding that the insurer's denial on subjectivity grounds was unreasonable. In our prior order, we reversed the ALJ's penalty assessment in light of our decision that claimant was not a subject employee.

A carrier is liable for a penalty when it "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). "Unreasonableness" and "legitimate doubt" are to be considered in light of all the evidence available at the time of the denial. *Id.*

After further consideration of the penalty issue, we continue to conclude that the insurer's denial was not unreasonable. Although the court has now held that the Oregon-Washington interstate agreement does not govern injuries at "non-temporary" workplaces, prior to the issuance of the *Carothers* decision, the statutory scheme and reciprocity agreement could reasonably be interpreted to conclude that claimant was not an Oregon subject employee. Therefore, we find that the insurer had "legitimate doubt" regarding its liability for claimant's injury at the Washington job site. Thus, we reverse the ALJ's penalty assessment.

We now turn to the issue of claimant's attorney fee. In a case in which a claimant finally prevails in respect to any claim or award for compensation after remand from the Supreme Court, Court of Appeals or Board, the ALJ, Board or appellate court shall approve or allow a reasonable attorney fee for services before every prior forum. ORS 656.388(1).

Claimant has finally prevailed after remand with respect to his low back claim. Under such circumstances, ORS 656.388(1) provides for an attorney fee award for claimant's counsel's services before every prior forum. At hearing, the ALJ awarded claimant's counsel an assessed fee of $3,200 for prevailing over the insurer's denial. ORS 656.386(1). We reinstate that award. Inasmuch as we have not disallowed or reduced the compensation awarded by the ALJ, claimant's counsel is entitled to an assessed attorney fee under ORS 656.382(2) for services on Board review. Furthermore, claimant's counsel is entitled to a fee for services before the Court of Appeals for prevailing against our previous decision which upheld the insurer's denial. ORS 656.386(1).

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on Board review and before the Court of Appeals is $3,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the subject worker issue (as represented by the hearing record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved and the risk that claimant's counsel might go uncompensated. Claimant is not entitled to an attorney fee for his counsel's unsuccessful services devoted to the penalty issue.

Accordingly, on reconsideration, the ALJ's order dated December 5, 1996 is reversed in part and affirmed in part. That portion of the order which assessed a penalty is reversed. The remainder of the order is affirmed. For services before the court and before the Board on review, claimant's counsel is awarded $3,500, to be paid by the insurer. This attorney fee is in addition to the $3,200 attorney fee granted by the ALJ's order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOEL C. GUZEK, Claimant
WCB Case Nos. 93-15107 & 93-11893
ORDER ON REVIEW
Sather, Byerly, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Brazeau's order that: (1) found the Hearings Division lacked jurisdiction over any federal claims claimant may have made; (2) declined to postpone claimant's scheduled hearing; (3) upheld Liberty Northwest Insurance Corporation's compensability and responsibility denials of claimant's current low back condition; and (4) upheld the self-insured employer's "de facto" denial of the same condition. On review, the issues are postponement, compensability and responsibility.

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

Postponement

At hearing, claimant moved for an indefinite postponement of this matter on the ground that he has been rendered incapable of preparing for hearing because of his need to prepare his criminal appeal. On review, claimant argues that the ALJ erred by declining his request for postponement.

OAR 438-006-0081 provides that a scheduled hearing shall not be postponed except by order of an Administrative Law Judge upon a finding of extraordinary circumstances beyond the control of the party or parties requesting the postponement. "Extraordinary circumstances" do not include incomplete case preparation, unless the judge finds that completion of the record could not be accomplished with due diligence. OAR 438-006-0081(4).

After reviewing the record, we agree with the ALJ's reasoning and conclusion that claimant has had ample time to prepare his case and there has been no showing of "extraordinary circumstances." On this record, we find the ALJ did not err in declining to postpone the hearing.

ORDER

The ALJ's order dated January 8, 1998 is affirmed.

In the Matter of the Compensation of
DUSTIN LUCKHURST, Claimant
WCB Case No. 97-03907
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
Moscato & Hallock, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Hoguet's order that set aside its partial denial of claimant's claim for a current left knee condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of his findings of ultimate fact. We summarize the relevant facts as follows.

Claimant was working as a courier on December 4, 1996, when he tripped and fell forward, striking his left knee against the flat edge of a concrete curb. He received conservative treatment and his injury claim was accepted for a left knee contusion. The left knee condition initially improved with treatment until claimant felt a significant increase in left knee pain on February 1, 1997. Diagnostic studies showed osteochondritis dissecans involving the lateral aspect of the femoral condyle bone and overlying cartilage, with a loose osteochondral fragment. Dr. McLean, consulting orthopedic surgeon, performed arthroscopic surgeries in May and June 1997 to remove the loose fragment.

By letter dated April 22, 1997, the employer denied claimant's current left knee condition.

The osteochondritis dissecans preexisted and combined with the December 4, 1996 injury to cause claimant's need for treatment of the loose osteochondral fragment, including surgeries.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant had established the compensability of his current left knee condition and need for treatment under ORS 656.225(1). On review, the employer argues that ORS 656.225(1) does not apply to the facts of this case and that its denial should be upheld. We agree and reverse.

ORS 656.225 provides, in pertinent 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."

We have previously held that the application of ORS 656.225 is limited, by its terms, to "disability solely caused by or medical services solely directed to a worker's preexisting condition." *E.g., Anne M. Walker*, 49 Van Natta 600 (1997); *Linda F. Hansen*, 48 Van Natta 2560 (1996). Therefore, where a worker's disability or need for medical services was caused by a "combined condition," *i.e.*, the combination of a preexisting condition *and* the compensable injury, we have held that the provisions of ORS 656.225(1) are not germane to the compensability issue. *E.g., Mitchell J. Thompson*, 50 Van Natta 289, 291 n 3 (1998); *Ann M. Walker*, 49 Van Natta at 600; *Paul E. Hargreaves*, 48 Van Natta 1676, 1677 (1996).

The ALJ found that the December 4, 1996 industrial injury contributed to the formation of the loose osteochondral fragment in the left knee by causing the fragment to separate from the preexisting osteochondral dissecans. (O&O p. 3). The ALJ also found that the loose fragment caused the increased left knee pain that resulted in claimant's need for treatment beginning in February 1997. (*Id.*) On review, claimant does not challenge the ALJ's findings but, instead, concedes that the December 1996 injury caused the loose fragment in the knee, (Resp. Br. p. 3)[1]. Given the undisputed fact that claimant's treatment beginning in February 1997 was directed to the removal of the loose fragment, and claimant's concession that the fragment was caused, at least in part, by the December 1996 injury, we do not find that claimant's treatment was "solely directed" to the preexisting osteochondral dissecans. Rather, the record shows that claimant's treatment was directed to a "combined condition" within the meaning of ORS 656.005(7)(a)(B). Therefore, the provisions of ORS 656.225(1) do not apply to claimant's current left knee condition.

The ALJ also found that claimant did not establish the compensability of his "combined condition" under the "major contributing cause" standard under ORS 656.005(7)(a)(B). Claimant does not challenge this conclusion on review.[2] Accordingly, claimant's current left knee condition is not compensable, and the employer's partial denial shall be reinstated and upheld.

ORDER

The ALJ's order dated January 27, 1998 is reversed. The self-insured employer's partial denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

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[1] Even if claimant's concession was disregarded, the persuasive medical evidence establishes that claimant's work injury was a contributing factor in his need for treatment.

[2] Even if claimant had raised a challenge, the persuasive medical evidence supports the ALJ's conclusion that the "major contributing cause" standard of ORS 656.005(7)(a)(B) has not been satisfied.

In the Matter of the Compensation of
CAROL VAN DE HEY, Claimant
WCB Case No. C8-01328
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Welch, et al, Claimant Attorneys
Barbara Woodford, Defense Attorney

Reviewed by Board Member Biehl and Haynes.

On June 10, 1998, 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, paragraph 12, the CDA provides that claimant has settled a third party lawsuit for $50,000 and that the insurer's statutory share is $22,222. Page 3, paragraph 13 of the CDA provides that, in consideration for a partial release by the insurer of $5,000 of its lien, claimant releases his rights to all worker's compensation benefits allowed by law.

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

In *Anthony G. Allen*, 49 Van Natta 460 (1997), the sole consideration for the CDA was the carrier's waiver of $80,000 of its $250,000 statutorily recoverable third party lien. The CDA did not provide the specific amount of the third party settlement. However, the parties expressly stipulated that the insurer's statutory share would be approximately $250,000. Although the exact amount of the third party lien was not known, the amount of the insurer's otherwise recoverable lien and the amount of its waiver were known. Under those circumstances, we found that the "value" of the consideration flowing to claimant under the CDA ($80,000) was sufficiently ascertainable to gain our approval.

In the present case, the CDA provides the amount of the third party settlement, but does not expressly identify the total amount of the carrier's lien. However, the parties have indicated that the insurer's "statutory share" from the third party settlement would be $22,222 and that the consideration for the CDA is the insurer's waiver of $5,000 of its "statutory share."

Although the total amount of the insurer's lien is not expressly identified, we interpret the parties' representation that the insurer's "statutory share" would be $22,222 to mean that the insurer would otherwise be able to recover all of that specified amount from the third party settlement. Under such circumstances, we find that the "value" of the consideration flowing to claimant under the agreement (i.e. the insurer's $5,000 waiver of its otherwise recoverable third party lien) is sufficiently ascertainable to gain our approval.

Accordingly, as interpreted herein, the CDA is in accordance with the terms and conditions prescribed by the Board. Therefore, the parties' CDA 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
KELLY J. ZANNI, Claimant
WCB Case No. 97-08927
ORDER ON REVIEW
Martin L. Alvey, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that affirmed the Order on Reconsideration that awarded 9 percent (17.28 degrees) scheduled permanent disability for the loss of use or function of the right arm. On review, the issue is extent of scheduled permanent partial disability.

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

On review, claimant contends that she is entitled to an additional award of scheduled permanent disability award for loss of muscle strength in the right upper extremity due to her injury. She relies on the strength loss findings made by physical therapist Scott Thompson and ratified by her attending physician, Dr. Benz. (Exs. 13-3, 14).

Evaluation of a worker's disability is as of the date of issuance of the reconsideration order. ORS 656.283(7). When rating impairment, only the opinions of the attending physician and the medical arbiter, if any, may be considered. *See Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666 (1994); *Roseburg Forest Products v. Owen*, 129 Or App 442 (1994). Where a medical arbiter is used, as in this case, we do not automatically rely on the medical arbiter's opinion in evaluating impairment, but rather, rely on the most thorough, complete, and well-reasoned evaluation of impairment due to the injury. *See David L. Glenn*, 49 Van Natta 1251 (1997); *Kenneth W. Matlack*, 46 Van Natta 1631 (1994); *Carlos S. Cobian*, 45 Van Natta 1582 (1993).

After considering the impairment findings ratified by the attending physician, Dr. Benz, and those made by the medical arbiter, Dr. Neumann, we agree with the ALJ's conclusion that Dr. Neumann provided the most reliable evaluation of claimant's right forearm strength as of the date of issuance of the Order on Reconsideration. The Order on Reconsideration issued on October 17, 1997. (Ex. 25). Less than three weeks earlier, on September 30, 1997, Dr. Neumann tested claimant's muscle strength in the hands, wrists, elbows and shoulders, and found 5/5 strength grading in all parameters in both upper extremities. (Ex. 23-5). Muscle grading of 5/5 is valued as zero percent impairment under the standards for rating disability. *See* OAR 436-035-0007(18)(a), 436-035-0110(8) (WCD Admin. Order 96-072).

Dr. Benz, on the other hand, ratified muscle strength findings that were made by therapist Thompson on May 14, 1997, five months prior to the issuance date of the reconsideration order. (Exs. 13, 14). Those findings were normal, with the exception of 4+/5 grading in the right wrist extensors, right thumb extensors and right forearm pronators and supinators. (Ex. 13-3).

The fact that the medical arbiter's examination was performed closer in time to the issuance date of the reconsideration order is not always decisive. *See, e.g., Charlene L. Vinci*, 47 Van Natta 1919 (1995). However, we have held that a medical arbiter's report may be more probative when there is a significant time gap between the closing examination and the medical arbiter's examination. *E.g., James A. Hanson*, 50 Van Natta 23, 24 (1998); *Ronald L. Tipton*, 48 Van Natta 2521, 2522 n 5 (1996); *David Gonzalez*, 48 Van Natta 376 (1996). Here, we find that the time gap between therapist Thompson's evaluation and Dr. Neumann's medical arbiter examination (*i.e.*, four and one-half months) was significant. We therefore conclude that Dr. Neumann's report provided more probative evidence of claimant's disability as of October 17, 1997, the issuance date of the reconsideration order.

Claimant argues that Dr. Neumann's muscle strength findings were not well-reasoned because they were inconsistent with his finding that claimant's grip strength was greater in her (non-dominant) left hand than in her (dominant) right hand. (Ex. 23-3). The apparent implication from claimant's argument is that a loss of grip strength in her right hand, as measured by a dynamometer, would necessarily indicate *ratable* loss of muscle strength in the right upper extremity. However, claimant presented no medical evidence to support her allegation of internal inconsistency. Furthermore, we lack

the medical expertise to conclude that a grip strength deficit necessarily indicates ratable loss of muscle strength, particularly in the face of Dr. Neumann's specific measurements of 5/5 grading "in both upper extremities in all muscle groups tested." (Ex. 23-5). Based on this record, therefore, we are not persuaded that Dr. Neumann's report is internally inconsistent. Because claimant bears the burden of proving that she is entitled to an increased award, *see* ORS 656.266, and we do not conclude that the record preponderates in her favor, we must affirm the ALJ's order.

ORDER

The ALJ's order dated March 11, 1998 is affirmed.

June 25, 1998 Cite as 50 Van Natta 1189 (1998)

In the Matter of the Compensation of
EULA M. ZARLING, Claimant
WCB Case No. 97-02653
ORDER ON REVIEW
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) took administrative notice of a "post-reconsideration" Opinion and Order; (2) declined to grant her permanent and total disability (PTD); and (3) affirmed an Order on Reconsideration which awarded no unscheduled permanent disability for her accepted lumbosacral strain and right SI joint dysfunction conditions. On review, the issues are administrative notice, evidence, remand, extent of unscheduled disability and permanent total disability.

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

Claimant, age 43 at the time of hearing, compensably injured her low back on October 4, 1995. Following litigation, the SAIF Corporation accepted a lumbosacral strain and right SI joint dysfunction. (Exs. 8, 9).

In June 1996, claimant changed attending physicians and began treating with Dr. Cockrell. (Ex. 13). Dr. Cockrell performed a closing examination on September 26, 1996 and declared claimant medically stationary. Dr. Cockrell reported, among other things, that claimant's range of motion and sensory examination findings were inconsistent and invalid. (Ex. 17).

On October 21, 1996, SAIF issued a denial of claimant's current disability and need for treatment on the grounds that her compensable injury had ceased to be the major cause. (Ex. 21). SAIF also denied that claimant's somatic over-focusing and functional overlay were related to her compensable injury. Thereafter, on October 22, 1996, SAIF closed the claim with an award of 17 percent unscheduled permanent disability for the lumbosacral back. (Ex. 22).

Claimant requested reconsideration challenging, among other things, the impairment findings used to rate her disability and the rating of her unscheduled permanent disability. Claimant also asserted that she was permanently and totally disabled under the "odd lot" doctrine. (Ex. 27) As part of the reconsideration proceeding, both claimant and SAIF submitted additional medical and vocational reports relating to claimant's condition at the time of claim closure. (*See, e.g.* Exs. 26 through 34, 36).

Claimant was seen by Dr. Farris for a medical arbiter's examination on February 1, 1997. Dr. Farris reported that claimant's examination lacked objective findings of a medical condition, and concluded that claimant had no permanent impairment related to her accepted conditions of SI joint dysfunction and lumbosacral strain. (Ex. 35)

An Order on Reconsideration dated March 18, 1997, as amended March 19, 1997, determined that claimant had not proven any permanent impairment due to her accepted conditions and reduced her unscheduled permanent disability award to zero. (Exs. 37, 38). Claimant requested a hearing.

At hearing, SAIF requested that the ALJ take administrative notice of an October 21, 1997 final Opinion and Order (Ex. 39) which upheld its denials of claimant's current condition. The ALJ took official notice of the Opinion and Order, noting that it was the law of the case that, as of September 20, 1996, claimant's compensable injury of October 4, 1995 had ceased to be the major cause of her current condition and need for treatment. The ALJ further found that claimant failed to prove an entitlement to permanent partial or permanent total disability benefits.

On review, claimant contends the ALJ erred in admitting Exhibit 39 (the October 21, 1997 Opinion and Order) but declining to admit additional medical and vocational evidence regarding her accepted conditions. Claimant further contends that she is entitled to cross-examine the two vocational experts who evaluated her at SAIF's request. Finally, claimant asserts that she is entitled to an award of permanent disability due to her October 4, 1995 injury.

As an initial matter, we treat claimant's contention that she remains entitled to cross-examine SAIF's vocational experts as a request for remand. We may remand for further evidence if we determine that the case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. *Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). In addition, 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 the hearing. *Compton v. Weyerhaeuser Co.*, 301 Or 641 (1986).

Here, after reviewing the transcript of hearing, we conclude that the record is sufficiently developed and that claimant knowingly waived her right to cross-examine SAIF's vocational experts. At hearing, the ALJ explained to claimant that, although she was prohibited, pursuant to ORS 656.283(7), from testifying at hearing and submitting exhibits that were not part of the reconsideration record,[1] she was nevertheless entitled to cross-examine the vocational consultants who evaluated her at SAIF's request, if she elected to do so.[2] (Tr. 9-10). After further discussions with the ALJ, however, claimant chose not to hold the record open for the cross-examination of the vocational experts. Rather, claimant agreed to proceed to closing argument on the record admitted at that point.[3] (Tr. 27-28). Insofar as claimant expressly elected at hearing not to request a continuance for the cross-examination of SAIF's vocational consultants, we find no compelling reason to remand.

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[1] In "extent" cases, ORS 656.283(7) specifically prohibits the ALJ from considering evidence on an issue regarding a notice of closure or determination order unless the evidence was submitted on reconsideration and made a part of the reconsideration order. *See, e.g., Precision Castparts v. Plummer*, 140 Or App 227 (1996); *Joe R. Ray*, 48 Van Natta 325, *on recon* 48 Van Natta 548 (1996).

[2] *See, e.g., George D. Koskela*, 49 Van Natta 529 (1997); *Virginia McClearen*, 48 Van Natta 2536 (1996), *aff'd Rogue Valley Medical Center v. McClearen*, 152 Or App 239 (1998).

[3] After the ALJ explained to claimant that she had the choice whether or not to cross-examine the vocational experts, the following exchange took place:

"[ALJ]: It's not something you have to do, and it's not always to your advantage, but that's -- you know, I don't know this record, and you obviously paid a lot of attention to it.

"[Claimant]: Okay. All right. I can argue that, I guess.

"[ALJ]: So we're going to have closing argument today, then the record will be closed.

"[Claimant]: Okay.

"[ALJ]: No more evidence. No more arguments.

"[Claimant]: All right.

"[ALJ]: And then I'll issue a decision based on the record that I have admitted to this point.

"[Claimant]: All right." (Tr. 27-28).

Second, we find no error in the ALJ's decision to take official notice of the October 1, 1997 Opinion and Order. Although ORS 656.283(7) prohibits the consideration of evidence that was not submitted on reconsideration and made part of the reconsideration record, we have previously held that an ALJ or the Board may take administrative notice of a subsequent litigation order involving the same claimant (so long as the litigation order is not considered as evidence on any issue regarding the rating of claimant's accepted conditions), where the order is otherwise relevant to the claim. *See, e.g., Janet R. Christensen*, 50 Van Natta 1152 (1998) (Board took official notice of the fact that certain conditions were found compensable subsequent to the Order on Reconsideration). Here, the ALJ took official notice of Exhibit 39 (the October 1, 1997 Opinion Order) not for purposes of rating claimant's accepted lumbosacral strain and right SI joint dysfunction, but rather to clarify the scope and substance of SAIF's current condition denials.

Finally, we agree with the ALJ that a preponderance of the evidence fails to establish that claimant has sustained any permanent loss of earning capacity due to her compensable injury. *See* ORS 656.214(5).

For the purpose of rating permanent 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).

In this case, we find that Dr. Ferris, the medical arbiter, provided the most thorough and complete evaluation of claimant's permanent injury-related disability. Acknowledging that SAIF had accepted a lumbosacral strain and right SI joint dysfunction arising out of claimant's work activity on October 4, 1995, Dr. Ferris reported that her examination findings were unrelated to these conditions. Specifically, Dr. Ferris noted that claimant's October 1995 lumbosacral strain had resolved and was no longer symptomatic and that an SI joint dysfunction would not produce the results found on her examination of claimant. (Ex. 35-4). Dr. Ferris also reported that claimant exhibited nonphysiologic responses, including positive Waddell's and Marxer's testing and concluded that claimant's examination lacked valid objective findings of a medical condition. *Id.*

Furthermore, although claimant's attending physician, Dr. Cockrell, found a loss of lumbar motion and limited claimant to sedentary work, we find that Dr. Cockrell's report does not provide persuasive evidence of permanent disability due to claimant's compensable conditions.

Consequently, we affirm the ALJ's order which affirmed the Order on Reconsideration in its entirety.

ORDER

The ALJ's order dated February 18, 1998 is affirmed.

In the Matter of the Compensation of
BETTY J. CLARK, Claimant
WCB Case Nos. 97-06118 & 96-04140
ORDER ON RECONSIDERATION
Dennis O'Malley, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Claimant requests reconsideration of our May 29, 1998 Order on Review that: (1) reversed that part of an Administrative Law Judge's (ALJ's) order that set aside the self-insured employer's denial of her aggravation claim for her current left shoulder condition under a June 1995 injury claim; and (2) affirmed that part of the ALJ's order that upheld the employer's denial of the same condition as an aggravation of claimant's October 1992 compensable injury. Specifically, claimant contends that the Board considered and relied upon two exhibits, Exs. 135 and 137, which were withdrawn by the parties and never admitted as evidence.

Claimant is correct that Exhibits 135 and 137 were withdrawn by the parties at hearing. (*See* Tr. at 6, 8). Consequently, they should not be considered on Board review. Nevertheless, having reconsidered the evidence concerning the compensability of claimant's current left shoulder condition without considering Exhibits 135 and 137, we adhere to our determination that claimant has failed to establish a compensable aggravation.

As set forth in our original order, claimant must show an actual worsening resulting from her original injury to establish a compensable aggravation. ORS 656.273(1); Gloria T. Olson, 47 Van Natta 2348 (1995). Because claimant's current condition, diagnosed as left shoulder impingement syndrome, is not an accepted condition under either her 1992 or 1995 claim, claimant must first establish that her impingement syndrome is compensable and then show a worsened condition resulting from the original injury.

Claimant does not dispute our determination, based on the medical evidence, that her current left shoulder condition must be evaluated as a "combined condition" under ORS 656.005(7)(a)(B) because of her preexisting condition, an anatomical impingement (Type II acromion) that contributed to her impingement syndrome.

As noted in our original order, several physicians offered opinions concerning the cause of claimant's current condition. Dr. Davis, who treated claimant in the months following her 1995 injury, determined that claimant's impingement syndrome was degenerative in nature and probably not related to either her October 1992 or June 1995 compensable injuries. (Ex. 140). Dr. Marble, who evaluated claimant at the employer's request, concluded that claimant's left shoulder discomfort was of uncertain etiology, but probably not related to her industrial injuries. (Ex. 121). Drs. Mosqueda and Butler, who treated claimant in 1996, concurred with Dr. Marble's assessment. (Exs. 123, 124). Similarly, Dr. Jones, who evaluated claimant in April 1997, determined that claimant's impingement syndrome was related to degenerative processes rather than her 1992 or 1995 injuries. (Ex. 133).

Dr. Grewe, who began treating claimant's left shoulder in July 1996, opined that claimant's impingement syndrome preexisted her June 1995 injury, but that the June 1995 injury aggravated her condition. (Ex. 130). Because Dr. Grewe does not identify either of claimant's injuries as the major contributing cause of her impingement syndrome or its worsening, and offers no further explanation for his opinion that claimant's June 1995 accident aggravated her condition, his opinion does not support the compensability of claimant's current condition.

Dr. Gritzka, who examined claimant on one occasion in October 1997, opined that claimant's June 1995 accident caused a worsening of her left shoulder symptomatology. Although Dr. Gritzka's opinion arguably supports the compensability of claimant's current left shoulder condition as an aggravation of her June 1995 injury, we continue to find that his opinion is unpersuasive, as it is based on an incomplete history and conclusory. See Miller v. Granite Construction, 28 Or App 473, 476 (1977) (medical opinions that are not based on a complete and accurate history are not persuasive); Moe v. Ceiling Systems, 44 Or App 429 (1980) (rejecting conclusory medical opinion). Indeed, as explained in our original order, unlike claimant's treating physicians (who documented claimant's symptoms following her October 1992 and June 1995 injuries), Dr. Gritzka does not distinguish between claimant's complaints of pain consistent with her chronic trapezius strain versus her other symptoms consistent with an impingement syndrome.

Accordingly, on reconsideration, as supplemented and modified herein, we adhere to and republish our May 29, 1998 order. The parties rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

June 26, 1998 Cite as 50 Van Natta 1193 (1998)

In the Matter of the Compensation of
LAWRENCE R. HOWELL, Claimant
WCB Case No. 97-05861
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that upheld the insurer's denial of claimant's occupational disease claim for a bilateral upper extremity condition. On review, the issue is compensability.

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

The ALJ upheld the insurer's denial, finding that claimant had failed to sustain his burden of proving a compensable occupational disease claim for bilateral epicondylitis. In reaching this conclusion, the ALJ determined that "objective findings" did not exist to support the diagnosis of epicondylitis.

Noting that he need not prove a specific diagnosis in order to establish a compensable occupational disease claim, claimant asserts on review that a preponderance of the medical evidence establishes that work activities are the major contributing cause of his bilateral upper extremity condition.

We agree with claimant that he does not have to prove a specific diagnosis in order to prove 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); *Frances M. McLaughlin*, 49 Van Natta 1112, *on recon* 49 Van Natta 1786 (1997). However, claimant must prove the existence of an occupational disease by medical evidence supported by objective findings. ORS 656.802(2)(d). Based on the medical evidence from Dr. Eusterman and Dr. Sudakin, we agree with the ALJ that there is insufficient evidence of "objective findings" to support the occupational disease claim. (Exs. 4, 6, 7, 9, 20-15, 20-16, 20-26).[1] Therefore, we conclude that the ALJ properly upheld the insurer's denial.

ORDER

The ALJ's order dated March 30, 1998 is affirmed.

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[1] Claimant argues that, because there were sufficient findings for Drs. Polansky, McDonald, Davis and Krieg to diagnose epicondylitis, the claim should not fail for lack of objective findings. We disagree. Dr. Eusterman testified that physicians often give a patient the benefit of the doubt even if they do not have objective findings. (Ex. 20-27). More importantly, we are persuaded that Dr. Eusterman and Dr. Sudakin provided the most thorough evaluations regarding the existence of objective findings. Based on their reports and Dr. Eusterman's testimony, we conclude that the occupational disease claim is not supported by "objective findings." ORS 656.802(2)(d).

In the Matter of the Compensation of
DENNIS A. VANDERLINDEN, Claimant
WCB Case Nos. 97-08510 & 97-07387
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of those portions 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 upper extremity condition issued on behalf of the noncomplying employer, Ken's High Desert Transit (Ken's); and (2) upheld the denial of claimant's occupational disease claim for the same condition issued by Business Insurance Co. (BICO) on behalf of Intermountain Transport, Inc. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant, a truck driver who had previously experienced bilateral carpal tunnel syndrome in the mid-1980's in California, began working for Ken's, a noncomplying employer, in early 1996. In October 1996, claimant began to experience bilateral arm symptoms of numbness and tiredness, but did not seek medical treatment or miss work. Claimant left employment at Ken's in November 1996 and began driving trucks for Intermountain, insured by BICO, in January 1997.

Claimant's symptoms returned and increased and he eventually sought treatment in May 1997. Dr. Coe became claimant's attending physician and diagnosed either a recurrence of carpal tunnel or, more likely, cubital tunnel syndrome. (Ex. 4). Claimant subsequently received considerable medical treatment and evaluation and was diagnosed with bilateral tendinitis.

On August 5, 1997, BICO denied responsibility for the bilateral tendinitis claim. (Ex. 21). SAIF denied compensability and responsibility for the occupational disease claim on October 6, 1997, but later conceded compensability at hearing. (Ex. 27).

The ALJ determined that SAIF/Ken's was responsible for claimant's bilateral arm condition. In making this determination, the ALJ reasoned that the last injurious exposure rule (LIER) was not applicable because the medical evidence established actual causation, *i.e.*, that claimant's employment for Ken's was the major contributing cause of his condition.

On review, SAIF contends that the medical evidence is insufficient to prove actual causation. Therefore, SAIF asserts that LIER is applicable and that, when the rule is applied, BICO/Intermountain should be held responsible. For the following reasons, we agree with SAIF.

LIER is applied in situations involving successive employers, where each employment is capable of contributing to the disease and the finder of fact is unable to determine which employment actually caused the condition. *Bracke v. Baza'r*, 293 Or 239, 248-49 (1982). On the other hand, where actual causation is established with respect to a specific employer, it is not necessary to rely on judicially created rules of assignment pertaining to successive employments in determining responsibility. *See Runft v. SAIF*, 303 Or 493, 501-02 (1987); *Winfred L. Swonger*, 48 Van Natta 280 (1996), *aff'd mem* 145 Or App 548 (1997).

We turn first to the issue of whether actual causation was established in this case. Because of claimant's multiple work exposures, the causation issue presents a complex medical question requiring competent medical evidence. *Uris v. Compensation Department*, 247 Or 420 (1967).

Dr. Coe initially concurred with a medical report in which a panel of examining physicians (Drs. Rich and McKillop) concluded that claimant's work exposure at Ken's was the "cause of his current arm problems." (Exs. 14, 27B). However, the McKillop/Rich opinion is not persuasive because it is unexplained.[1] *See Moe v. Ceiling Systems*, 44 Or App 429 (1980) (rejecting conclusory medical opinion). As for Dr. Coe, we do not find that his opinion is consistent because he later concluded that claimant's employment as a truck driver for over 20 years was the major contributing cause of claimant's bilateral arm condition. (Ex. 28B). Even assuming that this later report accurately reflects Dr. Coe's opinion, it still does not establish that a particular employer in that period actually caused claimant's condition.

The only remaining doctor to address causation (Dr. Stewart) rendered his opinion in the form of a "check-the-box" concurrence with the Rich/McKillop report. (Ex. 18). We discount the probative value of that report for the same reasons we discounted Dr. Coe's concurrence. It follows that Dr. Stewart's opinion does not establish actual causation.

Accordingly, on this record, we do not find persuasive medical evidence that proves that a particular employment actually caused claimant's bilateral arm condition. Therefore, we apply LIER to determine responsibility.

LIER provides that, when a worker proves that an occupational disease was caused by work conditions that existed when more than one carrier was on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. *Boise Cascade Corp. v. Starbuck*, 296 Or 238, 241 (1984). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. *Bracke*, 293 Or at 248. If a claimant receives treatment for a compensable condition before experiencing time loss due to the condition, the date the claimant first began to receive treatment related to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim. *Timm v. Maley*, 125 Or App 396, 401 (1993), *rev den* 319 Or 81 (1994).

Here, claimant first received treatment for his bilateral arm condition in May 1997. (Ex. 2). Claimant was working for BICO's insured, Intermountain, at the time. Under LIER, we assign initial responsibility for that condition to BICO/Intermountain. BICO/Intermountain can shift responsibility to SAIF/Ken's, the prior carrier, by showing that claimant's work activity at the earlier employer was the sole cause of claimant's bilateral arm condition, or that it was impossible for conditions while BICO/Intermountain was on the risk to have caused that condition. *See FMC Corp. v. Liberty Mutual Ins. Co.*, 70 Or App 370, 374, *mod* 73 Or App 223, *rev den* 299 Or 203 (1985).

For the reasons previously discussed, we find no persuasive medical evidence that establishes that SAIF/Ken's employment was the sole cause of claimant's condition. Nor is there evidence that it was impossible for claimant's employment at Intermountain to have caused the bilateral arm condition. Therefore, we conclude that BICO/Intermountain is responsible for claimant's bilateral arm condition. Because the ALJ concluded otherwise, we reverse.

ORDER

The ALJ's order dated January 30, 1998 is reversed. BICO/Intermountain's responsibility denial is set aside and the claim is remanded to BICO/Intermountain for processing in accordance with law. SAIF/Ken's responsibility denial is reinstated and upheld. The ALJ's attorney fee award regarding the responsibility issue is payable by BICO/Intermountain, rather than SAIF/Ken's.

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[1] The Rich/McKillop panel later agreed in a "check-the-box" concurrence letter that employment at Ken's was the major contributing cause of claimant's condition. (Ex. 29). Because that report is also conclusory, we also give it little weight. *See Marta I. Gomez*, 46 Van Natta 1654 (1994) (Board will give little, if any weight, to conclusory, poorly reasoned opinions, such as unexplained "check-the-box" reports).

In the Matter of the Compensation of
NORMA E. VINSON, Claimant
Own Motion No. 98-0064M
OWN MOTION ORDER DENYING RECONSIDERATION
Bischoff & Strooband, Claimant Attorneys

On May 27, 1998, claimant submitted correspondence to the Board wherein she raised issues regarding the classification of her claim and noted that she had requested a hearing on the matter before the Hearings Division. Claimant additionally asserted that a Board's order can be set aside as a result of mistake or misrepresentation. We responded to claimant's May 27, 1998 submission by letter dated June 3, 1998, wherein we acknowledged receipt of claimant's correspondence but were unclear as to what relief she was requesting.

On June 16, 1998, we received claimant's June 12, 1998 response. In addition to the issues raised previously, claimant also asserted that she did not previously request reconsideration of our February 13, 1998 order because she did not receive a copy of the order. We interpret claimant's latest submission as a request for reconsideration of our February 13, 1998 order, which reopened her claim for the provision of temporary disability compensation.

Pursuant to OAR 438-012-0065(2), a reconsideration request must be filed within 30 days after the mailing date of the order, or within 60 days after the mailing date if there was good cause for the failure to file within 30 days. The standard for determining if good cause exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect" recognized by ORCP 71B(1) and *former* ORS 18.160. *Anderson v. Publishers Paper Co.*, 78 Or App 513, 517, *rev den* 301 Or 666; *see also Brown v. EBI Companies*, 289 Or 455 (1980). Lack of due diligence does not constitute good cause. *Cogswell v. SAIF*, 74 Or App 234, 237 (1985). However, OAR 438-012-0065(3) also provides that "[n]otwithstanding section (2) of this rule, in extraordinary circumstances the Board may, on its own motion, reconsider any prior Board order." *See Larry P. Karr*, 48 Van Natta 2182 (1996); *Jay A. Yowell*, 42 Van Natta 1120 (1990).

Here, claimant's request for reconsideration was received on June 16, 1998, more than 60 days after the issuance of our February 13, 1998 own motion order.[1] Claimant's attorney asserts that claimant did not seek reconsideration of our February 13, 1998 order because she did not receive a copy of the order. To begin with, claimant's attorney's statements or argument are not probative evidence regarding the question of whether claimant received a copy of our previous order. *See generally Marlene J. Andre*, 48 Van Natta 404 (1996); *Earl J. Prettyman*, 46 Van Natta 1137 (1994).

However, even if we were to consider claimant's attorney's assertion, a party's failure to receive a copy of a Board order is not determinative. Rather the pivotal issue is whether a copy of the order was mailed to the claimant. *Michael D. Hogan, Jr.*, 47 Van Natta 1519 (1995). The Board's order and file indicates that copies of the order were mailed to all parties. Specifically, the Board's file contains the original Board order which carries a notation beside claimant's name indicating that a copy of the order was mailed to claimant's mailing address. Additionally, there has been no contention from the remaining parties to this proceeding which indicates that the Board's mailing was defective. We are persuaded, at a minimum, that copies of the Board's February 13, 1998 order were mailed to all parties to the proceeding. Thus, we do not find claimant's attorney's assertion that claimant did not receive a copy of the order "good cause" for her failure to timely file a request for reconsideration.

Finally, under extraordinary circumstances, the Board may, on its own motion, reconsider any prior Board order. OAR 438-012-0065(3). Here, litigation is presently pending before the Hearings Division regarding claimant's claim classification. In the event that claimant prevails at that hearing, we may be willing to reconsider this matter. Nonetheless, until that pending litigation is resolved, we find that no extraordinary circumstances currently exist to persuade us that an exception outside the deadlines imposed by OAR 438-012-0065(2) is appropriate.

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[1] Claimant may argue that her May 27, 1998 submission, received by the Board on June 2, 1998, should actually be considered as her request for reconsideration. Regardless of which submission we interpret to be claimant's request for reconsideration, both the May 27 and June 12, 1998 requests are untimely. OAR 438-012-0065.

Accordingly, we deny the request for reconsideration of our prior order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JANET F. BERHORST, Claimant
Own Motion No. 98-0129M
OWN MOTION ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requested reconsideration of our April 15, 1998 Own Motion Order wherein we declined to reopen her 1983 claim for the payment of temporary disability compensation because she failed to establish she was in the work force at the time of her current disability.

In order to allow sufficient time to consider the motion for reconsideration, we abated our order and requested that the SAIF Corporation respond to the motion. SAIF responded to the motion on May 18, 1998 and provided the Board with additional documents supporting its contentions. In its response, SAIF requested an evidentiary hearing be held regarding claimant's work force status. Claimant submitted a rebuttal to SAIF's response on May 26, 1998. Having received the parties' position briefs and supplemental documentation, we proceed with our review.

SAIF's Request for an Evidentiary Hearing

SAIF requested an evidentiary hearing to allow: (1) the cross-examination of claimant's last employer; (2) claimant's testimony regarding her willingness to work; and (3) the deposition of Dr. Bailey, claimant's attending physician. Claimant responded to SAIF's request by arguing that SAIF had ample opportunity to obtain claimant's statement, her employer's statement and to depose Dr. Bailey prior to issuing its recommendation and the Board's April 15, 1998 order. We agree. Additionally, on review of the record and the documents supplemented by the parties, we find the record sufficiently developed. Thus, we are not inclined, at this time, to grant SAIF's request for an evidentiary hearing. OAR 438-012-0040(3).

Entitlement to Temporary Disability Compensation

In order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990). Here, claimant must prove that she was in the work force on December 29, 1997, when her condition worsened requiring hospitalization. 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).

We previously found that claimant had established, through her March 12, 1998 affidavit that she was willing to work. However, we found that claimant had failed to provide medical documentation in support of her contention that she was unable to work and/or that it would have been futile for her to seek work due to her compensable condition. With their responsive briefs, both parties submitted several medical reports in support of their contentions. The following is a brief review of the documents supplemented:

On December 19, 1996, claimant sought treatment with Dr. Bailey, her attending physician, for increased pain over the prior 6 months. Dr. Bailey diagnosed chronic low back pain and prescribed Ibuprofen. His chart note did not mention or comment on claimant's work status or her ability to work.

On February 6, 1997, claimant was seen by Dr. Herring on a referral from Dr. Bailey. Dr. Herring's impression was of "persistent and worsening back and leg symptoms following a fusion over twenty years ago." He ordered diagnostic imaging tests and provided claimant with a new anti-inflammatory. Dr. Herring noted that "Physical therapy had been cut off by the insurer, apparently because they did not want to provide palliative care if she was not working."

Claimant was seen by Dr. Miller on April 29, 1997, for further evaluation of her neurological condition. Dr. Miller diagnosed progressive pain due to degenerative disc disease. He recommended further diagnostic tests in the form of a lumbar diskogram. There is no mention in Dr. Miller's report regarding claimant's work force status or ability to work.

On September 19, 1997, claimant was seen by Dr. Van Pett on referral from Dr. Herring. Dr. Van Pett recommended a diagnostic CT/myelogram with possible nerve conduction tests and returned claimant to Dr. Herring's nonsurgical care, "including work related limitations." Dr. Van Pett saw claimant on October 17 and October 31, 1997, concluding that claimant would benefit from surgical intervention. Dr. Van Pett did not address claimant's work force status following either of these visits.

Claimant underwent some pre-operative tests on November 10, 1997 at Sacred Heart Medical Center. On the chart note of that visit, claimant's occupation was listed as "homemaker," and claimant's employer was listed as "homemaker." Claimant underwent L2-3 hemilaminectomy and microdiskectomy, and bilateral L2-3 foraminotomies on December 29, 1997.

On January 12, 1998, claimant returned, for a follow-up visit, to Dr. Bailey. Dr. Bailey opined that claimant was much improved since her surgery. He also authorized time loss from "her last appointment 12/19/96 through until she is release[d] by neurosurgeon."

Claimant contends the medical record demonstrates her inability to work and/or seek work due her compensable condition. She argues that even though most of her physicians do not use the "magic words" regarding her ability to work and/or seek work, that her documented deteriorating physical condition implicitly demonstrates she was unable to work due to her compensable condition. Claimant further relies on Dr. Bailey's January 12, 1998 chart note wherein he retroactively authorized time loss from her first visit to him on December 19, 1996 until released by her treating neurosurgeon.

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, all but one of claimant's treating physicians fail to even address her work force status, as discussed above. Further, we are not persuaded by claimant's argument that her documented deteriorating condition is sufficient to satisfy her burden of proof that she was unable to work due to her compensable condition. As previously discussed, none of the doctors claimant treated with during 1997 correlate her deteriorating physical condition with an inability to work and/or seek work.

Claimant's reliance on Dr. Bailey's retroactive authorization of time loss is misplaced. We have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction,[1] is the date she enters the hospital for the proposed surgery. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). The relevant time period for which claimant must establish she was in the work force is the time prior to her December 29, 1997 surgery, when her condition worsened requiring that surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App at 273; *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997); *Michael C. Batori*, 49 Van Natta 535 (1997); *Kenneth C. Felton*, 48 Van Natta 725 (1996). Dr. Bailey did not see claimant prior to her undergoing surgery on December 29, 1997. In fact, Dr. Bailey did not treat or see claimant since her visit to him on December 19, 1996 until her return visit on January 12, 1998. We give the most weight to opinions that are both well-reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259 (1986). In this case, we find that Dr. Bailey's assertion, more than a year later, that claimant was unable to work due to her compensable condition for the entire previous year, without providing a well-reasoned opinion based on complete information, is conclusory, at best, and insufficient to satisfy claimant's burden of proof.

Finally, claimant's own characterization of her work force status, that of being a "homemaker," during her pre-operative visit on November 10, 1997, is unrebutted.

Thus, we continue to find that claimant has not proven that she was unable to work and that it would have been futile for her to seek work due to her compensable condition.

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[1] The Board in its own motion jurisdiction can only authorize temporary disability from the time of surgery or hospitalization. See ORS 656.278(1)(a).

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our April 15, 1998 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
PATRICK J. CALDWELL, Claimant
WCB Case No. 97-01990
ORDER ON REVIEW
Dobbins, McCurdy & Yu, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Biehl and Bock.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Herman's order that: (1) upheld the SAIF Corporation's denial of his injury claim for a lumbosacral strain; and (2) upheld SAIF's denial of his injury claim for a herniated disc at L3-4. 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

Lumbar Strain

On page 3 of the ALJ's order, we delete the last paragraph and replace it with the following discussion.

At hearing, claimant argued that he had two separate compensable conditions: a lumbosacral strain and a disc herniation at L3-4. The ALJ found that the medical evidence was persuasive that there was only one medical condition for which claimant sought treatment, *i.e.*, a herniated disc.

For the following reasons, we agree with claimant's contention that he has established a compensable low back strain. Claimant acknowledges that he had preexisting degenerative changes in his back, although he notes that he had no back symptoms while working for the employer before November 29, 1996. The persuasive medical evidence establishes that claimant had preexisting degenerative disc disease in the lumbar spine, which combined with the November 29, 1996 work incident to produce his need for treatment. (Exs. 20, 28, 39, 41). Consequently, claimant must establish that the work injury was the major contributing cause of the disability or need for treatment of the combined condition. *See* ORS 656.005(7)(a)(B).

Claimant testified that his back "gave out" on November 29, 1996, when he bent down to pick up a box off the floor. (Tr. 14). On December 2, 1996, Dr. Acosta diagnosed sciatica. (Exs. 2, 3). On December 6, 1996, Dr. Harpole diagnosed acute lumbosacral strain with left radicular pain. (Exs. 4, 5). On December 16, 1996, Dr. Harpole diagnosed lumbosacral strain, as well as left sacroiliac strain and possible S1 left radiculopathy. (Ex. 7). Dr. Harpole continued to diagnose lumbosacral strain on December 27, 1996. (Ex. 8). Claimant's treatment included medication, ice and heat treatments, exercise, a TENS unit and physical therapy. (Exs. 5, 7).

A CT scan on December 31, 1996, showed a central disc protrusion at L3-4. (Ex. 9). On the same date, Dr. Browning diagnosed a "[l]umbosacral strain of November 29, 1996[,]" as well as a central herniated nucleus pulposus at L3-4. (*Id.*) In later January 1997 reports, Dr. Browning diagnosed a herniated disc at L3-4. (Exs. 12, 15, 17).

In April 1997, Dr. Browning referred claimant to Dr. Tahir, neurosurgeon, because claimant's pain intensity had increased. (Ex. 24-2). Dr. Tahir diagnosed a herniated disc at L3-4. (Ex. 26-3). On June 2, 1997, he performed a hemilaminectomy and diskectomy at L3-4. (Ex. 29).

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, absent persuasive reasons to do otherwise, we generally rely on the opinion of a worker's treating physician. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find no persuasive reason not to rely on the opinion of Dr. Browning.

Dr. Browning began treating claimant in December 1996. Her initial diagnosis was a "[l]umbosacral strain of November 29, 1996[,]" as well as a central herniated nucleus pulposus at L3-4. (Ex. 9). In later reports, she continued to include references to claimant's acute lumbosacral strain, although her "assessment" referred to a herniated nucleus pulposus at L3-4. (Exs. 12,17). Dr. Browning agreed with claimant's attorney that, based on claimant's history, the examination and review of medical records, claimant's work activity on November 29, 1996 was the major contributing cause of the lumbosacral strain. (Ex. 24A-2).

Dr. Browning's conclusion is supported by the first report from Dr. Strum, who examined claimant on behalf of SAIF. Dr. Strum diagnosed a "[l]umbosacral strain, related to on-the-job incident of November 29, 1996" and preexisting degenerative disc disease, multiple levels, and possible disc herniation. (Ex. 20-5, -6). Dr. Strum opined that, based on the mechanism of injury, claimant had a very minor musculoligamentous injury with symptoms that would have been expected to resolve within a matter of a few hours, if not a few days. (Ex. 20-6, -7). He reported that claimant's preexisting degenerative disc disease combined with the on-the-job episode and "in fact, in my opinion, within the first few days after this incident became the major contributing cause of his continuing problems, resultant disability and need for treatment." (Ex. 20-7). In a later report, Dr. Strum continued to believe that claimant had sustained a minor musculoligamentous strain on November 29, 1996, although he felt that the major contributing cause of the combined condition was the degenerative disc disease. (Ex. 41). In that report, Dr. Strum did not indicate that he was changing his earlier opinion. Dr. Strum's first report indicates that the strain was the major contributing cause, at least initially, for claimant's disability and need for treatment.

In contrast, Dr. Tahir reported in September 1997 that he had not diagnosed a lumbosacral strain, but rather a herniated disc at L3-4. (Exs. 36, 37). However, we note that Dr. Tahir did not examine claimant until April 30, 1997, five months after the injury. On the other hand, the more persuasive medical reports establish that claimant sustained a lumbosacral strain as a result of the November 29, 1996 incident. Drs. Harpole and Browning examined claimant shortly after the injury and reported that he had a lumbosacral strain. (Exs. 4, 5, 7, 8, 9). In addition, although Dr. Young diagnosed a protrusion at L3-4, he believed that claimant had sustained some type of soft tissue injury such as a back strain or sprain. (Ex. 28-3). Dr. Strum believed that claimant had sustained a lumbosacral strain as a result of the November 29, 1996 incident. (Ex. 20-5).

Based on Dr. Browning's opinion, we conclude that claimant's work activity on November 29, 1996 was the major contributing cause of the lumbosacral strain. (Exs. 20-7, 24A-2). Although Dr. Young concluded that the preexisting degenerative condition and not the injury was the major predominant cause of claimant's symptoms and need for treatment. (Ex. 28-3), we note that he performed a records review and did not examine or treat claimant. We are more persuaded by the opinion of Dr. Browning, who had an opportunity to examine and treat claimant for several months. *See Weiland v. SAIF*, 64 Or App at 814. We conclude that claimant has established compensability of the lumbosacral strain.

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

Disc Herniation at L3-4

We adopt and affirm the ALJ's "Conclusions of Law and Opinion" with the following changes. In the third paragraph on page 3, we change the date in the last sentence to "June 1997." As noted previously, we delete the last paragraph on page 3. We agree with the ALJ's reasoning and conclusion

that claimant has not established that the November 29, 1996 injury was the major contributing cause of the disc herniation at L3-4.

ORDER

The ALJ's order dated January 14, 1998 is reversed in part and affirmed in part. That portion of the ALJ's order that upheld SAIF's denial of the lumbosacral strain is set aside and the claim is remanded to SAIF for processing according to law. The remainder of the ALJ's order is affirmed. For services at hearing and on review concerning the lumbosacral strain, claimant's attorney is awarded $3,000, payable by SAIF.

In the Matter of the Compensation of
SCOTT D. CHAMBERS, Claimant
WCB Case Nos. 97-02881 & 97-02558
ORDER ON REVIEW
Brothers & Ash, Claimant Attorneys
Reinisch, et al, Defense Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The self-insured employer (Express Personnel) requests review of Administrative Law Judge (ALJ) Baker's order that: (1) set aside its compensability and responsibility denials of claimant's "new injury" claim for his current low back condition; and (2) upheld the SAIF Corporation's denials (on behalf of Entre Prises USA) of claimant's aggravation claim for the same condition. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

Both SAIF and Express Personnel denied compensability. Claimant acknowledges that compensability in this matter is properly determined pursuant to ORS 656.005(7)(a)(B). Consequently, claimant must prove that his work activities were the major contributing cause of his disability or need for medical treatment for his combined condition. ORS 656.005(7)(a)(B); SAIF v. Nehl, 148 Or App 101, recon 104 Or App 309 (1997); Gregory C. Noble, 49 Van Natta 764, 767 (1997). Determination of the major contributing cause involves evaluating the relative contribution of different causes of claimant's need for treatment of the combined condition and deciding which is the primary cause. Dietz v. Ramuda, 130 Or App 397, 401 (1997), rev dismisssed 320 Or 416 (1995). Furthermore, given the combination of the preexisting degenerative condition and the work incident(s), the determination of the major contributing cause is a complex medical question, the resolution of which requires medical evidence. See Uris v. Compensation Dept., 247 Or 420, 424 (1967).[1]

The ALJ found that the opinion of Dr. Newby, claimant's treating physician and surgeon, established compensability. Express Personnel contends that the opinions of Drs. Watson, Thompson and Williams are more persuasive than Dr. Newby's opinion. Specifically, Express Personnel argues that Dr. Newby has not explained how claimant's work activity caused his disc bulges or why the 1996 and 1997 injuries were the major cause of claimant's need for treatment and disability.

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[1] Express Personnel also contends that the case may be analyzed pursuant to ORS 656.802(2)(b). Nevertheless, based on Dr. Newby's explanation, we conclude that compensability is most properly analyzed under ORS 656.005(7)(a)(B). Ex. 34. We note, however, that Dr. Newby believed that claimant's degenerative disc disease was primarily the result of heavy labor performed throughout his life. Ex. 34.

After reviewing the expert medical opinions, we conclude that the ALJ correctly relied on the opinion of Dr. Newby. Contrary to Express Personnel's argument, we find that Dr. Newby did explain his opinion. Based on claimant's 1997 MRI, Dr. Newby reported that the 1997 injury "played the major role in [claimant's] inability to return back to work since there has been some mild but definite progression on the interval MRI scan." (Ex. 37A, 33). Dr. Newby also testified that, considering claimant's age (34 years) and the amount of changes in his back, claimant's occupation played a role in causing "at least 51 percent or greater" of his current abnormalities. (Ex. 37A, 8). Finally, Dr. Newby testified that, based on his comparison of claimant's baseline scan to the scan following the 1997 incident, claimant's bulge at L3-4 had worsened as a result of work, and his need for treatment was a direct result of the worsening. (Ex. 37A, 11).

Accordingly, we conclude that Dr. Newby has considered claimant's degenerative condition and has explained his reasons for believing that work is the major cause of claimant's current low back condition. Moreover, considering Dr. Newby's status as claimant's treating doctor and surgeon, we conclude that he is in the best opinion to provide an opinion on causation. See Weiland v. SAIF, 64 Or App 810, 814 (1983); Argonaut Insurance Company v. Mageske, 93 Or App 698 (1988). We therefore affirm the ALJ's conclusion on the issue of compensability.

Responsibility

Here, there has been no prior accepted claim for claimant's multi-level degenerative disc disease with central disc protrusions at L3-4, L4-5, and L5-S1. Because the claim has not been accepted, ORS 656.308(1) does not apply in determining responsibility. SAIF v. Yokum, 132 Or App 18 (1994) (ORS 656.308(1) does not apply to initial claim determinations). Instead, we generally resort to the judicially created rules governing the initial assignment of responsibility in successive employment cases, e.g., the last injury rule (for injury claims) and the last injurious exposure rule (for occupational disease claims). See John J. Saint, 46 Van Natta 2224 (1994). Where, however, causation is proven as to a specific employment, we need not resort to those rules. See Eva R. Billings, 45 Van Natta 2142 (1993); Runft v. SAIF, 303 Or 493, 502 (1987). Rather, we will assign responsibility to the carrier with respect to whom actual causation has been established.

In this case, based on Dr. Newby's opinion, we conclude that actual causation has been established with respect to the 1997 injury with Express Personnel. Specifically, Dr. Newby testified that the 1997 injury played the major role in claimant's inability to return to work, and claimant's condition and need for treatment were due to the 1997 injury. Ex. 37A-28. Accordingly, we conclude that Dr. Newby's opinion establishes that the 1997 incident actually caused claimant's low back condition. Therefore, we agree with the ALJ that Express Personnel is responsible for that condition.

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

ORDER

The ALJ's order dated December 10, 1997 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by the employer (Express Personnel/AIG).

In the Matter of the Compensation of
RONALD D. FULLER, Claimant
WCB Case No. 95-04992
ORDER OF ABATEMENT
Pozzi, Wilson, et al, Claimant Attorneys
Rick Dawson (Saif), Defense Attorney

The SAIF Corporation requests abatement and reconsideration of our May 28, 1998 Order on Review that affirmed that portion of an Administrative Law Judge's (ALJ's) order that found a Determination Order procedurally invalid based on inadequate notice.

In order to consider this matter, we withdraw our May 28, 1998 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
HELEN L. COELHO, Claimant
WCB Case Nos. 97-08996 & 97-03356
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Nichols' order that set aside its denials of claimant's claim for her current left shoulder, upper back and cervical condition. On review, the issue is compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

We summarize the facts as follows. Claimant works as a driver and merchandiser delivering and displaying magazines in stores. This job requires claimant to load and unload magazines which are often placed in large "banana" boxes in a delivery van. The weight of the boxes varies, but some boxes weigh in excess of seventy pounds. In February 1995, claimant filed a claim for a left shoulder strain that occurred while she was lifting a box of magazines into the back of the van. Claimant was treated for the injury by Dr. Dew. The claim was accepted for a nondisabling left shoulder strain.

By April 1995, claimant resumed her normal work duties without pain. She had full range of motion of the shoulder without tenderness. Dr. Dew felt that claimant's shoulder strain had resolved and that she was medically stationary without lasting deficits from the injury.

Claimant returned to Dr. Dew in May 1996 with pain complaints that were similar to her prior complaints. Claimant gave a history relating the pain to her work activities. Dr. Dew diagnosed left cervical thoracic myofascitis. Claimant was seen by Dr. Dew on October 1, 1996. At that time, Dr. Dew diagnosed left shoulder bursitis, cervicothoracic myofascitis and tension headaches.

On March 27, 1997, the employer issued a partial denial for additional conditions and treatment in relation to the February 1995 claim. Specifically, the denial denied "osteopathic somatic dysfunction in the C-spine region with C1 resisting Rot, R and C2 resisting Sb/Rot to the R in flexion, cervicothoracic myofascitis, and tension cephalgia related to the above mentioned."

On July 21, 1997, claimant's attorney wrote to the employer making a claim for an occupational disease for claimant's left shoulder condition.

Claimant was seen by Dr. Miller, who declined to address the issue of causation of claimant's left shoulder problems, but diagnosed moderate impingement syndrome of the left shoulder.

Claimant was examined in October 1997 by Drs. Gripekoven and Reimer at the employer's request. Claimant reported an improvement in symptoms after being promoted to a less strenuous job. She reported that her neck pain, which had come on gradually nine months earlier, was now constant. She also complained of mid-back pain, radiating into her right shoulder with headaches and intermittent numbness into her left hand.

On December 3, 1997, the employer denied claimant's occupational disease claim.

CONCLUSIONS OF LAW AND OPINION

Relying on the opinion of Dr. Dew, claimant's treating physician, the ALJ set aside the employer's denials of both an "aggravation" claim and the occupational disease claim.

Claimant asserted alternative theories of compensability at hearing. She argued that her condition was compensable as either an occupational disease or a consequence of the 1995 left shoulder strain claim. The employer argues that even if claimant established compensability of her claim as both an "aggravation" and an occupational disease claim, both denials should not have been set aside because responsibility principles apply to claims with the same carrier to determine under which claim the new condition should be processed. *See David L. Large*, 46 Van Natta 96 (1994); *Peggy Holmes*, 45 Van Natta 278 (1993). In her brief, claimant agrees that "it is unlikely that one condition - in this instance, cervical myofascitis - would be compensable under both claims * * *." (Resp. Br. at 9). For the reasons which follow, we find that claimant has established compensability of her condition as an occupational disease, but not as a compensable consequence[1] of the 1995 left shoulder claim.

There are two expert medical opinions which address the cause of claimant's current condition. Dr. Dew is claimant's treating physician. He characterized claimant's condition as a new injury. He was unable to state that claimant's February 22, 1995 compensable injury was the major contributing cause of her current condition and did not believe that claimant had sustained an objective worsening of her February 22, 1995 condition. (Ex. 12). In a June 6, 1997 chart note, Dr. Dew described a discussion with claimant regarding the nature of claimant's condition. He stated, in part:

> "We discussed basically the terminology problem as far as causes of injuries and aggravation of injuries and whether or not a reaggravation is from the original cause or from a new cause of a new work related incident. Basically it comes down to a problem of semantics. Certainly I think all of her shoulder pain is somehow related to and aggravated by her lifting, etc. that she does at work. However I think it is hard to say that the original claim for which she became medically stationary was the main contributing cause for the reaggravation of the pain. We basically discussed the difficulties here because I don't know the legal ramifications or terminology for this."

Dr. Dew indicated that the impingement syndrome diagnosed by Dr. Miller was a distinct and separate diagnosis from the cervicothoracic myofascitis and that both conditions were caused by the work activities. Upon comparison of claimant's findings in April 1995 with her findings in May and October 1996, Dr. Dew also indicated that the findings demonstrated a worsening of the previous left shoulder strain condition.

Claimant was examined, on behalf of the employer, by Drs. Reimer and Gripekoven. These physicians could not relate claimant's current symptoms to her work activities or to her February 1995 compensable injury.

We do not find any medical evidence in this record that is sufficient to establish that the cervicothoracic myofascitis condition is compensably related to the February 1995 compensable injury. To establish compensability of the cervicothoracic myofascitis as a compensable consequence of the injury, claimant must establish that the injury was the major contributing cause of the consequential condition. *See* ORS 656.005(7)(a)(A). Here, however, even if the material contributing cause standard applied, the evidence does not support compensability. In this regard, rather than implicating the February 1995 injury as the cause of claimant's condition, Dr. Dew relates the condition to claimant's *work activities*. Under such circumstances, we find that the March 27, 1997 "consequential condition" denial should be upheld.

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[1] The ALJ and the employer's brief refer to the March 27, 1997 denial as an "aggravation" denial. The denial indicates that the employer had received medical bills for additional treatment rendered since the "closure" of claimant's claim for the February 1995 compensable injury. However, the denial then lists specific conditions including cervicothoracic myofascitis and indicates that it is a partial denial of these conditions. Under such circumstances, we do not find that the denial is a denial of an aggravation. Rather, we find that it is a denial that the conditions listed are related to the February 1995 injury as compensable consequences of that injury. This understanding of the denial is consistent with the employer's counsel's statements at hearing. (Tr. 2-3).

With regard to her occupational disease claim, the employer asserts that claimant's 1995 accepted strain condition is a "preexisting disease" because it preceded the onset of claimant's claim. On this basis, the employer argues that claimant must prove that the employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease. *See* ORS 656.802(2)(b).

Claimant alleges that her work activities with the employer caused her cervicothoracic myofascitis. Based on this record, we are unable to conclude that the accepted left shoulder strain combined with claimant's work activities to cause the cervicothoracic myofascitis. In this regard, Dr. Dew believed that claimant's condition was a "new" injury as opposed to a reaggravation of the prior injury. Although Dr. Dew ultimately opined that the left shoulder strain had worsened, he did not indicate that the left shoulder strain and the work activities combined to cause the cervicothoracic myofascitis. Rather, he indicated that the cervicothoracic myofascitis was related to claimant's work activities. Under such circumstances, we are not persuaded that claimant's claim is based on a worsening of a preexisting condition under ORS 656.802(2)(b).

With regard to claimant's occupational disease claim, we rely on the opinion of Dr. Dew, rather than that of Drs. Gripekoven and Reimer. We generally defer to the treating physician's opinion absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, Dr. Dew has consistently related claimant's cervicothoracic myofascitis to her work activities and we find no persuasive reasons not to rely on Dr. Dew's opinion with regard to claimant's occupational disease claim.[2] Under such circumstances, we are persuaded that she has established that her work activities are the major contributing cause of that condition.

The employer argues that Dr. Dew's opinions are based on an incorrect history because he was unaware that claimant's work activities became less strenuous after she was promoted to a supervisory position in the spring of 1997 (after her problems had already begun). We are unable to conclude that Dr. Dew had an incorrect history. In a July 1997 chart note, Dr. Dew stated that claimant's job required a lot of merchandising, driving and carrying boxes. In a September 1997 chart note, Dr. Dew indicated claimant continued to do the same job stocking magazine racks. Although claimant testified that her job became less demanding after the promotion, she still occasionally had to perform the same driving and lifting duties even after the spring of 1997. Under these circumstances, we are not persuaded that Dr. Dew's history was inaccurate.

The employer also argues that Dr. Dew's opinion is unpersuasive because it is uncertain, fails to describe claimant's off work activities, does not weigh the role of the impingement syndrome diagnosed by Dr. Miller and is inconsistent and unexplained. We do not find Dr. Dew's opinion to be uncertain. Dr. Dew has consistently related claimant's cervicothoracic myofascitis condition to her work activities. There is no evidence in the record that claimant's condition was caused by off work activities. Dr. Dew was able to say that claimant's activities were greater than all other causes put together in the development of her current condition which he diagnosed as cervicothoracic myofascitis. Although Dr. Dew did not expressly state that claimant's work with the employer was the "major contributing cause" of her cervicothoracic condition, it is well settled that "magic words" are not necessary to establish medical causation. *See Liberty Northwest Ins. Corp. v. Cross*, 109 Or App 109 (1991), *rev den* 312 Or 676 (1992).

Based on this record, we are persuaded that claimant's work activities, rather than the impingement syndrome (which Dr. Dew also thought was related to claimant's work activities),[3] were the major contributing cause of claimant's condition. Accordingly, we find that the preponderance of the evidence supports compensability of claimant's cervicothoracic myofascitis as an occupational disease.

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[2] Although Dr. Dew offered apparently conflicting opinions about whether claimant's February 1995 condition had compensably worsened, we are persuaded that his opinions establish that claimant's cervicothoracic myofascitis is the result of claimant's work activities and is an occupational disease, rather than a worsening of the February 1995 compensable injury. In any case, because we have found that the March 27, 1997 denial was not a denial of aggravation claim and because no aggravation claim is apparently being pursued, we do not find Dr. Dew's comments about whether there has been a worsening to be relevant to the issues before us.

[3] At the time of hearing, claimant's attorney indicated that compensability of the impingement syndrome was not being litigated and that no claim had yet been made for that condition. (Tr. 11-12).

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

ORDER

The ALJ's order dated February 25, 1998 is affirmed in part and reversed in part. That portion of the ALJ's order which set aside the employer's March 27, 1997 partial denial of claimant's condition is reversed. The denial is reinstated and upheld. The remainder of the ALJ's order is affirmed. For services on review, with regard to the occupational disease claim, claimant's attorney is awarded $1,200, payable by the employer.

In the Matter of the Compensation of
DUSTIN L. CROMPTON, Claimant
Own Motion No. 97-0523M
SECOND ORDER OF ABATEMENT / ORDER OF POSTPONEMENT
Glen J. Lasken, Claimant Attorney
Sather, Byerly, et al, Defense Attorneys

The self-insured employer, through Sedgwick, its claims processing agent, requested reconsideration of our December 11, 1997 order, as reconsidered January 21, 1998 and March 19, 1998, in which we ultimately authorized reopening of claimant's claim to provide temporary total disability compensation beginning March 12, 1997, the date he was hospitalized for surgery. With its request for reconsideration, Sedgwick submits: (1) a copy of a March 12, 1993 Proposed and Final Order Concerning a Bona Fide Medical Services Dispute; and (2) copies of job descriptions for a "machine set-up operator" and a "blueprinting machine operator."

In order to allow sufficient time to consider the motion for reconsideration, we abated our prior orders and allowed claimant time to respond to Sedgwick's motion. In addition, by letter dated May 15, 1998, we requested the parties' written responses regarding several issues. Having received the parties' responses, we proceed with our reconsideration. After further consideration, we conclude that this own motion matter must remain abated pending resolution of the litigation regarding the reasonableness and necessity of the surgeries performed by Dr. Treible, claimant's treating surgeon.

In its November 13, 1997 Own Motion Recommendation, Sedgwick recommended that we deny reopening claimant's claim. However, Sedgwick provided no basis for its recommendation. Although Sedgwick submitted copies of many medical documents, none of those documents was relevant to claimant's current condition. Sedgwick simply answered "unknown" to questions on the Own Motion Recommendation form that related to: (1) the causal relationship of claimant's surgeries in question to the accepted condition; (2) the reasonableness and necessity of the surgeries in question; and (3) claimant's work force status at the time of disability. Moreover, there was no evidence that Sedgwick had either issued a partial denial denying compensability of claimant's current low back condition and need for treatment or requested Director review of the reasonableness and necessity of the surgeries. In addition, Sedgwick argued that several allegedly unresolved claims processing issues prevented the reopening of claimant's claim.

After rejecting Sedgwick's claims processing arguments, we concluded that Sedgwick did not contest the compensability or the reasonableness and necessity of claimant's surgeries. Furthermore, based on the fact that Sedgwick did not contest claimant's final detailed affidavit regarding his work activities and his work search efforts at the time of disability, we concluded that claimant had established that he was in the work force at the relevant time. Accordingly, we authorized reopening claimant's claim for own motion benefits.

In its current request for reconsideration, Sedgwick contested our finding that claimant was in the work force at the time of disability. In addition, for the first time, Sedgwick appeared to be contesting compensability of claimant's current low back condition and the appropriateness of low back surgeries performed in March and April 1997. On May 15, 1998, we requested the parties' responses to this apparent change in Sedgwick's position.

In its response, Sedgwick stated that it was not denying compensability at this time and, thus, would not be issuing a denial. However, Sedgwick stated it was requesting Director review of the reasonableness and necessity of the low back surgeries performed by Dr. Treible. Included with Sedgwick's response was a copy of its May 28, 1998 letter to the Director requesting review and copies of several supporting documents.

With his response, claimant submitted additional documentation and argument regarding the work force issue. In addition, claimant argued that Sedgwick's challenge to the reasonableness and necessity of the surgeries was "not timely and not well-founded." Furthermore, claimant argued that "in light of the fact that the employer is not contesting the compensability of Claimant's condition, and in light of the fact that Claimant did have surgery and was taken off of work, it is our position that the employers' [sic] after-the-fact concerns regarding the propriety of this surgery are not relevant to the present question of whether or not Claimant's claim should be opened on Own Motion jurisdiction."

We disagree that the appropriateness of the surgeries is not relevant to the own motion matter. For the following reasons, given the change in the posture of this case, we are unable to decide the own motion matter at this time.

Pursuant to ORS 656.245(6), 656.327, and 656.704(3), the Director has subject matter jurisdiction regarding the reasonableness and necessity of medical services. *Newell v. SAIF*, 136 Or App 280 (1995) (Board lacks jurisdiction to review appropriateness of proposed medical treatment under ORS 656.327(1)). Here, the dispute pertains, in part, to the appropriateness of the low back surgeries performed by Dr. Treible. Because that dispute falls under ORS 656.327(1)(a), jurisdiction over that portion of the claim rests exclusively with the Director.[1] Furthermore, subject matter jurisdiction cannot be waived by the parties, the Board, or the court. *Nelson v. SAIF*, 43 Or App 155 (1979); *Bill D. Coleman*, 48 Van Natta 2154 (1996); *Daryl R. Gabriel, II*, 48 Van Natta 137 (1996); *see also Southwest Forest Ind. v. Anders*, 299 Or 205 (1985) (if the issue of jurisdiction is not raised by the parties, it is the fact-finder's duty to raise a want of jurisdiction on its own motion).

Moreover, contrary to claimant's argument, the issue of the appropriateness of the surgeries in question is essential to the issue of claimant's entitlement to having his claim reopened for own motion benefits. In *Thomas E. Suby*, 50 Van Natta 718 (1998) [*Suby I*], and *Thomas E. Suby*, 50 Van Natta 1088 (1998) [*Suby II*], we recently addressed the relationship between a Director's order that found a surgery not reasonable and necessary and the claimant's entitlement to temporary and permanent disability benefits related to that surgery. We found that the Director's final determination that the surgery in question was not reasonable and necessary broke the chain of causation between the accepted condition and any disability associated with that surgery. Thus, we found the claimant not entitled to any disability benefits related to the inappropriate surgery, whether those benefits were classified as procedural, substantive, temporary, or permanent.

Here, under the reasoning in *Suby I and II*, the ultimate determination resulting from the employer's request for review of the disputed surgeries would have a significant impact on the question of claimant's entitlement to temporary disability under ORS 656.278(1). Under these circumstances, we defer action on this request for own motion relief and request that the parties keep us informed regarding the Director's review and submit a copy of the Director's order when it is issued. After issuance of that order, the parties should advise the Board of their respective positions regarding own motion relief. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

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[1] Therefore, any dispute that claimant has about Sedgwick's processing of its request for review of the reasonableness and necessity issue, including any argument regarding the timeliness of Sedgwick's request for review of that issue, should be made to the Director.

In the Matter of the Compensation of
AGUSTIN DOMINGUEZ, Claimant
WCB Case No. 97-07106
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Bethlahmy's order that: (1) determined that claimant's thoracic/lumbar strain injury claim was not prematurely closed; (2) declined to award additional temporary disability; (3) affirmed an Order on Reconsideration that did not award any unscheduled permanent disability; and (4) approved the insurer's request for an offset. On review, the issues are premature claim closure, temporary disability, unscheduled permanent disability, and offset. We reverse, and set aside the claim closure.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant's claim was not prematurely closed by a Notice of Closure dated May 21, 1997. In reaching this conclusion, the ALJ relied on the medical opinion of claimant's attending physician, Dr. Breen, who concurred with the May 1, 1997 medical report of a consulting physician, Dr. Corrigan, who opined that claimant's back condition was medically stationary.

On review, claimant contends that the ALJ's conclusion was in error. Claimant cites the opinion of the medical arbiter, Dr. Gritzka, who reported that claimant was in need of further medical treatment and diagnostic studies and that claimant's back condition was not medically stationary. (Ex. 16). For the following reasons, we agree with claimant that the claim was prematurely closed.

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 May 21, 1996 Notice of Closure, considering claimant's condition at the time of closure and not 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).

As previously noted, the claim was closed based on Dr. Breen's concurrence with Dr. Corrigan's report of his consulting examination. However, in February 1997, a panel of examining physicians (Drs. Watson and Laycoe) had opined that claimant was not considered medically stationary until further assessment and treatment had been performed.[1] (Ex. 7A-4). The Watson/Laycoe panel specifically recommended a contrasted MRI scan if claimant failed to maintain improvement. *Id.* The MRI scan was never performed.

After the May 21, 1997 claim closure, claimant requested reconsideration, as a part of which proceedings Dr. Gritzka performed a medical arbiter's examination on July 24, 1997. Dr. Gritzka reported that claimant's condition was not medically stationary. Dr. Gritzka recommended further

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[1] Nothing restricts consideration of opinions regarding medically stationary status to those opinions rendered by attending physicians. *See Charlotte A. O'Neal*, 47 Van Natta 1994, 1996 (1995); *William M. Heck*, 48 Van Natta 1072, 1073 (1996).

treatment, to include screening for a seronegative spondyloarthropathy, an MRI scan of the lumbar spine to determine whether claimant had a herniated or protruded disc, and a program of "Mckenzie" exercises or "William's flexion exercises." (Ex. 16-7). Dr. Gritzka also recommended epidural steroid injections and noted that claimant could require surgical decompression or a surgical foraminotomy in light of the presence of an "anatomic variant" described as a "conjoined nerve root." According to Dr. Gritzka, claimant had not reached maximum medical improvement.

Based on Dr. Gritzka's well-reasoned and thorough evaluation of claimant's condition, as well as the evaluation and recommendations of Drs. Watson and Laycoe, we are persuaded that claimant's back condition was not medically stationary at the time of claim closure in May 1997. We emphasize that our conclusion is not based on a change in claimant's back condition after claim closure. To the contrary, Dr. Gritzka's report does not indicate that there had been any change in claimant's condition since claim closure. Thus, we find that the report is relevant to claimant's condition at closure, which is the appropriate period in which to determine the propriety of the closure. *Sullivan*, 73 Or App at 697.

Moreover, we find Dr. Gritzka's opinion more persuasive than that of the attending physician at claim closure, Dr. Breen, whose opinion is limited to an unexplained concurrence with Dr. Corrigan's report. (Ex. 11A). As for Dr. Corrigan's report, we do not find his conclusion that claimant was medically stationary to be as well reasoned and thoroughly explained as Dr. Gritzka's contrary conclusion. (Ex. 11-5). Thus, we find Dr. Gritzka's opinion more persuasive.

In conclusion, we find that the May 21, 1997 closure notice was prematurely issued. Therefore, we reverse the ALJ's decision upholding the claim closure.[2]

Claimant's attorney is entitled to an out-of- compensation fee for his services at hearing and on review. ORS 656.386(2). Claimant's counsel is awarded an out-of-compensation fee equal to 25 percent of increased compensation created by this order, not to exceed $3,800, to be paid by the insurer directly to claimant's counsel. OAR 438-015-0055(1).

ORDER

The ALJ's order dated March 9, 1998 is reversed. The August 12, 1997 Order on Reconsideration is modified to set aside the May 21, 1997 Notice of Closure as premature, and the claim is remanded to the insurer for further processing in accordance with law. Claimant's counsel is 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 by the insurer directly to claimant's counsel.

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[2] Given our conclusion, we need not address the remaining issues concerning extent of disability, temporary disability and offset.

In the Matter of the Compensation of
NANCY B. FAST, Claimant
WCB Case No. 97-10016
ORDER ON REVIEW
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Brazeau's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for a cervical spine condition. Following her request for review, claimant submitted a copy of a decision from the Employment Department.[1] In addition, also following claimant's request for review, two medical reports were submitted directly to the Board on claimant's behalf.[2] We treat such submissions as a motion to remand to the ALJ for the taking of additional evidence. On review, the issues are remand and compensability.

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

Neither party submitted briefs on review. However, the filing of briefs is neither required nor 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). In other words, we conduct our review of the entire record presented before the ALJ whether or not the parties submit briefs. Accordingly, we have reviewed the ALJ's order in accordance with our *de novo* review authority.

In her request for review, claimant indicated that she would be providing additional documentation from Dr. Cross, her family physician, and Dr. Newby, her treating surgeon. Apparently in response to queries from claimant's husband, Drs. Newby and Cross submitted letters directly to the Board on claimant's behalf. Furthermore, with a letter dated June 15, 1998, claimant submitted a copy of an April 23, 1998 decision from the Employment Department finding claimant eligible for unemployment benefits. We treat these submissions as a request for remand for the admission of additional evidence. *Judy A. Britton*, 37 Van Natta 1262 (1985).

Our review is limited to the record developed by the ALJ. We may remand to the ALJ for the taking of additional evidence if we determine that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). However, to merit remand for consideration of additional evidence it must be clearly shown that relevant, material evidence was not obtainable with due diligence at the time of the hearing. *Compton v. Weyerhaeuser Co.*, 301 Or 641 (1986).

The additional evidence submitted by Dr. Cross on claimant's behalf is a May 29, 1998 letter stating that Dr. Cross was contacted by claimant's husband and given a copy of an administrative decision that was "evidently in [claimant's] favor." Dr. Cross states that the administrative decision found that claimant had a ruptured disc due to her work activities and had to leave work as a result, a finding with which Dr. Cross agrees.

The June 2, 1998 letter from Dr. Newby's office was signed by Physician's Assistant (PA) Smith on behalf of Dr. Newby. This letter states that claimant related her neck and right arm pain to her non-ergonomic work station. The letter also states that it is the opinion of PA Smith and Dr. Newby that claimant's work station is more than 51 percent responsible for her symptoms and need for surgery.

We are not convinced that this evidence was not obtainable with due diligence at the time of the hearing. In other words, the record does not provide a persuasive reason why claimant could not have obtained medical opinions from Drs. Cross and Newby before the hearing and submitted the opinions at that time.

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[1] Because it is unclear whether SAIF was sent a copy of this document, we are attaching a copy of it to SAIF's copy of this order.

[2] Because it is unclear whether claimant and SAIF were sent copies of these documents, we are attaching copies of these documents to their copies of this order.

In addition, even if we considered these documents, they would not change the result. In this regard, Dr. Newby's June 2, 1998 opinion is unexplained. As addressed by the ALJ, under the facts of this case, persuasive medical evidence regarding causation must sufficiently weigh the relative contributions from claimant's preexisting degenerative cervical condition and the alleged occupational disease involving her cervical spine. *See Dietz v. Ramuda*, 130 Or App 397 (1994) (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; the "precipitating" or immediate cause of an injury may or may not be the "major contributing cause"); *see also James S. Modesitt*, 48 Van Natta 2542 (1996); *Alec E. Snyder*, 47 Van Natta 838 (1995) (persuasive medical opinion must weigh the relative contribution of different causes; "but for" analysis not well reasoned). Therefore, even if we were to consider Dr. Newby's opinion, it would not change the result.

The same applies to Dr. Cross' letter, much of which deals with his interpretation of the ALJ's decision. We are not persuaded that this interpretation is reasonably likely to affect the outcome of this case. Dr. Cross obviously misinterprets the ALJ's opinion as being favorable to claimant, whereas it actually upheld the denial of claimant's claim.

Finally, the decision from the Employment Department finding claimant eligible for unemployment benefits is not relevant to the issue before us, *i.e.*, the cause of claimant's cervical condition.

For all of these reasons, we are not persuaded that the record has been improperly, incompletely or otherwise insufficiently developed. Accordingly, we deny claimant's motion for remand.

ORDER

The ALJ's order dated March 27, 1998 is affirmed.

In the Matter of the Compensation of
PHILIP B. OBERMAN, Claimant
WCB Case No. C8-01361
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Gary Tyler, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Member Biehl and Haynes.

On June 12, 1998, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for his compensable injury. We approve the proposed disposition.

The proposed agreement states that the total due claimant is $3,000 (subject to Support Enforcement Withholding Orders DHR 005970143241 and DHR 005DA1704441) and the total due claimant's attorney is $1,000. ORS 656.234(2)(b) provides: "moneys payable pursuant to ORS * * * 656.236 * * * are subject to an order to enforce child support obligations pursuant to ORS 25.311." Additionally, ORS 656.234(3)(b) provides that the amount of child support obligation subject to enforcement shall not exceed one-fourth of moneys paid under 656.236.

The agreement does not specify the amount to be withheld for child support. However, consistent with the statute, we conclude that it is the parties' intention that no more than one-fourth of the moneys paid under the CDA shall be subject to the order to enforce child support. *See Douglas J. Yarington*, 50 Van Natta 254 (1998).

As interpreted herein, the CDA is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' agreement is approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
MICHAEL P. SOTO, Claimant
WCB Case Nos. 97-08402 & 97-07039
ORDER ON REVIEW
Bischoff, Strooband, et al, Claimant Attorneys
Snarskis, Yager, et al, Defense Attorneys
John M. Pitcher, Defense Attorney

Reviewed by Board Members Hall and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) upheld the self-insured employer's compensability and responsibility denials of his occupational disease claim for bilateral carpal tunnel syndrome; and (2) upheld Industrial Indemnity's compensability and responsibility denials of the same condition. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following change. In the second paragraph on page 2, we change the citation in the first sentence to "(Ex. 1)."

CONCLUSIONS OF LAW AND OPINION

Claimant relies on the opinion of Dr. Amstutz to establish compensability of his bilateral carpal tunnel syndrome (CTS). To establish an occupational disease, he must prove that his employment conditions were the major contributing cause of his CTS condition. ORS 656.802(2)(a).

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). Because resolution of the matter involves expert analysis rather than expert external observation, we do not give special deference to opinions from the treating physician. *See Allie v. SAIF*, 79 Or App 284 (1986).

We are not persuaded by the opinion of Dr. Amstutz. In Dr. Amstutz's April 15, 1997 report, he noted that claimant performed "very repetitious and heavy gripping work with his hands." (Ex. 1). He diagnosed bilateral CTS and performed a right carpal tunnel release on September 16, 1997. (Ex. 11). In a concurrence letter from claimant's attorney, Dr. Amstutz agreed that claimant's strapper machine operator position "is repetitive work involving heavy gripping with the hands and consistent with the development of carpal tunnel syndrome disease." (Ex. 16-1). He said that if claimant handled 300 to 500 "runners" a day weighing from nine to thirteen pounds each, that would be even more indicative that his job was the cause of CTS. (Ex. 16-2). Dr. Amstutz agreed that claimant's work as a strapper machine operator was the major contributing cause of bilateral CTS. (*Id.*)

We do not find Dr. Amstutz's opinion persuasive. Dr. Amstutz provided only a brief summary of claimant's work activities and we are not persuaded that he had an accurate understanding of how claimant performed his job. Furthermore, Dr. Amstutz did not explain *how* claimant's work activities caused his CTS condition.

There are no other medical opinions that support compensability of claimant's CTS condition. After considering all the factors, Dr. Jewell did not believe it was within reasonable medical probability that claimant's work activities would be considered major in contributing to the CTS condition. (Exs. 5, 15). Dr. Jewell reasoned that claimant's work activities were varied with respect to multiple patters of hand ergonomics and that claimant was not performing work activities that were predominantly wrist flexed and finger flexed. He concluded that claimant's CTS condition was idiopathic. (*Id.*) Likewise, Dr. Button concluded that claimant's CTS was idiopathic. (Exs. 4, 14).

At best, the medical opinions are in equipoise. Consequently, we conclude that claimant has failed to carry his burden of proving compensability by a preponderance of the evidence.

ORDER

The ALJ's order dated February 27, 1998 is affirmed.

In the Matter of the Compensation of
DONALD A. WESTLAKE, Claimant
WCB Case No. 97-08301
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Michael Johnson's order that: (1) declined to admit Exhibit 21; and (2) affirmed an Order on Reconsideration award of 32 percent (102.4 degrees) unscheduled permanent disability for claimant's left shoulder condition. On review, the issues are evidence and extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following change. In the second paragraph of the findings of fact on page 2, we change the date in the first sentence to "March 29, 1996."

CONCLUSIONS OF LAW AND OPINION

Evidence

A September 17, 1997 Order on Reconsideration awarded claimant 32 percent unscheduled permanent disability for his shoulder condition. (Ex. 20). On November 13, 1997, the insurer denied compensability of claimant's "pre-existing degenerative arthritis or changes at the A-C joint and the inferior spur on your distal clavicle." (Proposed Ex. 21).

At hearing, the parties disagreed as to whether claimant was entitled to an additional 5 percent surgical value related to the resection of the distal clavicle. The ALJ declined to admit the insurer's November 13, 1997 denial into evidence. The ALJ concluded that the issue concerning the unscheduled permanent disability award for the clavicle resection arose out of the Order on Reconsideration and, therefore, the issue was properly before him. However, the ALJ reasoned that the insurer's denial was not part of the reconsideration record and could not be admitted at the hearing.

The insurer argues that the ALJ erred in excluding Exhibit 21, its November 13, 1997 denial. The insurer contends that ORS 656.283(7) did not apply because the issue of the denial arose separately from and following closure. The insurer relies on *amended* ORS 656.262(10),[1] asserting that the statute allows a carrier to deny a condition that is not formally accepted, but that is included in the rating of permanent disability.

The issue here is not whether the insurer was authorized under *amended* ORS 656.262(10) to issue a denial of claimant's degenerative arthritis of the AC joint and the inferior spur of the distal clavicle. Claimant asserts that the insurer's November 13, 1997 denial is before the Hearings Division in another case and the propriety of that denial is not presently before the Board.[2] Rather, one of the

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[1] *Amended* ORS 656.262(10) provides, 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."

The amendments to ORS 656.262(10) are fully retroactive and apply to this claim. *See Bay Area Hospital v. Landers*, 150 Or App 154, 157 (1997).

[2] We note that the hearing request regarding the November 13, 1997 denial was not consolidated with the hearing request regarding the September 17, 1997 Order on Reconsideration.

issues in this case is whether the November 13, 1997 denial was admissible in a hearing concerning the extent of claimant's permanent disability. However, we need not address the insurer's evidentiary arguments because we find that, even if Exhibit 21 was admitted into evidence, the result in this case would not change. For the following reasons, we conclude that claimant is not presently entitled to 5 percent permanent disability for the distal clavicle resection.

Extent of Unscheduled Disability

The ALJ concluded that the Order on Reconsideration correctly included the surgical procedure for claimant's distal clavicle in awarding permanent disability for the left shoulder.

The insurer argues that, even if the November 13, 1997 denial is not admitted into the record, claimant is still not entitled to a 5 percent unscheduled permanent disability award for the distal clavicle resection. The insurer relies on ORS 656.268(16) and argues that no medical evidence establishes that claimant's degenerative changes and the interior spur on the distal clavicle were related to the compensable injury.

We briefly review the procedural facts. A June 17, 1997 Notice of Closure awarded claimant 27 percent unscheduled permanent disability for his left shoulder. (Ex. 13). The worksheet attached to the Notice of Closure indicated claimant received 2 percent impairment for external rotation, 4 percent for abduction and 5 percent for resection of the acromion. (Ex. 13-3). Claimant requested reconsideration. (Ex. 14). Among other things, he contested the rating of unscheduled permanent disability, specifically the rating of 5 percent for surgery. (*Id.*) Claimant asserted that the rating of unscheduled permanent disability should be 10 percent due to the distal clavicle resection and subacromial decompression. (*Id.*)

On June 27, 1997, the insurer wrote to the Department, objecting to claimant's assertion that he should receive a 5 percent award for a distal clavicle resection. (Ex. 15). The insurer stated, in part:

> "The distal clavicle condition is not an accepted part of this claim and the attending physician agreed that the degenerative conditions in the AC joint preexisted our injury.
>
> "An IME done on 7/20/96 lists the degenerative changes in the AC joint as preexisting. This report was concurred with in its entirety by the attending physician, Dr. Carlsen, on 8/8/96. On 9/23/96, Dr. Jacobson mentions the preexisting spur off the distal clavicle and says that is will be addressed when the decompression is done. An IME done on 10/25/96 notes that the AC joint degenerative changes preexisted our injury. In addition, in Dr. Jacobson's 11/25/96 pre operative report he says that while he's in their [sic] doing the decompression he will clean up the distal clavicle." (*Id.*)

The Department's "Medical Arbiter Questions" referred to the accepted conditions as fracture dislocation left ankle and acute impingement syndrome of the left shoulder. (Ex. 17).

A September 17, 1997 Order on Reconsideration awarded claimant 32 percent unscheduled permanent disability for his shoulder condition. (Ex. 20-5). Pursuant to OAR 436-035-0330(13), claimant was given impairment values of 5 percent each for partial resection of the acromion and the clavicle, for a total surgical value of 10 percent. (Ex. 20-2). The Order on Reconsideration also stated:

> "The insurer argues that claimant is not entitled to a value for the clavicle resection because the spurring and degenerative changes in the acromioclavicular joint preexisted the injury and were not an accepted part of the claim. However, the insurer accepted the left shoulder impingement syndrome, which was related to hypertrophic degenerative changes in the acromioclavicular joint. The preponderance of medical opinion establishes that the surgical procedure was necessary to treat the accepted impingement syndrome which was directly caused by the March 21, 1996 incident. The insurer did not deny any part of the left shoulder condition." (Ex. 20-3).

The insurer requested a hearing on the September 17, 1997 Order on Reconsideration.

After reviewing the record, we agree with the insurer that there is no evidence that the distal clavicle was an accepted condition or that it constituted "direct medical sequelae" to the accepted condition. ORS 656.268(16) provides that "[c]onditions that are direct medical sequelae to the original accepted condition shall be included in rating permanent disability of the claim unless they have been specifically denied."

Under ORS 656.266, claimant has the burden of proving the nature and extent of any disability resulting from a compensable injury. In *Julio C. Garcia-Caro*, 50 Van Natta 160 (1998), we considered whether the claimant's unaccepted cervical and thoracic conditions were "direct medical sequela" under ORS 656.268(16) of the accepted right shoulder tendonitis condition. Based on the language of ORS 656.268(16), as well as ORS 656.262(7) and 656.283(7), we concluded that, in the absence of evidence that the unaccepted conditions were "direct medical sequela" of the *accepted condition* (as opposed to the accidental injury from which the accepted condition arose), the claimant was not entitled to permanent disability based on the unaccepted conditions. *See also Donald D. Davis*, 50 Van Natta 357, *on recon* 50 Van Natta 682 (1998) (the claimant failed to show that claimant's epicondylitis condition was a "direct medical sequela" of the accepted left elbow contusion).

In evaluating claims at closure, the focus is on accepted conditions. *See James L. Mack*, 50 Van Natta 338, 339 (1998). Here, the insurer accepted acute impingement syndrome of the left shoulder. (Ex. 5). Claimant argues that he is entitled to a permanent disability award for the distal clavicle resection. Based on this record, we find no medical evidence that establishes that the distal clavicle was an accepted condition or that it constituted "direct medical sequelae" to the accepted condition of acute impingement syndrome.

On August 28, 1997, Drs. Scheinberg, Olson and Ballard performed a medical arbiter examination. (Ex. 19). They referred to "[p]ersistent pain in the left shoulder, post debridement of the glenohumeral joint and arthroscopic subsacromial decompression and small repair of the left rotator cuff." (Ex. 19-5). The only reference in the report to the distal clavicle resection was in their description of the surgical procedure for the shoulder. (Ex. 19-2). However, their report did not indicate that the distal clavicle resection was part of the accepted condition or that it was a "direct medical sequela" of the accepted acute impingement syndrome of the left shoulder.

On May 12, 1997, Dr. Jacobson, who had performed the shoulder surgery, reported that claimant was stationary, but still had significant pain in this left shoulder. (Ex. 11-1). He opined that claimant's "shoulder problem is a direct result of his on-the-job injury. I see no reason for apportionment in this case." (*Id.*) Dr. Jacobson's report, however, did not refer to the distal clavicle resection and did not indicate that the clavicle condition was a "direct medical sequela" of the accepted acute impingement syndrome of the left shoulder.

Dr. Peterson, who examined claimant shortly before the shoulder surgery, reported that the impingement syndrome was directed to symptoms arising from the March 21, 1996 incident. (Ex. 7-5). However, he did not refer specifically to the distal clavicle resection nor did he indicate that it was a "direct medical sequela" of the accepted condition.

Because claimant has failed to show that the distal clavicle resection is an accepted condition or a "direct medical sequela" of the accepted acute impingement syndrome of the left shoulder, we conclude that he is not entitled to a permanent disability award based on the distal clavicle resection. *See* ORS 656.268(16); *Julio C. Garcia-Caro*, 50 Van Natta at 163. In reaching this conclusion, we make no comment as to compensability of the distal clavicle condition. Compensability of that condition will eventually be resolved in connection with litigation of the insurer's post-closure denial. Should claimant prevail over the denial, the insurer will be required to reopen the claim for processing of that condition pursuant to ORS 656.262(7)(c), which will ultimately require evaluation of that condition when the claim is closed.

ORDER

The ALJ's order dated February 13, 1998 is reversed. The unscheduled permanent disability award in the Notice of Closure is reinstated and affirmed.

In the Matter of the Compensation of
KATHLEEN M. BUTLER-REEVES, Claimant
Own Motion No. 98-0156M
OWN MOTION ORDER
Welch, Bruun, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable lumbosacral strain and right knee strain injury. Claimant's aggravation rights expired on July 20, 1986. 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 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 was not in the work force at the time of the current disability.[1] Claimant has submitted various medical reports dating from 1994 through June 1998 and a June 11, 1998 affidavit in response to SAIF's contentions.

In order to satisfy the third *Dawkins* criterion, claimant must first establish that he/she was willing to work. Failing to demonstrate his/her willingness to work, then he/she is not considered a member of the work force, and thus, is not entitled to temporary disability compensation. *See Arthur R. Morris*, 42 Van Natta 2820 (1990); *Stephen v. Oregon Shipyards*, 115 Or App 521 (1992); *Judith R. King*, 48 Van Natta 2303 (1996); *Marlene J. Andre*, 48 Van Natta 404 (1996). In claimant's June 11, 1998 affidavit, she asserts "I have been willing to work but my doctors have not released me for any type of work and have indicated that I could not handle any work at all." We are persuaded that claimant is willing to seek employment.

However, claimant must also satisfy the "futility" standard of the third *Dawkins* criterion, in order to be found in the work force. Of all the medical documentation claimant submitted, Dr. Grewe's, claimant's treating physician, June 16, 1998 report is the only report which addresses claimant's work force status. In this report, in response to claimant's attorney's question regarding whether claimant was capable of "performing any type of work," Dr. Grewe opined that claimant was "never felt to be 'totally disabled' in the sense that she could not perform at least sedentary and possible light duty level work." Dr. Grewe's response to claimant's attorney's question regarding whether claimant was unable to seek employment due to her compensable condition, was that she would be unable to seek employment after her February 4, 1998 surgery.

We have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction,[2] is the date she enters the

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[1] In support of its position, SAIF references our September 30, 1996 Own Motion Order wherein we found that claimant was not in the work force at the time of her current disability. While a prior finding does not irrevocably commit a claimant to an out-of-the-work-force status for the purposes of workers' compensation benefits, she must show that she was in the work force at the time of the current disability. *See Dean L. Watkins*, 45 Van Natta 1599 (1993). *See also Wausau Ins. Companies v. Morris*, 103 Or App 270, 273 (1990).

[2] The Board in its own motion jurisdiction can only authorize temporary disability from the time of surgery or hospitalization. *See* ORS 656.278(1)(a).

hospital for the proposed surgery. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). The relevant time period for which claimant must establish she was in the work force is the time prior to her February 4, 1998 surgery, when her condition worsened requiring that surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App at 273; *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997); *Michael C. Batori*, 49 Van Natta 535 (1997); *Kenneth C. Felton*, 48 Van Natta 725 (1996).

Based on Dr. Grewe's statements, we find that claimant was not precluded from working, at least in a sedentary level, when her condition worsened requiring surgery. Additionally, Dr. Grewe opined that it would have been futile for claimant to seek work after her surgery. As discussed above, claimant needs to show that she was unable to work and that it would have been futile for her to seek employment prior to her February 4, 1998 surgery. Inasmuch as claimant has failed to meet her burden of proof regarding the futility standard of the third *Dawkins* criterion, we conclude claimant was not in the work force at the time of the current worsening of her compensable condition.

Accordingly, claimant's request for temporary disability compensation is denied. *See id.*

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

IT IS SO ORDERED.

June 30, 1998 Cite as 50 Van Natta 1217 (1998)

In the Matter of the Compensation of
DONALD M. FRANKE, Claimant
Own Motion No. 98-0246M
OWN MOTION ORDER
Dale C. Johnson, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable low back injury. Claimant's aggravation rights expired on February 26, 1981. 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 required 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 was not in the work force at the time of the current disability. In response, claimant submits copies of paychecks dated January 15, 1998 through February 14, 1998. Claimant contends his condition worsened on February 5, 1998 when he sought treatment from Dr. Grewe, his attending physician. Subsequent to that visit, claimant continued to work at his usual occupation until Dr. Grewe performed a diagnostic myelogram on April 22, 1998. On April 25, 1998, claimant was hospitalized for problems following the myelogram. On May 15, 1998, claimant underwent exploration and replacement of his electrical stimulator.

The paychecks demonstrate that claimant was working when he first sought treatment for his worsened condition on February 5, 1998. Further, claimant's contention that he continued to work at his usual occupation until he required hospitalization following the April 22, 1998 myelogram, is unrebutted. Thus, we conclude that claimant was in the work force at the time of his current worsening which resulted in the need for hospitalization and surgery.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning April 25, 1998, the date he was hospitalized. 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
MERLIN H. PURKERSON, Claimant
WCB Case No. 97-08145
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Black's order that set aside its partial denial of claimant's L1-2 and L2-3 disc herniations and degenerative disc disease. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

We do not find that the August 26, 1997 partial denial was a "preclosure denial." *See* Opinion and Order, p. 3. (*See* Exs. 12, 13).

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

CONCLUSIONS OF LAW AND OPINION

Claimant has a long history of low back problems, beginning with a 1958 injury and associated spinal fusion surgery. He also had low back injuries in 1983, 1989, 1990, January 1994, and June 1995. On November 4, 1996, claimant suffered a lumbosacral strain at work, which the insurer accepted on March 3, 1997. (Ex. 9; *see* Ex. 11). Later in November 1996, claimant experienced a sharp onset of low back pain with a shooting sensation into his left flank area (at home), and another onset of low back pain at work when he caught himself to avoid falling from a ladder.

A December 9, 1996 MRI revealed degenerative disk conditions, a herniation at L1-2, a possible herniation at L2-3, and the lumbosacral fusion. (Ex. 4).

On July 22, 1997, Dr. Kitchel, treating physician, stated that claimant had been released to his regular work on January 2, 1997, and that he was medically stationary on February 13, 1997 without permanent impairment. (Ex. 10). An August 18, 1997 Notice of Closure closed the November 1996 injury claim. (Ex. 12). On August 26, 1997, the insurer issued a partial denial of claimant's "L1-2 and L2-3 disk herniation[s] with degenerative disk disease." Claimant requested a hearing.

The ALJ set aside the partial denial, finding that Dr. Goodwin's opinion persuasively established that claimant's November 4, 1996 work injury was the major contributing cause of his herniated discs. We disagree.

Claimant's preexisting low back degeneration contributes to his current disability and need for treatment. Thus, his claim is for a "combined condition," involving the accepted November 4, 1996 strain injury and the preexisting condition. Under these circumstances, claimant bears the burden of proving that his work injury is the major contributing cause of his current disability and/or need for treatment for his low back. *See* ORS 656.005(7)(a)(B). To prove major causation, claimant must establish that his compensable injury contributes more to his current condition than all other causes combined. *See McGarrah v. SAIF*, 296 Or 145, 146 (1983); *Dethlefs v. Hyster Co.*, 295 Or 298, 309-310 (1983).

The medical evidence concerning causation is provided by Drs. Butters, Kitchel, Goodwin, and Kirschner.

Dr. Butters examined claimant on November 4, 1996, diagnosed "an acute low back strain superimposed on previous back problems," and referred claimant to Dr. Kitchel, who had treated claimant for back pain on three prior occasions. (Ex. 3).

Dr. Kitchel examined claimant and ordered an MRI. (Ex. 3A). After examining claimant on November 16, 1996, December 2, 1996, and December 10, 1996, Dr. Kitchel initially opined that claimant had suffered a "work related injury," that the "current problem is a work related injury," and that the November 4, 1996 work injury was "the major precipitating cause of [the] herniations and the need for [claimant's] current treatment."[1] (Exs. 3B, 3C, 4A, 4B). Dr. Kitchel referred claimant to Dr. Goodwin, in the same office. (Ex. 5).

On January 11, 1997, Dr. Kirschner examined claimant, reviewed his history, and opined that claimant did not have significant nerve root compression and that his symptoms did not have radicular quality.[2] (Ex. 6-5). He stated that claimant had significant preexisting degenerative disease which combined with the work injury to cause claimant's need for treatment; and that claimant's *strain* was due to "the on-the-job incident," but the preexisting condition was the major contributing cause of persistent symptoms (as of twelve weeks post-injury). (Ex. 6-6). Dr. Kirschner opined that claimant's strain condition would be medically stationary by the end of January 1997, but future low back problems were to be anticipated, because of claimant's preexisting condition. (Ex. 6-7).

On February 13, 1997, Dr. Kitchel concurred with Dr. Kirschner's report. (Ex. 8).

On November 19, 1997, Dr. Goodwin opined that claimant's work injury was the major contributing cause of his "disc herniations and need for treatment." (Ex. 17).

On December 12, 1997, Dr. Kitchel indicated that claimant's current symptoms were related primarily to his degenerative disc disease, not the November 1996 strain. (Ex. 19; *see* Ex. 20). Dr. Goodwin disagreed. (Exs. 19A, 21).

The ALJ found Dr. Kitchel's "late-1997 change of view" unpersuasive because it was inadequately explained. However, considering claimant's contributory preexisting condition and Dr. Kitchel's concurrence with Dr. Kirshner's reasoning that the preexisting condition became the cause of claimant's persistent problems (as of twelve weeks post-injury), we find Dr. Kitchel's late 1997 causation opinion persuasive. (Exs. 6, 8; *see* Exs. 19, 20). *See Kelso v. City of Salem*, 87 Or 630 (1987) (Physician's changed opinion persuasive, because change explained).

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[1] Until at least January 7, 1997, Dr. Kitchel apparently believed that claimant's symptoms correlated with his disc findings. (*See* Ex. 4B).

[2] Dr. Kirschner opined that claimant *may* have L-2 nerve root irritation, but he noted that symptoms of such a problem began off work, without concurrent increased back pain.

The only contrary opinion is provided by Dr. Goodwin, who continues to believe that claimant's work injury is the major contributing cause of his "disc herniations and need for treatment." (Ex. 17). We do not find Dr. Goodwin's opinion persuasive, because there is no indication that the doctor considered or evaluated the relative contribution of the preexisting condition (identified by all other physicians as at least a predisposing factor) in forming his causation opinion. (*Id.*, *see* Exs. 19A, 21). *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev den* 321 Or 416 (1995). Accordingly, on this record, we find that the November 1996 compensable injury is not the major contributing cause of claimant's L1-2 and L2-3 disk herniations with degenerative disk disease. Under these circumstances, the denial is upheld.

ORDER

The ALJ's order dated February 11, 1998 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

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Cite as 326 Or 557 (1998) March 26, 1998

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Dale R. Shipley, Claimant.

SAIF CORPORATION and Great Shakes, Inc., *Respondents on Review,*
v.
Dale R. SHIPLEY, *Petitioner on Review,*
and DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, *Intervenor.*
(WCB 95-02156; CA A92310; SC S44301)

On review from the Court of Appeals.*

Argued and submitted January 5, 1998.

Scott M. McNutt, Sr., Coos Bay, argued the cause and filed the brief for petitioner on review.

Michael O. Whitty, Salem, argued the cause and filed the brief for respondents on review.

Mary H. Williams, Assistant Attorney General, Salem, argued the cause for intervenor. With her on the brief were Hardy Myers, Attorney General, and Michael D. Reynolds, Solicitor General.

Douglas A. Swanson, of Swanson, Thomas & Coon, Portland, filed a brief on behalf of *amicus curiae* Oregon Trial Lawyers Association.

Before Carson, Chief Justice, and Gillette, Van Hoomissen, Graber, and Durham, Justices.**

326 Or App 558> GRABER, J.

The decision of the Court of Appeals is affirmed, except that the final order of the Workers' Compensation Board is vacated.

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* Judicial review from the Workers' Compensation Board. 147 Or App 26, 934 P2d 611 (1997).

** Fadeley, J., retired January 31, 1998, and did not participate in this decision; Kulongoski, J., did not participate in the consideration or decision of this case.

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326 Or App 560> The question in this workers' compensation case is where to resolve a medical services dispute that claimant raised before the Workers' Compensation Board (Board) at a hearing that originally had been set to review a denial of compensability. We hold that the Board did not have authority to conduct a hearing involving a medical services dispute.

Claimant suffered a compensable left knee injury in September of 1989. The resulting claim was closed in 1991 with an award of temporary and permanent partial disability. Claimant's left knee symptoms persisted for some period, and he took medications for those symptoms.

In December of 1994, claimant fell on the stairs of his home, after which he experienced swelling and pain in the left knee. Claimant required medical services. He sought to reopen his 1989 claim to obtain compensation for those recent medical services.

The State Accident Insurance Fund (SAIF), his employer's insurer, denied claimant's request to reopen his 1989 claim on two grounds. First, SAIF asserted that the accepted condition (the 1989 knee injury) had not worsened, *i.e.*, that there was no compensable aggravation. Second, in the alternative, SAIF asserted that the present knee condition had no work connection, in that the fall at home was the major contributing cause of any disability or need for treatment.

After receiving SAIF's denial, claimant filed a request for a hearing with the Board. At the hearing, claimant withdrew the aggravation claim and conceded that he had suffered no new compensable injury. In other words, claimant no longer challenged the denial of compensability. Instead, claimant argued that the post-1994 medical treatments were materially related to the original compensable 1989 condition and that he therefore was entitled to benefits for those medical services, based on the accepted claim.

SAIF responded that the latest medical treatments were not necessitated by, or related to, the original compensable 1989 condition. An administrative law judge issued an <326 Or 560/561> order concluding that the 1989 compensable injury was a material contributing cause of the post-1994 need for medical services, ORS 656.245(1)(a), and, consequently, that claimant's medical services claim was compensable. On review, the Board affirmed.

SAIF petitioned for judicial review, arguing for the first time that the Board had no jurisdiction and that claimant's remedy, if he wished to challenge SAIF's denial on the theory that was tried at the hearing, was with the Director of the Department of Consumer and Business Services (Director).[1] The Court of Appeals agreed with SAIF:

> "The fact that SAIF's denial encompassed more than what claimant was seeking does not enlarge the scope of this dispute beyond the scope of the claim. This is and has always been a medical services dispute subject to the exclusive jurisdiction of the Director pursuant to ORS 656.245(6)." *SAIF v. Shipley*, 147 Or App 26, 29, 934 P2d 611 (1997).

Accordingly, the Court of Appeals reversed the Board's decision and remanded the matter. *Ibid.*

Claimant petitioned for review, and this court allowed the petition. For the reasons that follow, we now affirm the decision of the Court of Appeals, except that we vacate the Board's final order.

To resolve the question before us, we turn to an analysis of the pertinent statutes, because an agency has only those powers that the legislature grants and cannot exercise authority that it does not have. *See Ore. Newspaper Pub. v. Peterson*, 244 Or 116, 123, 415 P2d 21 (1966) ("In the absence of a statute which grants a presumption of validity to administrative regulations, an administrative agency must, when its rule-making power is challenged, show that its regulation falls within a clearly defined statutory grant of authority." (citation omitted)). In interpreting those statutes, we apply the template described in *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-12, 859 P2d 1143 (1993). **<326 Or 561/562>** Because the legislature's intention respecting the present question is clear from an examination of the text and context of the relevant statutes, we confine our discussion to the first level of analysis identified in *PGE*.

ORS 656.245 addresses the review of medical services disputes, including questions about what treatment is appropriate for a particular compensable injury. ORS 656.245 provides, in part:

> "(1)(a) For every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions caused in material part by the injury for such period as the nature of the injury or the process of the recovery requires * * *, including such medical services as may be required after a determination of permanent disability.
>
> "* * * * *
>
> "(6) *If a claim for medical services is disapproved for any reason other than the formal denial of the compensability of the underlying claim and this disapproval is disputed, the injured worker,* the insurer or self-insured employer *shall request administrative review by the director* pursuant to this section, ORS 656.260 or 656.327. The decision of the director is subject to the contested case review provisions of ORS 183.310 to 183.550." (Emphasis added.)

ORS 656.260 provides for resolution of medical services disputes when managed health care providers are involved. ORS 656.327 provides, in part:

> "(1)(a) If an injured worker, an insurer or self-insured employer or the Director of the Department of Consumer and Business Services believes that the medical treatment, not subject to ORS 656.260, that the injured worker has received, is receiving, will receive or

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[1] An argument that the lower tribunal lacked jurisdiction may be raised for the first time on appeal. *Ailes v. Portland Meadows, Inc.*, 312 Or 376, 383, 823 P2d 956 (1991). The parties may not waive lack of subject-matter jurisdiction. *Wink v. Marshall*, 237 Or 589, 592, 392 P2d 768 (1964).

> is proposed to receive is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services, the injured worker, insurer or self-insured employer shall request review of the treatment by the director and so notify the parties.
>
> "(b) Unless the director issues an order finding that no bona fide medical services dispute exists, the director shall review the matter as provided in this section. Appeal of an order finding that no bona fide medical services dispute <326 Or 562/563> exists shall be made directly to the Workers' Compensation Board * * *. The decision of the board is not subject to review by any other court or administrative agency."

The remainder of ORS 656.260 and 656.327 pertain to the manner in which the Director is to review medical information to resolve a medical services dispute.

ORS 656.704 underscores that a medical services dispute is to be resolved by the Director and describes the two avenues of review that apply in workers' compensation cases. ORS 656.704 provides, in part:

> "(1) Actions and orders of the Director of the Department of Consumer and Business Services, and administrative and judicial review thereof, regarding matters concerning a claim under this chapter are subject to the procedural provisions of this chapter and such procedural rules as the Workers' Compensation Board may prescribe.
>
> "(2) Notwithstanding ORS 183.315(1), actions and orders of the director and the conduct of hearings and other proceedings pursuant to this chapter, and judicial review thereof, regarding all matters other than those concerning a claim under this chapter, are subject to ORS 183.310 to 183.550 and such procedural rules as the director may prescribe. * * *
>
> "(3) *For the purpose of determining the respective authority of the director and the board to conduct hearings, investigations and other proceedings* under this chapter, and for determining the procedure for the conduct and review thereof, *matters concerning a claim* under this chapter are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue. However, such matters *do not include any disputes arising under ORS 656.245,* 656.248, 656.260, 656.327, *any other provisions directly relating to the provision of medical services to workers* or any disputes arising under ORS 656.340 except as those provisions may otherwise provide." (Emphasis added.)

Two points are clear from reading the text of those statutes. First, when claimant sought a hearing before the Board, the Board had authority to conduct a hearing regarding the dispute, because the matter *at that time* concerned a claim. Claimant's theory was that the 1994 condition was an **<326 Or 563/564>** *aggravation* of the 1989 condition or, possibly, a *new compensable injury*. SAIF's formal denial was of the compensability of that underlying claim respecting the 1994 condition.

Second, by contrast, the issue, *as ultimately presented at the hearing*, was a claim for *medical services only*, which claimant alleged were directly and materially related to the 1989 injury. The underlying claim for that purpose was the 1989 claim, which all parties agree is compensable. Accordingly, the issue at the hearing was a medical services dispute that, pursuant to ORS 656.245(6), was subject to review by the Director. In other words, had the parties submitted only this issue from the outset, the answer regarding review by the Director would not have been in doubt.

What creates uncertainty is that the issue presented to SAIF for an initial response was not the same as the issue presented at the hearing. When the issue changes from one that is within the Board's jurisdiction to one that otherwise is outside the Board's jurisdiction, what do the statutes require the Board to do? That is a question of first impression in this court.

Claimant argues that the dispositive factor is the employer's or insurer's original formal denial. He relies on the beginning phrase in ORS 656.245(6): "If a claim for medical services is disapproved for any reason other than the formal denial of the compensability of the underlying claim," then a dispute goes to the Director. Here, claimant argues, SAIF disapproved his claim by formally denying the

compensability of the underlying claim for aggravation or for a new compensable injury. Claimant then reasons that the claim was not "disapproved for a [] reason other than the formal denial of the compensability of the underlying claim" and that the dispute therefore was not one for the Director under the terms of ORS 656.245.

The problem with claimant's argument is that the "claim for medical services," as related directly to the 1989 compensable injury, did not arise as a discrete claim until the time of the hearing, when claimant chose to forego a challenge to SAIF's denial of compensability and to reframe the issue as a medical services dispute. SAIF did not disapprove that claim until the hearing. When it did so, it did so *not* on **<326 Or 564\565>** the ground that the 1989 injury was not compensable, but on the ground that the current need for medical services did not relate materially to the compensable 1989 injury, as required by ORS 656.245.

The issue that the Hearings Division properly could decide and that the Board properly could review was SAIF's denial of the compensability of claimant's 1994 injury, either as an aggravation of the compensable 1989 injury or as a new compensable injury. When the hearing began, however, claimant chose not to challenge the denial of compensability. Instead, he decided to pursue a different theory, linking the post-1994 medical services to the underlying, compensable 1989 claim. SAIF's response did not deny the compensability of the 1989 injury but only the relatedness of the recent medical services to that injury.

When the issue was thus refrained, the administrative law judge and the Board had no authority to decide it. The statutes contain no provision for transferring a case from the Board to the Director. That being so, dismissal was required.

The decision of the Court of Appeals is affirmed, except that the final order of the Workers' Compensation Board is vacated.[2]

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[2] The Court of Appeals reversed and remanded the final order of the Board. However, because the Board did not have jurisdiction to entertain the question that it ultimately decided, the Court of Appeals should have vacated, rather than reversed and remanded, the Board's order.

Cite as 153 Or App 237 (1998) April 1, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Michael D. Wingo, Claimant.

Michael D. WINGO, *Petitioner,*
v.
DPR CONSTRUCTION and SAIF Corporation, *Respondents.*
(WCB 96-01814; CA A96019)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 21, 1997.
James S. Coon argued the cause for petitioner. With him on the briefs was Susan Dobrof.
David Runner argued the cause and filed the brief for respondents.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
EDMONDS, J.
Affirmed.
Armstrong, J., dissenting.

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153 Or App 239> Claimant seeks review of an order of the Workers' Compensation Board denying him payment of temporary total disability (TTD) benefits. He assigns error to the Board's application of *former* OAR 436-60-030(11)(b)[1] to the facts of this case in arriving at its conclusion that he is not eligible for TTD. We review the Board's decision for errors of law and substantial evidence, ORS 183.482(8)(a) and (c), and affirm.

The material facts are not in dispute. Claimant was a member of a carpenter's union and was dispatched by the union to employer in September 1995. Claimant suffered a compensable injury on October 2, 1995, but did not claim any TTD because employer provided him with a light duty job and continued to pay him the same wage as before the injury.

While claimant was continuing to work for employer, the union notified him that he was in arrears in his union initiation fees and dues. The union and claimant agreed that claimant would pay $50 per week to catch up with his obligations. When claimant failed to make a payment in accordance with that agreement, the union's business manager wrote a letter to employer on December 13, 1995, requesting that employer remove claimant from its employ in accordance with the labor agreement between employer and the union.[2] Employer's representative received the letter on December 20 and attempted to verify claimant's status with the union on that day. On December 21, the union's business agent[3] confirmed that the information in the **<153 Or App 239/240>** letter was correct, and employer immediately terminated claimant's employment.

Unbeknownst to employer, claimant had brought his union dues current as of December 19, 1995. On December 22, after claimant had been terminated, the union's business manager wrote a second letter to inform employer that claimant was "no longer in violation of the Agreement" and was cleared "to return to work at [employer's] discretion."[4] However, employer declined to re-employ claimant.

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[1] The parties agree that *former* OAR 436-60-030(11)(b) (1995) is the rule under which this case is to be resolved.

[2] The contract provided, in part:

"*Section 9.* All requests by the Union for removal of an employee for non-payment of or failure to tender initiation fees and or dues or for improper dispatch shall be made to the employer in writing. The Employer then agrees to terminate the employee no later than the end of the next shift following Employer's receipt of the Union's request for such termination, provided the Union supplies, upon request, a replacement within the same period."

[3] The business manager and business agent are different individuals. The business manager dealt with claimant regarding union dues, while the business agent was the union official who had contact with employer.

[4] A hand-written note on the bottom of the second letter said, "Arrangements had already been discussed between [the business manager] and [claimant]. Removal was sent in error."

After he was fired, claimant filed a claim for TTD, which employer denied. The administrative law judge (ALJ) concluded that claimant was eligible for TTD payments because his physical condition prevented him from working at his regular job and his modified, light-duty job no longer existed.[5] Employer appealed the ALJ's decision, and the Board reversed, concluding that "[b]ecause claimant was fired in accordance with the labor agreement with his union, * * * claimant's termination was for violation of a normal employment standard."

ORS 656.268 provides, in part:

> "(3) Temporary total disability benefits shall continue until whichever of the following events first occurs:
>
> "* * * * *
>
> "(c) The attending physician advises the worker and documents in writing that the worker is released to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment[.]"

153 Or App 241> *Former* OAR 436-60-030(11)(b) was promulgated pursuant to ORS 656.268(3)(c) and provided:

> "(11) Temporary partial disability compensation paid under subsection (10) shall continue until:
>
> "* * * * *
>
> "(b) The job no longer exists or the job offer is withdrawn by the employer. This includes, but is not limited, to termination of temporary employment, layoff or plant closure. A worker shall be included in this subsection who has been released to and doing modified work at the same wage as at the time of injury from the onset of the claim. The worker is entitled to temporary total disability compensation as of the date the job is no longer available. For purposes of this rule, a worker *quitting the job or the employer discharging the worker for violation of normal employment standards is not a withdrawal of a job offer, but shall be considered the same as the worker failing to begin employment pursuant to ORS 656.268(3)(c).*" (Emphasis supplied.)

On review, claimant does not challenge the validity of the rule but argues that the "violation of a normal employment standards" provision of the rule is inapplicable to the facts underlying his claim. He explains that, "He was, in fact, *not* in violation of any normal employment standard on the day he was discharged." (Emphasis in original.) The first question raised by claimant's argument is whether, as a matter of law, a discharge for failure to pay union dues in accordance with a labor agreement is a discharge for "violation of normal employment standards" within the meaning of the rule. In interpreting a statute or an administrative rule, our task is to ascertain the intent of the body that promulgated it. *Perlenfein and Perlenfein,* 316 Or 16, 20, 848 P2d 604 (1993). We begin with the text and the context of the regulation. *Bartz v. State of Oregon,* 314 Or 353, 357, 839 P2d 217 (1992). The text of the rule provides that when an injured worker who is performing modified work at the same wage as before the injury is discharged for violating a normal employment standard, that worker is to be regarded as ineligible for TTD payments in the same way as an injured worker who was offered modified employment but failed to begin it under ORS 656.268(3)(c). Our cases construing the statute under **<153 Or App 241/242>** which the rule is promulgated are therefore instructive in determining the meaning of the rule.

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[5] In arriving at that conclusion, the ALJ explained:

> "[Claimant's] termination resulted from the terms of the employer's labor agreement with claimant's union. The termination did not result from claimant's violation of a normal employment standard. * * * Here, claimant was separated from his employment for reasons unrelated to his job performance or conduct. Although employer has no obligation to pay claimant temporary disability benefits during a period of time when it is contractually prohibited from employing claimant, once the conditions that lead to claimant's termination were lifted, and where, as here, the job no longer existed or the job offer was withdrawn, temporary disability benefits are due."

In *Safeway Stores, Inc. v. Hanks*, 122 Or App 582, 857 P2d 911 (1993), the employer locked the claimant out of the work place during a labor dispute. There was no evidence that the claimant's separation from employment was due to her voluntary choice. *Id.* at 585. The Board concluded:

> "The unilateral termination provisions in ORS 656.268(3)(c) are based on the premise that the client is or *could be* working. Here, claimant is physically unable to perform her regular work, and the offer of modified employment has been temporarily withdrawn. Through no fault, or choice of her own, claimant is unable to work, as a result of her injury." *Id.* (Emphasis in original.)

We upheld the Board's construction of ORS 656.268(3)(c) and its determination that the claimant was eligible for temporary disability benefits during the period of time that she could not work due to the employer's election to lock her out of the work place.

In *Hanks*, we distinguished two cases in which we held that the claimant was not eligible for TTD. In *Roseburg Forest Products v. Wilson*, 110 Or App 72, 821 P2d 426 (1991), we upheld the employer's termination of TTD because the claimant, who was offered modified work, refused to cross a picket line due to a strike at the job site. In *Roseburg Forest Products v. Phillips*, 113 Or App 721, 725, 833 P2d 1359, *rev den* 314 Or 727, 843 P2d 454 (1992), we held that the employer was not required to begin the payment of TTD because the claimant "withdrew from the work force when he decided to participate in the strike." We concluded in *Hanks* that, "Unlike in [*Wilson and Phillips*], claimant did not withdraw from the work force. The separation resulted from employer's action."

We conclude that when the legislature authorized employers to terminate TTD payments under ORS 656.268(3)(c) if "the worker fails to begin [modified] employment," it intended the statute to apply when the failure was the result of the conduct of the worker. Because OAR 436-60-030(11)(b) was promulgated in accordance with the provisions of the statute and expressly directs that a discharge for violation of **<153 Or App 242/243>** normal employment standards be treated in the same manner, we conclude that the rule likewise focuses on the conduct of the worker.

In this case, a valid labor agreement existed between employer and the union. According to the labor agreement, employees were required to be members in good standing of the union, which included paying union initiation fees and dues in a prescribed manner. The labor agreement required employer to discharge employees when the union informed it that the employee had not paid union dues as prescribed. We conclude on these facts that the maintenance of union membership, including payment of dues, was a "normal employment standard" that was applicable to claimant. See *Amuchastiegui v. Dep't of Employment*, 4 Or App 456, 457-58, 479 P2d 526 (1971) (holding that the voluntary failure to pay union dues that resulted in termination of employment pursuant to a collective bargaining agreement constituted the employee's "voluntary termination" within the meaning of ORS 657.176(2)). Therefore, under these circumstances, a discharge that resulted from claimant's failure to pay union dues constitutes a discharge for the violation of normal employment standards within the meaning of OAR 436-60-030(11)(b).

Next, we must determine whether the Board's finding that employer fired claimant for failing to pay his union dues is supported by substantial evidence. Claimant points to the Board's finding that he had caught up his payment of dues before employer terminated his employment and characterizes the termination as a "mistake," because he "was *not* in violation of any normal employment standard on the day he was discharged." (Emphasis in original.) Employer responds in its brief to this court:

> "The fundamental flaw in [claimant's] argument is that [OAR 436-60-030(11)(b)] does not require claimant to be in violation of a normal employment standard 'on the day he was discharged.' It requires that claimant be terminated '*for* violation of normal employment standards.' In other words, the violation of normal employment standards must have caused the termination.
>
> **153 Or App 244>** "Claimant's failure to pay union dues was a violation of a normal employment standard and that violation caused his termination. Employer's action in terminating claimant's employment was dictated by the labor agreement between it and claimant's union. Employer had no choice but to terminate claimant's employment when it received the union's demand. The union did not authorize employer to employ claimant again until after the termination had occurred.

> "Claimant's actions between the time of the union's two notices did not affect employer's reason for terminating claimant. They could not have. They were unknown to employer until after the termination. The Board's finding that claimant was terminated as required by the labor agreement for violation of a normal employment standard is supported by substantial evidence, and its conclusion based on its findings is reasonable." (Emphasis in original.)

We agree with employer. The Board found that the discharge was the result of claimant's conduct and not the result of a "mistake" by employer. Claimant does not dispute the finding that he initially fell in arrears in the payment of his union dues and that he failed to abide by his agreement to catch up. The information in the first letter from the business manager to employer was accurate at the time that the letter was written. Although it was not required to do so, employer contacted the appropriate union representative and verified that the information in the letter was accurate. Claimant had violated a normal employment standard at that point in time, and that is the reason for which employer discharged claimant. There is no "mistake" about that fact. Claimant's subsequent payment of his union assessments did not nullify the fact that an earlier violation of an employment standard had occurred.[6] Thus, the Board's finding that employer fired claimant as a direct consequence of his failure to pay his **<153 Or App 244/245>** union dues is supported by substantial evidence in the record. It follows that the Board did not err when it applied OAR 436-60-030(11)(b) as a ground on which to deny TDD benefits to claimant.

Affirmed.

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[6] The dissent compares this case with a case in which a business agent sends a false notice to the employer that the claimant is in arrears and the employer then proceeds to terminate the claimant. It asserts that termination occurred in this case because of "incomplete information through no fault of claimant." 153 Or App 246. That analysis glosses over the uncontroverted fact that claimant was in arrears in his union dues when the union sent notification of the arrearage to employer. The violation of normal employment standards occurred when claimant did not pay his dues in a timely manner as required by his union.

ARMSTRONG, J., dissenting.

Because I disagree with the majority's conclusion that, under the specific facts of this case, there was substantial evidence for the Board to have found that claimant was fired for violating a normal employment standard, I respectfully dissent.

The majority errs, I believe, when it agrees with employer that it was irrelevant whether, at the time of the firing, claimant was in violation of a normal employment standard. Quoting from employer's brief, the majority states: "'Claimant's actions between the time of the union's two notices did not affect employer's reason for terminating claimant. * * * They were unknown to employer until after the termination.'" 153 Or App 244. Employer did not receive the first notice from the union until after claimant had become current in his union obligations, however, even though the notice had been sent before claimant had made his payment. Hence, at all times that employer was involved, claimant was in compliance with the union's dues requirements.

The majority states that employer's action nevertheless was valid because claimant had violated his agreement with the union at one time, and that, under its agreement with the union, employer had no choice but to comply with the union's request to fire claimant. If that were the case, however, it seems strange that employer would have called the union to confirm claimant's status before filing him. I believe that it is logical to assume that, had employer received correct information from the union's business agent, and had it known that claimant was in good standing with the union, employer would not have fired claimant.

The problem in this case is that the union's left hand did not know what its right hand had been doing. Had the information been channeled properly, the union's business **<153 Or App 245/246>** agent would have been able to inform employer on December 21 that claimant had made the payment due under his agreement with the union and that employer should, therefore, disregard the letter requesting termination. The union's letter of December 22, notifying employer of claimant's compliance with his agreement, was the standard notification letter, but the union business manager added a

handwritten acknowledgment that the termination letter had been sent in error. The note read: "Arrangements had already been made between Chet [the business manager] and Mike [claimant]. Removal was sent in error." That letter can only be read as an admission by the union that claimant had not been in violation of a normal workplace standard at the time of the termination. Neither the Board nor the majority addresses that aspect of the letter in their respective opinions, and that, I believe, is where their error lies. This is not a case where a claimant fulfills an obligation only after he has been terminated for failing to act on the obligation and then asks for reinstatement. Rather, this is a case where claimant was terminated because the parties involved were working with incomplete information through no fault of claimant.

In other words, the facts establish that claimant was not terminated for violating a normal employment standard. He was terminated because the union had misinformed employer that he had. In fact, this case is legally indistinguishable from one in which the business agent, for purely malicious reasons, sends a false notice to employer that claimant is in arrears in his union dues and then confirms that status when called by employer, which proceeds to terminate claimant. According to the majority's analysis, claimant would be ineligible to receive TTD benefits on those facts because it does not matter whether claimant has, in fact, violated normal employment standards, but only whether employer has terminated him on the belief that he has. *Former* OAR 436-60-030(11)(b) cannot be understood to operate that way. Hence, the majority errs in concluding that substantial evidence supports the Board's finding that employer terminated claimant for violating a normal employment standard.

For the foregoing reasons, I respectfully dissent.

Cite as 153 Or App 354 (1998) April 1, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Berkley R. Conner, Claimant.

Berkley R. CONNER, *Petitioner,*
v.
B & S LOGGING and Liberty Northwest Insurance Corporation, *Respondents.*
(95-01484; CA A94371)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 10, 1997.
Donald M. Hooton argued the cause and filed the brief for petitioner.
Alexander Libmann argued the cause and filed the brief for respondents.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
ARMSTRONG, J.
Affirmed.

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153 Or App 356> Claimant seeks review of an order of the Workers' Compensation Board that held that Liberty Northwest Insurance Co. was not responsible for claimant's compensable injury. We review for errors of law and substantial evidence, ORS 183.482(8), and affirm.

Claimant was first injured in 1985 while working as a logger for Liberty's insured, when he caught his foot in a branch while attempting to avoid being hit by a falling tree. He submitted a claim for a "strained, twisted knee" that was accepted by Liberty. That claim was closed in April 1986 without an award of permanent disability. Claimant injured the same knee again in 1991, when he slipped and fell on a piece of discarded linoleum while working for a new employer that was insured by Kemper Insurance Co. Kemper accepted claimant's claim for a left knee strain. After claimant's second injury, but before the closure of his second claim, claimant underwent testing and surgery that revealed that he suffered from an osteochondral defect within the weight-bearing portion of the lateral femoral condyle. The condition was treated with arthroscopic surgery, and the claim with Kemper was closed in March 1992 without an award of permanent disability.

In 1994, claimant began to experience pain and instability in his left knee. An examination revealed an anterior cruciate insufficiency of the left knee and degenerative change over the lateral femoral condyle of the left knee. Claimant submitted a claim for the new condition to Kemper. Kemper arranged for claimant to be examined by Dr. Farris. Farris agreed with the earlier diagnoses, but was unable to state unequivocally that the current condition of claimant's knee had been caused by either the 1985 or 1991 workrelated injury. On the basis of Farris' report, Kemper denied both the compensability of and its responsibility for the claim and suggested that claimant seek compensation from Liberty. Liberty, in turn, denied the claim and suggested that claimant's knee condition had been caused by the later injury suffered while claimant was employed by Kemper's insured. Claimant appealed both denials, but entered into a Disputed **<153 Or App 356/357>** Claim Settlement with Kemper in which he dropped his appeal of that denial in exchange for a payment of $10,000.

After a hearing on claimant's appeal of Liberty's denial of responsibility, the administrative law judge (ALJ) concluded that claimant had not established Liberty's responsibility for either the anterior cruciate ligament (ACL) instability or the degenerative changes to the lateral femoral condyle. Relying on Farris' report, the ALJ concluded that claimant's ACL condition was Kemper's responsibility. As for the degenerative changes to the lateral femoral condyle, the ALJ concluded that claimant had not established that they were a compensable result of the earlier injury.

Claimant requested review by the Board, contending that the ALJ had misinterpreted Farris' report and had based her decision on incomplete medical evidence. The Board subsequently adopted and affirmed the ALJ's order and supplemented it with its own conclusion that the resolution of the claim was governed by *Industrial Indemnity Co. v. Kearns*, 70 Or App 583, 690 P2d 1068 (1984). Claimant requested judicial review, raising two assignments of error. First, he contends that the Board erred in applying *Kearns* to his case, because *Kearns* has been overruled legislatively. Second, he contends that the Board's findings were not supported by substantial evidence. Because it is dispositive, we begin with claimant's second assignment of error.[1]

Substantial evidence e)dsts to support a finding of fact when the record, viewed as a whole, would permit a reasonable person to make the finding. ORS 183.482(8)(c). The claim at issue involves two distinct conditions, the ACL instability and the degenerative changes to the lateral femoral condyle. The compensability of them is governed by ORS 656.005(7)(a), which provides, in pertinent part:

> "A 'compensable injury' is an accidental injury arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is **<153 Or App 357/358>** 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.*"[2]

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[1] Claimant argues that the Board's supplementation of the ALJ's order with its own opinion must be seen as an intention by the Board to supersede the ALJ's order. We disagree. The Board clearly stated that it had adopted and affirmed the ALJ's order. Its supplementary discussion of *Kearns* states alternative ground to affirm the ALJ's decision.

[2] In his brief and at oral argument, claimant treats the earlier knee injuries as preexisting conditions that combined to cause the current condition, thus triggering ORS 656.005(7)(a)(B). The medical evidence indicates that the ACL instability is not a combined condition, however, but, rather, a new condition that may have been caused by one of the two injuries. In that case, ORS 656.005(7)(a)(A) provides the proper analysis. Even if we were to apply ORS 656.005(7)(a)(B), we would reach the same result in this case, because Farris' report can be read to conclude that the 1991 injury was the major contributing cause of the ACL instability, thus satisfying ORS 656.005(7)(a)(B).

We further note that the ALJ reached her original conclusion by applying ORS 656.308(1). However, claimant has framed the issue as an initial claim for previously unaccepted conditions caused by the earlier work-related injuries, and, ORS 656.308(1) does not apply to such a claim. *SAIF v. Yokum*, 132 Or App 18, 22-23, 887 P2d 380 (1994) ("[For ORS 656.308] to be triggered, there must be an accepted claim for the condition, for which some employer is responsible. In an initial claim context, no employer is responsible until responsibility is fixed.") Although both the ALJ and the Board incorrectly based portions of their analysis on ORS 656.308(1), we may nevertheless affirm a correct result that springs from an incorrect analysis if there is substantial evidence to support that result. *Tektronix, Inc. v. Nazari*, 117 Or App 409, 413, 844 P2d 258 (1992), *recon allowed* 120 Or App 590, 853 P2d 315, *rev den* 318 Or 27 (1993).

(Emphasis supplied.) Although it is true that, by issuing a denial of responsibility only, Liberty has conceded the compensability of claimant's condition, Liberty could still contest causation. *Castle & Cooke v. Alcanter*, 112 Or App 392, 395, 829 P2d 742 (1992). In order for Liberty to be held responsible for the ACL instability and the defect in the lateral femoral condyle, there must be substantial evidence in the record to support a finding that the 1985 injury was the major contributing cause of the consequential injury. ORS 656.005(7)(a)(A).

Regarding the ACL instability, the objective medical evidence consisted of Farris's report, medical intake records and test results, as well as answers to a set of questions sent by claimant to Dr. Rabie, the physician who treated him for **<153 Or App 358/359>** the 1991 injury. Farris stated that, although it was impossible to identify with certainty the major contributing cause of claimant's injury, the December 1991 and January 1992 test results were consistent with a finding that the 1991 injury was the cause of the current ACL instability. On this record, we conclude that a reasonable person could find that the 1991 injury was the major contributing cause of the ACL instability. The earlier test results were inconclusive, and Rabie's letter to claimant indicated only that he agreed that the 1985 injury could have been a *material* contributing cause of the current ACL instability. Having concluded that the 1991 injury was the *major* contributing cause of the ACL instability, the ALJ and the Board correctly ruled that Kemper was the responsible insurer. ORS 656.005(7)(a)(A).

As for the degenerative change to claimant's lateral femoral condyle, the AI.J concluded that there were no diagnostic studies or objective findings to connect that condition to the 1985 injury. The only medical evidence relating to that condition was Farris' report, in which he stated that the debris found during the 1992 arthroscopy was smaller than he would have expected for a seven-week-old injury. Based on that observation, Farris stated that it was probable that the defect predated the 1991 injury, but he did not go so far as to state that it was caused by the 1985 injury. Farris's final conclusion was that claimant's "present knee condition is the result of either the injury of 1985 or the injury of 1991, or a combination of the two."

Claimant argues that Farris' conclusion that the defect probably predated the 1991 injury, coupled with his conclusion that claimant's current knee condition was caused by one or both of the earlier injuries, necessarily compels a finding that the defect was caused by the 1985 injury, for which Liberty is responsible. We disagree. The record in this case shows that the defect was not discovered until an arthroscopy was performed in 1992, seven weeks after the second injury. According to Farris' report, the doctor conducting the arthroscopy found "a lot of small debris." Farris further stated that he would have expected to find larger debris if the defect had been caused by the latest injury. From this record we conclude that, although a reasonable person might find that the defect predated the 1991 injury, that is not the **<153 Or App 359/360>** same as a finding that the 1985 injury was the major contributing cause of the defect. Accordingly, the Board did not err in finding that the evidence was insufficient to support assigning responsibility for the injury to Liberty.[3]

Affirmed.

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[3] Because we conclude that the ALJ's initial conclusions were supported by substantial evidence in the record as a whole, we need not reach claimant's argument that *Industrial Indemnity v. Kearns* has been overruled legislatively.

Cite as 153 Or App 383 (1998) April 15, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Charlene A. Dieringer, Claimant.

THE NEW PORTLAND MEADOWS and TIG Insurance, *Petitioners,*

v.

Charlene A. DIERINGER, *Respondent.*

(WCB No. 94-13529; CA A91625)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 16, 1996.

Richard D. Barber, Jr., argued the cause for petitioners. With him on the brief was Bostwick, Sheridan & Brownstein.

Dean Heiling argued the cause for respondent. With him on the brief was Heiling, Dodge & Associates.

Before Deits, Chief Judge, and De Muniz and Haselton, Judges.

DEITS, C. J.

Affirmed.

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153 Or App 385> Petitioners, The New Portland Meadows and TIG Insurance (TNPM), seek review of a Workers' Compensation Board order setting aside TNPM's denial of claimant's claim for compensation. ORS 656.298. TNPM argues that the Board erred when it failed to consider a condition, which claimant incurred while she was employed out-of-state, as a "preexisting condition" for purposes of determining compensability. It also contends that the Board erred in its application of the last injurious exposure rule to determine responsibility. We affirm.

Claimant worked as a certified public accountant for Vanport Express (Vanport) in Vancouver, Washington, from February 1990 through August 1993. Her job duties included data entry and preparation of sales and financial reports. In January 1993, she began to experience aching and cramping in the palms of her hands, pain in her wrists and weakness in her arms. In August 1993, she sought treatment from Dr. Irvine. Irvine referred her to Dr. Brown, who diagnosed bilateral ulnar entrapment neuropathy across the cubital tunnels. Two days after that diagnosis, Vanport laid claimant off work. She was unemployed for about a month, during which time the symptoms improved to the point that she had only minor discomfort in her hands and wrists. On September 21, 1993, claimant began working at TNPM as a controller. Her duties were similar to those at Vanport, but she worked more hours and spent more time using the computer. Within weeks, her symptoms began to return. In May 1994, she again sought treatment from Irvine. He recommended surgery. On July 7,1994, claimant filed a claim with TNPM. She subsequently filed a claim with Vanport. Both claims were denied.

Claimant sought review of TNPM's denial of her claim.[1] After a hearing, the ALJ concluded that claimant's condition was caused by her employment at Vanport and that, therefore, her condition "preexisted" her employment at TNPM. The ALJ held that, because the condition preexisted **<153 Or App 385/386>** her claim against TNPM, ORS 656.802(2)(b) and ORS 656.005(7) applied and, consequently, claimant had to prove that the employment conditions at TNPM "were the major contributing cause of the combined condition and pathological worsening" of her bilateral ulnar entrapment neuropathy.

The ALJ then concluded that claimant's condition was not worsened by her employment at TNPM and affirmed TNPM's denial. Claimant sought review by the Board of that order. The Board reversed the decision of the ALJ. It concluded that claimant was relying on both employers to prove compensability and thus, for compensability purposes, there was no "preexisting condition." Further, it held that because Vanport could not be considered for purposes of determining responsibility under Oregon Workers' Compensation Law, the standard to be applied was whether claimant's employment with TNPM was "injurious and provided 'potentially causal' conditions" for her disease. It then concluded that claimant had met her burden of proof under that test and, accordingly, that TNPM was responsible for her condition.

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[1] Claimant also sought review in Washington of Vanport's denial. The record does not reveal how that claim was resolved.

TNPM assigns error to the Board's decision to set aside its denial. TNPM first argues that the Board misapplied ORS 656.005(7)(a)(B), ORS 656.005(24) and ORS 656.802(2)(b) in concluding that claimant did not have a preexisting condition for purposes of determining compensability. ORS 656.005(7)(a)(B) provides:

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

ORS 656.005(24) provides:

> "'Preexisting condition' means any * * * disease * * * that contributes or predisposes a worker to disability or a 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.)

153 Or App 387> ORS 656.802(2)(b) provides:

> "If an 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."

TNPM argues that the phrase "precedes the onset of an initial claim" as used in ORS 656.005(24) means that if the disease existed before the date that the claimant filed the claim against the particular employer, in this case TNPM, the condition was "preexisting" under ORS 656.005(24). In making this argument, TNPM relies on ORS 656.005(6), which defines a claim as a "written request for compensation" or a "compensable injury of which a subject employer has notice or knowledge." It asserts that because claimant's condition existed before she filed the claim with TNPM, ORS 656.005(7)(a)(B) and ORS 656.802(2)(b) apply, and the last injurious exposure rule is inapplicable.

The Board rejected this argument, explaining:

> "*Since claimant is relying on both her employments to prove compensability, there is no 'preexisting condition.'* Under ORS 656.005(24), a 'preexisting condition' is defined as any injury, disease, or 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 Laws 1995, ch 332 § 1 (24) (SB 369, § 1 (24)).
>
> "*This is* the initial claim for claimant's bilateral upper extremity condition. Here claimant has filed an occupational disease claim for bilateral upper extremity condition. Based on *Silveira v. Larch Enterprises,* [133 Or App 297, 891 P2d 697 (1995)], claimant may rely on both her employments, even her employment with Vanport which was not subject to Oregon's workers' compensation laws, for purposes of establishing that her bilateral upper extremity condition *is work related.* There is no evidence that claimant's condition preceded her employment with Vanport. Claimant's claim is not based on the worsening or combining of a preexisting disease or condition. Therefore, there is no upper extremity condition that preexisted the initial onset of this claim. Consequently, neither amended ORS **<153 Or App 387/388>** 656.802(2)(a)[2] *[sic]* nor ORS 656.005(7)(a)(B) apply this case." (Emphasis supplied; underline in original.)

We agree with the Board that this *is* the initial claim for claimant's bilateral upper extremity condition and therefore, it is *not* a preexisting condition under 656.005(24). Consequently, neither ORS C56.802(2)(b) ORS 656.005(7)(a)(B) applies.

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[2] As indicated in the Board's corrected order on review, this citation should have been to ORS 656.802(2)(b).

We next turn to TNPM's argument that the Board misapplied the last injurious exposure rule. As the Supreme Court explained in *Roseburg Forest Products v. Long*, 325 Or 305, 309, 937 P2d 517 (1997):

> "The last injurious exposure rule is both a rule of proof an a rule of assignment of responsibility.
>
> "As a rule of proof, the last injurious exposure rule allows a claimant to prove the compensability of an injury without having to prove the degree, if any, to which exposure to disease-causing conditions at a particular employment actually caused the disease. The claimant need prove only that the disease was caused by employment-relate exposure. * * *
>
> "As a rule of assignment of responsibility, the last injurious exposure rule assigns full responsibility to the last employer that could have caused the claimant's injury." (Citations and footnote omitted.)

See United Parcel Service v. Likos, 143 Or App 486, 488-89, 924 P2d 857 (1996).

TNPM's disagreement is not with the rule of proof aspect of the last injurious exposure rule. Rather, it contends that the Board erroneously applied the last injurious exposure rule in determining the responsible employer. Specifically, TNPM argues that, in determining if responsibility should remain with TNPM as the last employer, the Board erred in applying a "potentially causal" standard rather than an "actual causation" standard. TNPM argues that responsibility does not remain with it, because there was no evidence that claimant's employment with TNPM *actually* contributed to claimant's condition.

153 Or App 389> The Board did apply a "potentially causal" standard in concluding that TNPM was responsible because it was the last employer that could have caused claimant's injury. That is the proper standard to use in initially assigning responsibility under the last injurious exposure rule. *See Roseburg Forest Products*, 325 Or at 313; *see also Barrett Business Services v. Williams*, 148 Or App 1, 4, 939 P2d 50 (1997). In response to insurer's argument, however, the Board also explained that under this court's opinion in *Beneficiaries of Strametz v. Spectrum Motorwerks*, 135 Or App 67, 897 P2d 335, mod 138 Or App 9, 906 P2d 825 (1995), actual causation was immaterial. The Board stated:

> "Drs. Irvine Nye and Brown agreed that, based on the comparison of the August 1993 and August 1994 nerve conduction studies, there was no evidence of a worsening of claimant's condition during her employment at Portland Meadows. However, the critical issue is whether claimant's employment with Portland Meadows was injurious and provided 'potentially causal' conditions for her bilateral upper extremity condition. *See Silveira v. Larch Enterprises*, [133 Or App 297, 891 P2d 697 (1995)].
>
> "* * * * *
>
> "We are persuaded that, based on reports from Drs. Irvine and Nye, claimant's work activities at Portland Meadows were injurious and provided 'potentially causal' conditions for her bilateral upper extremity condition. Therefore, Portland Meadows is responsible for claimant's condition.
>
> "Although the insurer argues that there is no proof that claimant's employment with Portland Meadows actually caused her condition, even if the insurer is correct, that factor is not dispositive. In *Beneficiaries of Strametz v. Spectrum Motorwerks*, 135 Or App 67, 71, mod 138 Or App 9 (1995), the court said that it was immaterial that the employers in that case were not the actual cause of the claimant's disease. Rather, '[all] claimant must show to establish a compensable claim is that conditions at the Oregon employer were of the type that could have caused the disease. (*Id.*)'" (Some citations and references to exhibits omitted.)

153 Or App 390> After the Board's decision in this case, however, the Supreme Court reversed our decision in *Strametz*. *Beneficiaries of Strametz v. Spectrum Motorwerks*, 325 Or 439, 444, 939 P2d 617 (1997); *Roseburg Forest Products*, 325 Or at 313. Under those decisions, initial responsibility is assigned to the last employer that could have caused claimant's injury. However, that employer may avoid responsibility by showing either that conditions at its place of employment could not have caused claimant's disease or that a previous employment was the sole cause of the disease.

Here, the Board was correct in its initial assignment of responsibility to TNPM because it was the last employment that could have caused the disease. The Board was also correct that all claimant had to show to establish a compensable claim was that conditions at the TNPM were such that they could have caused claimant's disease. However, in view of the Supreme Court's decisions in *Roseburg Forest Products* and *Strametz*, the Board's statement that proof of actual causation at TNPM is immaterial is not entirely correct. Evidence of actual causation would be material if employer sought to avoid responsibility by proving that conditions at its place of employment could not have caused claimant's disease or that the employment at a previous employer was the sole cause of the disease.

Despite this inaccuracy in the Board's statement, however, it is not necessary to remand to the Board for reconsideration. The Board's comment was not necessary to its resolution of the argument that employer made, which was that claimant had to establish actual causation by her employment at TNPM in order to prove a compensable claim. As discussed above, that is not the standard used to assign initial responsibility under the last injurious exposure rule. The Board properly found that conditions at TNPM were "of the type that could have caused" claimant's disease and that finding is supported by substantial evidence. TNPM did not prove that it could not have been the actual causation of claimant's condition or that her employment at Vanport was the sole cause of the disease. The Board did not err in setting aside TNPM's denial of responsibility.

Affirmed.

Cite as 153 Or App 436 (1998) April 22, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Jean B. Rogers, Claimant.

Jean B. ROGERS, *Petitioner - Cross-Respondent,*
v.
HEWLETT-PACKARD COMPANY, *Respondent - Cross-Petitioner.*
(93-14437, 93-14436; CA A93959)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 10, 1997.
Donald M. Hooton argued the cause and filed the briefs for petitioner - cross-respondent.
Ruth Casby Rocker argued the cause for respondent cross-petitioner. With her on the brief was Hoffman, Hart & Wagner.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
WARREN, P. J.
On cross-petition, reversed and remanded; affirmed on petition.

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153 Or App 438> Claimant seeks review of an order in which the Workers' Compensation Board held that employer's acceptance of her aggravation claim as nondisabling was, as a matter of law, an acceptance of the claim as disabling. Claimant contends that the Board erred in denying her requests for penalties and for an attorney fee to be paid from her permanent disability award, as well as from any award of temporary disability. Employer cross-petitions, attacking the Board's holding that the claim is disabling as a matter of law. We reverse on the cross-petition and, therefore, do not consider the issues on the petition.

Claimant worked as a software engineer for employer, a job that could involve a significant amount of keyboard work. In 1991, as the result of a special project that required an unusual amount of keyboard work, she began to experience carpal tunnel syndrome. She filed a claim in September 1991, and employer accepted it as a nondisabling claim for bilateral wrist overuse. After a period of conservative treatment, and after modification of her work station, her symptoms declined. Employer notified her on August 5, 1992, that it considered her medically stationary.

In May 1993, claimant's keyboard work again increased, and her carpal tunnel symptoms began to return. She filed a claim that month. Employer denied it as a new injury claim but accepted it as a

nondisabling aggravation of her previous injury.[1] She sought a hearing on the acceptance, arguing that employer should have classified the claim as disabling. The administrative law judge rejected that argument, but on appeal the Board held that the claim was disabling. It did not base its decision on the evidence. It held that, by accepting an aggravation claim that sought to reclassify a nondisabling injury as disabling, employer, as a matter of law, accepted the claim as disabling. The Board, however, refused to award penalties for the denial and limited attorney fees to a portion of claimant's temporary disability, **<153 Or App 438/439>** excluding any award from permanent disability that she might receive at claim closure.

Because it is dispositive, we first consider employer's assignment of error on its cross-petition, that the Board erred in holding that the acceptance of the May 1993 claim as nondisabling was, as a matter of law, acceptance of the injury as disabling.[2] The foundation for the Board's ruling was its belief that the 1993 claim was a claim to reclassify the injury from nondisabling to disabling and that ORS 656.277(2) therefore applied. The Board then held that the statutes do not permit an employer to accept a reclassification claim as nondisabling; thus, as a matter of law, the acceptance meant that the injury was now classified as disabling.

Under ORS 656.277, employers are to process claims for nondisabling injuries in the same manner as claims for disabling injuries, with certain exceptions, of which ORS 656.277(2) is one. That statute provides:

> "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."

Although claimant's 1993 claim was for a new injury, the Board concluded that employer's acceptance of it as an aggravation claim brought the claim under ORS 656.277(2). It then reasoned:

> "It, therefore, follows that the only means by which a carrier can either agree or decline to reclassify a claim is by either accepting or denying the aggravation claim. *In other words, in accepting an aggravation claim, the carrier necessarily concedes that claimant's request for reclassification is meritorious, i.e., that the injury has become 'disabling.'*" (Emphasis supplied.)

Thus, according to the Board, employer's acceptance of the claim as a nondisabling aggravation was ineffective; the acceptance of any aggravation made the injury disabling. The Board treated employer as having only two options: to accept the claim as disabling or to deny it. The Board reasoned that **<153 Or App 439/440>** by accepting the claim as nondisabling, employer implied that it believed that claimant's condition had not worsened. However, by accepting the claim, it had accepted it as disabling. Under the Board's analysis, if employer had wanted to deny that claimant's injury was disabling, it should have denied the aggravation claim for lack of actual worsening.

The Board's reasoning is not entirely clear. The Board did not explain why it believed that an aggravation of a nondisabling claim must be disabling, and we can think of no reason for that conclusion.[3] In order to prove an aggravation claim, the injured worker must show that the worker has suffered "worsened conditions arising from the original injury." ORS 656.273(1). There appears to be no reason that a worsening of a nondisabling condition cannot also be nondisabling. A mild nondisabling injury may become a moderate injury while still remaining nondisabling. For instance, in this case

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[1] It is not clear why employer accepted the aggravation claim as nondisabling rather than simply paying claimant's medical expenses under ORS 656.245.

[2] The parties do not suggest that there is any evidence in the record that claimant's injury is disabling as a matter of fact.

[3] Cases such as *Smith v. SAIF Corp.*, 302 Or 396, 730 P2d 30 (1986), and *Fred Meyer, Inc. v. Farrow*, 122 Or App 164, 857 P2d 189 (1993), in which the question was whether a previously disabling injury had become more disabling and thus had worsened, are not relevant to this issue. In those cases, there already was a disabling injury; in this case there was not, and there is no evidence that the injury is disabling as a matter of fact. *See SAIF v. Frank*, 153 Or App 514, ___ P2d ___ (1998).

claimant could have originally suffered carpal tunnel symptoms that were sufficient to constitute a nondisabling compensable injury but that were relatively mild. Those symptoms could thereafter become moderate rather than mild without entitling her to compensation for a disabling injury. That change would fit the statutory definition of an aggravation, but the injury would be nondisabling. *See* ORS 656.005(7)(c).[4]

The Board's conclusion that accepting an aggravation claim filed under ORS 656.277(2) necessarily requires reclassifying the claim as disabling, thus, must be based on its understanding of the relevant law, not of the facts of this case. The difficulty, however, is that nothing in the statute limits the employer to either accepting an aggravation claim as disabling or denying that there has been any worsening. A claimant who makes an aggravation claim may only receive **<153 Or App 440/441>** medical services for the worsened condition, whether or not the injury has become disabling. ORS 656.273(1) provides that, after the last award or arrangement of compensation, an injured worker may receive "additional compensation for worsened conditions resulting from the original injury." It defines "worsened condition" as "an actual worsening of the compensate condition" and describes the evidence necessary to prove the worsening. Under ORS 656.273(2), a worker who wishes to obtain additional compensation for an actual worsening must file an aggravation claim. Because medical services are themselves compensation for the injury, ORS 656.005(8), an actual worsening that requires only medical services could justify an aggravation claim under this section. Thus, the statute clearly contemplates the possibility of a valid aggravation claim for a nondisabling injury.

Even assuming that the Board was correct that claimant made an aggravation claim under ORS 656.277(2) to reclassify her injury from nondisabling, that does not require the employer to accept the claim in that form. When it accepts a claim, an employer or insurer must specify what conditions it accepts as compensate and advise the claimant whether it considers the claim disabling or nondisabling. ORS 656.262(6). Nothing in the statutes modifies those rules for aggravation claims. *See* ORS 656.262(7). The employer or insurer may accept less than the entirety of the claim. If it does so, and if the claimant believes that the scope of the acceptance is inadequate, there is a remedy through the hearings process. *See* ORS 656.283. Thus, employer could limit its acceptance of the claim to what it believed the medical evidence supported. Employer could reject claimant's attempt to have her claim reclassified but still agree that her condition had actually worsened. When employer did just that in this case, it did not thereby unknowingly agree to reclassify the claim from nondisabling to disabling. After employer declined to reclassify the claim, claimant's recourse was to convince the Board that the injury had become disabling. In this case, that is primarily a question of fact, not of law. The Board erred in ruling otherwise.

On cross-petition, reversed and remanded; affirmed on petition.

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[4] Thus, the basis for the Board's suggestion that the alternative to employer's accepting the claim as a nondisabling aggravation was to deny that there was any actual worsening is, at best, far from obvious.

Cite as 153 Or App 498 (1998) April 22, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Doris A. Bailey, Claimant.

Doris A. BAILEY, *Petitioner,*
v.
REYNOLDS METALS and CIGNA Insurance Companies, *Respondents.*
(WCB No. 95-04385; CA A96259)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 24, 1997.
Robert Wollheim argued the cause for petitioner. With him on the brief was Welch, Bruun, Green & Wollheim.
Montgomery W. Cobb argued the cause for respondents. With him on the brief was Cobb & Woodworth, LLP.
Before Riggs, Presiding Judge, and Deits, Chief Judge,* and Landau, Judge.
RIGGS, P. J.
Affirmed.

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* Deits, C. J., *vice* Leeson, J.

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153 Or App 500> Claimant is a worker who was employed by Reynolds Metals (employer) in Arkansas in the 1970s and early 1980s, during which time she experienced several minor injuries to her back while operating a jackhammer. In 1984, claimant experienced a more serious injury that disabled her and ultimately required surgery at L5-Sl on the right. Claimant was laid off by employer in 1984 when no modified work could be found. She was rehired in 1989 and transferred to employer's plant in Troutdale, Oregon. In October 1989, claimant injured her neck, upper back, mid-back and shoulders while operating a jackhammer during the course of her employment with employer. She began a long course of treatment and had numerous diagnostic tests, none of which revealed any significant pathology. She was found to be medically stationary in June 1991 and enrolled in an authorized training program to become a computer medical secretary. That training led her to be hired by Kaiser Hospital in March 1992, where she worked at the time of the hearing.

Claimant's condition has been variously described as diffuse spinal strain, chronic strain and irritation. Her lumbar strain is superimposed on degenerative disc disease apparently related to the 1984 injury. Her claim against employer was closed in April 1992, with an award of time loss and 15 percent unscheduled permanent partial disability for loss of range of motion in the lumbosacral spine and nonmedical factors. An order on reconsideration increased claimant's award to 22 percent.

In January and February 1995, claimant sought treatment for a flare-up of back pain that came on suddenly while she was sitting at work and for pain in the left neck and left sciatic nerve that came on shortly thereafter. Dr. Johnson diagnosed muscle spasms. Cigna Insurance Companies (Cigna), employer's workers' compensation carrier, never had issued a formal written acceptance of claimant's 1989 injury and contended that the acceptance of the 1989 injury claim was limited to the lumbar strain and did not include the cervical or thoracic areas. In March 1995, it issued a denial of responsibility, a denial of an aggravation claim and a denial **<153 Or App 500/501>** of claimant's current condition for which she had filed a claim for medical services related to the cervical, thoracic and lumbar conditions. Employer's physician diagnosed claimant's condition as a continuation of symptoms that began with an injury in 1979. As such, employer asserted that claimant's injury "combined" with a "preexisting condition" as defined in ORS 656.005(24).[1] The administrative law judge (ALJ) found that employer had

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[1] ORS 656.005(24) provides:

" 'Preexisting condition' means any injury, disease, congenital abnormality, personality disorder or similar condition that contributes or predisposes a worker to disability or need for treatment and that precedes the onset of an initial claim for an injury or occupational disease, or that precedes a claim for worsening pursuant to ORS 656.273."

accepted a claim for cervical, thoracic and lumbar strain resulting from the 1989 incident and that employer's current condition denial should be set aside, as claimant met her burden of proof that her current condition and need for treatment are related to the accepted conditions.

The Workers' Compensation Board agreed with the ALJ that the scope of employer's acceptance of the 1989 claim included the cervical, thoracic and lumbar strains. Claimant conceded before the Board that, because she had a low back condition that preexisted her 1989 injury, the major contributing cause standard of ORS 656.005(7)(a)(B)[2] was applicable to determine the compensability of her current condition. The Board held that the major contributing cause standard set out in ORS 656.005(7)(a)(B) applied in determining the compensability of claimant's medical services claim for her current cervical, thoracic and low back conditions and that claimant had not met that burden.

Claimant seeks review of the Board's order, contending in her first assignment of error that the provisions of ORS chapter 656 requiring different treatment of workers who **<153 Or App 501/502>** have preexisting conditions violate the Americans with Disabilities Act (ADA), 42 USC § 12112(a), which prohibits an employer from discriminating against an individual because of that person's disability.[3] Specifically, she asserts that the ADA preempts two sections of the Workers' Compensation Act, ORS 656.005(24) and ORS 656.005(7)(a)(B), which she contends treat less favorably injured workers with preexisting conditions. Claimant asserts that, because she has a preexisting condition, she is treated less favorably than injured workers who have no preexisting condition, because the two cited statutes require her to carry a greater burden of proof in order to obtain compensation for her current condition. We conclude that the ADA does not prohibit the distinction that claimant identifies.[4]

The ADA prohibits discrimination in the employment of otherwise qualified individuals when such discrimination is based on disabilities, real or perceived. 42 USC § 12112(a). The Act specifically prohibits discrimination in the terms, conditions, and privileges of employment. *Id.* An entitlement to workers' compensation insurance benefits has been held by one federal district court to be a "privilege of employment." *Harding v. Winn-Dixie Stores, Inc.*, 907 F Supp 386, 390 (MD Fla 1995).

The ADA does not require, however, that all disabled persons have identical access to benefits of employment or prohibit meaningful distinctions between different groups of disabled persons. *Traynor v. Turnage*, 485 US 535, 549, 108 S Ct 1372, 99 L Ed 2d 618 (1988); *Easley by Easley v. Snider*, *36* **<153 Or App 502/503>** F3d 297 (3rd Cir 1994). It requires "meaningful access to benefits, with non-prejudicial

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[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."

[3] For purposes of the ADA, the term "disability" is defined as

"(A) a physical or mental impairment that substantially limits one or more of the major life activities of [an] individual;

"(B) a record of such impairment; or

"(C) being regarded as having such an impairment." 42 USC § 12102(2).

[4] To state a claim under the ADA, a person must show (1) that she is disabled as defined in the Act; (2) that she is qualified, with or without reasonable accommodation, to perform the essential functions of the job at issue; (3) that she was terminated or denied certain employment benefits, for which she was otherwise eligible; and (4) that such termination or denial of benefits was based on disability. 42 USC § 12112(a). Claimant is careful to point out that she does not bring a *claim, per se*, under the ADA. She seeks only to have its provisions enforced so as to preempt allegedly inconsistent Oregon law.

treatment based upon reasonable factors." *Alexander v. Choate,* 469 US 287, 301, 105 S Ct 712, 83 L Ed 2d 661 (1985) (The Rehabilitation Act[5] does not guarantee handicapped persons equal benefits from Medicaid.). Federal courts have held that the ADA does not require that all disabled persons receive equal eligibility for workers' compensation benefits "regardless of differences in each persons' disability." *Harding,* 907 F Supp at 391; *Cramer v. State of Florida,* 885 F Supp 1545 (MD Fla 1995). The Supreme Court of Massachusetts adopted the same analysis in *Williams v. Secretary of the Exec. Office of Human Serv.,* 414 Mass 551, 609 NE2d 447 (1993), where it held that the ADA "is to address discrimination in relation to nondisabled persons, rather than to eliminate all differences in levels or proportions of resources allocated and services provided to individuals with differing types of disabilities[.]" 609 NE2d at 454.

A person does not have a right to workers' compensation benefits under Oregon law merely because the person has been injured. The injury must be work related, *i.e.,* one arising out of and in the course of employment. ORS 656.005(7)(a). Pursuant to ORS 656.005(7)(a)(B), a worker whose injury combines with a preexisting condition to cause disability and a need for treatment must show that, of the multiple contributions to the disability and need for treatment, the job-related injury is the major contributing cause. In other words, the combined condition is work related if the work-related injury is its major contributing cause. Assuming for the moment that claimant's preexisting condition is a disability for purposes of the ADA so that she is a "qualified" **<153 Or App 503/504>** individual, *i.e.,* an individual with a disability,[6] we conclude that the more onerous burden of proof for workers with preexisting conditions is not discrimination because of a disability and conclude, further, that claimant has meaningful access to workers' compensation benefits for her work-related injury.

The reason that claimant is treated differently from workers who do not have preexisting conditions is not because of her disability but because of the relationship between her preexisting condition, her on-the-job injury, and her current condition. When there are multiple potential causes of a condition or need for treatment, the assessment of the relative contributions of each is a reasonable means of determining the work-relatedness of the combined condition, and hence a basis for distinction in the treatment of injured workers. If the work injury is shown to be the major contributing cause, when compared with the preexisting condition and other nonwork-related causes, then the condition is compensable, and the worker's benefits are the same as those of workers without preexisting conditions. The different treatment of workers with preexisting conditions is a meaningful distinction based on reasonable factors.

Further, we conclude that claimant's access to workers' compensation benefits, *i.e.,* her ability to establish work relatedness, is comparable to that of individuals who have nonwork-related exposures that contribute to the condition **<153 Or App 504/505>** for which compensation is sought. *See, e.g.,*

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[5] The Rehabilitation Act predates the ADA and prohibits discrimination by institutions receiving federal funds. Federal courts interpreting the latter have held that Rehabilitation Act cases are authoritative guidance in interpreting the ADA. *Sawinski v. Bill Currie Ford, Inc.,* 866 F Supp 1383,1386 (MD Fla 1994) (legislative history of the ADA indicates that Congress intended that the terms and regulations issued under the ADA track those of the Rehabilitation Act of 1973, and citing the Interpretative Guidance on Title 1 of the ADA, wherein the United States Equal Employment Opportunity Commission (EEOC) states:

> "'The range of employment decisions covered by this nondiscrimination mandate is to be construed in a manner consistent with the regulations implementing section 504 of the Rehabilitation Act of 1973.' ")

[6] The ADA protects "qualified" individuals with disabilities from employment discrimination based on that disability. An individual is "qualified" if she can perform the essential functions of the job, with or without reasonable accommodation. 42 USC §12111(8). A disability is any physical or mental impairment that substantially limits one or more of the major life activities of the individual. 42 USC §12101(2). "Major life activities" are those basic to existence, such as sitting, standing, lifting and reading and the mental and emotional processes that make up daily life, such as thinking, concentrating and interacting with others. 29 CFR §1630.2(i). A person's employment may be a major life activity. *Winnett v. City of Portland,* 118 Or App 437, 847 P2d 902 (1993). Despite the expansive definition of "disability," not all injuries or conditions that would be treated as "preexisting" for purposes of the workers' compensation law are disabilities under the ADA. Conditions may seriously affect a person's health but not substantially impair a major life activity. *See, e.g., Schultz v. Spraylat Corp.,* 866 F Supp 1535 (D Cal 1994) (sinus condition that prevents an employee from flying on business trips is not a disability for purposes of California's Fair Employment Housing Act, because it does not prevent him from participating in major life activities.).

ORS 656.005(7)(a)(A) (injury that is the consequence of a compensable injury is not compensable unless the compensable injury is the major contributing cause of the consequential condition); ORS 656.273(1) (in context of an aggravation claim, "if the major contributing cause of the worsened condition is an injury not occurring within the course and scope of employment, the worsening is not compensable"); ORS 656.802(2)(a) (claim for occupational disease must be established by evidence showing that employment conditions, as compared with nonwork conditions, were the major contributing cause of the disease); ORS 656.802(2)(b) (if a claim for occupational disease is based on the worsening of a preexisting disease or condition, the claimant must prove that work was the major contributing cause of the combined condition and pathological worsening of the disease).

We reject claimant's contention that the ADA preempts the two statutory provisions at issue. The ADA allows states to supplement, but not supplant, its provisions. 42 USC § 12201(b) provides:

> "Nothing in this chapter shall be construed to invalidate or limit the remedies, rights or procedures of any * * * law * * * that provides greater or equal protection for the rights of individuals with disabilities than are provided by this chapter."

Relying on that provision, courts have held that workers' compensation systems provide benefits in addition to a worker's rights under the ADA. The ADA protects workers who are able to work from discrimination in the terms and conditions of employment. Workers' compensation benefits, in contrast, protect workers precisely when they are not protected by the ADA, *Harding*, 907 F Supp at 392; Cramer, 885 F Supp at 1553, i.e., when they are unable to work because of disability. Thus, the provision of workers' compensation benefits to a worker who is disabled from work in part as a result of a preexisting condition complements, but does not supplant, the ADA. Different treatment of workers with preexisting conditions is not a source of conflict with the ADA, which does not relate to benefits for disabled workers. There <153 Or App 505/506> is no basis for preemption.[7] We reject without discussion claimant's remaining assignment of error.

Affirmed.

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[7] We note that the ADA expressly does not prohibit insurers, underwriters, or providers of health care benefits from underwriting, classifying or administering risks in a manner consistent with state law. 42 USC § 12201(c)(1)-(2).

Cite as 153 Or App 514 (1998) April 22, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Thomas T. Frank, Claimant.

SAIF CORPORATION and K & G Construction Company, *Petitioners,*

v.

Thomas T. FRANK, *Respondent.*

(WCB 96-00302; CA A96873)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 16, 1998.
David L. Runner argued the cause and filed the brief for petitioners.
Daniel Denorch argued the cause and filed the brief for respondent.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
EDMONDS, J.
Affirmed.

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153 Or App 516> SAIF Corporation (SAIF) seeks review of a Workers' Compensation Board order in which the Board ruled that claimant was entitled to permanent disability compensation without first proving a "permanent worsening" of his compensable condition. We review for errors of law, ORS 183.482(8)(a), and affirm.

Claimant sustained a compensable low back injury on October 18, 1992, which SAIF accepted as a nondisabling lumbosacral strain. SAIF paid for claimant's chiropractic treatment through August 1993. On July 27, 1994, claimant reinjured his low back and filed a new injury claim, which SAIF denied. Claimant requested a hearing on the denial, but before the hearing occurred SAIF and claimant entered into a stipulation. The stipulation provides, in part, that SAIF agrees to "reopen" the 1992 claim "as an aggravation and process the claim according to law." On July 20, 1995, SAIF sent claimant a letter in which it told claimant that "[Y]our claim has * * * been reclassified as a disabling claim." In September 1995, a notice of closure awarded claimant temporary total disability payments for the period between July 30, 1994, and August 7, 1994, and no permanent disability.

Claimant requested reconsideration and was examined by a medical arbiter. The arbiter identified restrictions in the range of motion of claimant's back and concluded that he "has a mild chronic lumbosacral strain, dating from the October 18, 1992, injury, that does not restrict his work activity." On reconsideration, the department ruled that the evidence did not demonstrate a permanent worsening, as defined by former OAR 435-36-005(9), of claimant's low back condition and affirmed the award of no unscheduled permanent disability.

Claimant requested a hearing. The administrative law judge (ALJ) ruled that claimant was entitled to a five percent permanent disability award for the loss of range of motion found by the arbiter. Although SAIF argued that **<153 Or App 516/517>** claimant was required to demonstrate a permanent worsening and had not done so, the ALJ ruled that such a showing was unnecessary. He explained:

> "In reviewing this claim for an assessment of permanent disability benefits, the Appellate Reviewer applied the 'redetermination' requirements [of former OAR 436-35-007(5)[1]] following an aggravation claim. I do not find that that analysis applies under the facts of this case. Here, claimant has never had a first determination of permanent

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[1] *Former* OAR 436-35-007(5) provided:

"When a claim has been reopened pursuant to ORS 656.273, the worker's condition at the time of determination is compared with the worker's condition as it existed on the last award or arrangement of compensation. If the worker's condition has permanently worsened, the worker is entitled to have the extent of permanent disability redetermined. If the workers' condition has not permanently worsened, the worker is not entitled to have the extent of permanent disability redetermined under these rules. There shall be no redetermination for those conditions which are either unchanged or improved. In any case, the impairment value for those conditions not permanently worsened shall continue to be the same impairment value that were established at the last arrangement of compensation."

> disability because his claim was initially accepted as nondisabling. This is the first determination of disability subsequent to the reclassification of his claim to disabling in July, 1995. Had claimant's condition not worsened, he would not have been able to establish the aggravation which was accepted in July, 1995. It is only until his claim qualifies for closure that we can determine, in the first instance, whether that worsening was permanent. Based on the report of the medical arbiter, we can determine that the worsening was permanent."

SAIF appealed the ALJ's decision to the Board. The Board adopted and affirmed the ALJ's order with supplementation. It agreed with the ALJ that *former* OAR 436-35-007(5) was inapplicable. It also ruled that former OAR 436-35-005(9), which defines "permanently worsened," did not apply in the absence of a prior permanent disability award. It reasoned that, because there had been no last award or arrangement of compensation for the nondisabling injury, claimant was not required to prove a permanent worsening of his condition as a result of the compensable 1994 injury in order to have his permanent disability determined under the 1992 claim. The Board concluded that because "the arbiter **<153 Or App 517/518>** made valid, verifiable, objective findings of reduced range of motion, which establish that claimant has permanent impairment as a result of his lumbar strain," claimant was entitled to an award of five percent permanent disability.

SAIF seeks review of the Board's decision. It points out that ORS 656.277(2) provides that, after the lapse of one year from the date of injury, a "claim that a non-disabling injury originally was or has become disabling" is to be treated as a claim under ORS 656.273(1). Thus, it follows, according to SAIF, that the legislature intended that a claimant be required to prove a permanent worsening of his condition after the expiration of the one-year period before the claimaint can recover permanent disability. SAIF explains:

> "If the nondisabling status of an original claim, once final one year after the date of injury, does not constitute a 'last award or arrangement of compensation' under the Workers' Compensation Law, then it is impossible for a claimant with such a claim to prove a compensable aggravation under ORS 656.273(1). Yet, ORS 656.277(2) expressly requires a claimant to prove a compensable aggravation of an original claim in nondisabling status to be entitled to further compensation. Obviously, therefore, the legislature intended that once the nondisabling classification of an original claim becomes final under ORS 656.277(2), that finality fixes the claimant's permanent disability award at zero and constitutes a 'last award or arrangement of compensation' for purposes of ORS 656.273(1)."

SAIF concludes that claimant must prove a permanent worsening of his condition since October 1993 (one year after the 1992 injury) and that the Board erred when it awarded permanent disability in the absence of a finding that any permanent worsening had occurred.

Our task is to discern the intention of the legislature when ORS 656.273(1) and ORS 656.277(2) are read together and to determine whether those statutes are applicable to the facts in this case. We examine first the text and the context of the statutes. ORS 656.277 provides, in part:

> "Claims for nondisabling injuries shall be processed in the same manner as claims for disabling injuries, except that:
>
> **153 Or App 519>** "(1) If within one year after the injury, the worker claims a nondisabling injury originally was or has become disabling, the insurer or self-insured employer, upon receiving notice or knowledge of such a claim, shall report the claim to the Director of the Department of Consumer and Business Services for determination pursuant to ORS 656.268.
>
> "(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."[2]

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[2] ORS 656.005(7)(d) defines a "nondisabling compensable injury" as "any injury which requires medical services only." ORS 656.005(7)(c) defines a "disabling compensable injury" as "an injury which entitles the worker to compensation for disability or death."

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."

Under ORS 656.273(1), a "worsened condition" for a disabling claim occurs when there is a change in condition that makes a claimant more disabled, either temporarily or permanently, than he was when the original claim was closed. *Smith v. SAIF*, 302 Or 396, 399, 730 P2d 30 (1986). When SAIF reclassified claimant's injury as disabling on July 20, 1995, it implicitly acknowledged that claimant's condition had worsened from nondisabling to disabling. ORS 656.277(2) incorporates the requirements of ORS 656.273(1) when there is a claim that a nondisabling claim "originally was or has become disabling." Claimant initially did not claim that his nondisabling condition had become disabling. Rather, he filed the claim arising out of the 1994 injury as a claim for a new injury. The parties then agreed that claimant's condition would be processed as an aggravation of his original condition rather than as a separate claim for a new injury.[3] Thereafter, SAIF reclassified claimant's original **<153 Or App 519/520>** nondisabling injury as a disabling injury and agreed to pay temporary disability.

SAIF's voluntary reclassification of claimant's injury from nondisabling to disabling creates a different situation from that contemplated by ORS 656.277(2) and ORS 656.273(1). The process under those statutes is triggered by a "*claim* that a nondisabling injury originally was or has become disabling," ORS 656.277(2) (emphasis supplied), a fact previously acknowledged by SAIF in its July 20, 1995, letter to claimant and before the notice of closure. Here, claimant did not make such a claim. It would seem somewhat redundant if claimant were required to prove what SAIF did not contest, *i.e*, a worsening of claimant's condition from nondisabling to disabling, to have his new claim processed to closure.

Moreover, we reject SAIF's argument that claimant must prove a permanent worsening to be entitled to compensation for his permanent impairment. In *Fred Meyer, Inc. v. Farrow*, 122 Or App 164, 166, 857 P2d 189 (1993), the employer argued that because ORS 656.273(1) does not distinguish between scheduled and unscheduled disabilities, a claimant who alleges a worsening of a scheduled disability must demonstrate a loss of earning capacity. We first explained that loss of earning capacity is the appropriate standard for measuring the worsening of an unscheduled disability. We then rejected employer's argument, holding

> "that aggravations are *measured by the same standard that made the condition originally compensable.* An aggravation of an unscheduled injury is measured by increased loss of earning capacity. An aggravation of a scheduled injury is measured by increased loss of use." *Id.* at 167. (Emphasis supplied.)

The same reasoning applies here. In this case, SAIF agreed to treat claimant's condition as an aggravation of the **<153 Or App 520/521>** 1992 nondisabling injury. Consequently, whether an aggravation has occurred is measured by whether the nondisabling injury has worsened. It would be inappropriate to impose a permanent worsening requirement where permanent impairment was not the standard that made the condition originally compensable. *See Rogers v. Hewlett Packard Co.*, 153 Or App 436, ___ P2d ___ (1998). Furthermore, SAIF's suggestion that the legislature intended the expiration of

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[3] SAIF and claimant initially agreed to treat claimant's condition as an aggravation of the 1992 injury, followed by SAIF's acknowledgment that claimant's condition had changed and was disabling. SAIF relies on *Stepp v. SAIF*, 304 Or 375, 745 P2d 1207 (1987), for the proposition that the threshold requirement to recover increased permanent partial disability or permanent total disability under ORS 656.273(1) is a greater permanent injury than formerly existed. The holding in *Stepp* was later codified in ORS 656.273(8), which provides:

> "If a worker submits a claim for aggravation of an injury or disease for which permanent disability has been previously awarded, the worker must establish that the worsening is more than waxing and waning of symptoms of the condition contemplated by the previous permanent disability award." Or Laws 1995, ch 332, §31.

Here, no previous award for permanent disability had been awarded to claimant when the parties agreed that the 1994 condition would be treated as an aggravation of the 1992 injury.

the one-year period to serve as the baseline for the measurement of the permanent worsening is not supported by any language in the statutes. We conclude for these reasons that the Board did not err in holding that claimant was not required to demonstrate a worsening beyond what SAIF acknowledged in July 1995.

Affirmed.

Cite as 153 Or App 634 (1998) April 29, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Anette D. Batey, Claimant.

SAIF CORPORATION and Blue Cross/Blue Shield of Oregon, *Petitioners,*
v.
Anette D. BATEY, *Respondent.*
(WCB No. 95-12921; CA A95030)

Judicial Review from Workers' Compensation Board.
Argued and submitted June 26, 1997.
David L. Runner, Appellate Counsel, argued the cause and filed the brief for petitioners.
Kimberley Chaput argued the cause for respondent. On the brief were Gregory A. Bunnell and Pozzi, Wilson, & Atchison.
Before Deits, Chief Judge, and De Muniz and Haselton, Judges.
DEITS, C. J.
Affirmed.

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153 Or App 636> SAIF seeks review of a Workers' Compensation Board order awarding claimant a 25 percent penalty under ORS 656.262(11)(a) (1995), and attorney fees under ORS 656.382(1) (1995) and ORS 656.386(1) (1995). We affirm.

In October 1994, claimant sought treatment for pain in her right wrist and arm. In November 1994, she filed a workers' compensation claim alleging an injury date of September 28, 1994. SAIF accepted her claim for "overuse syndrome" as nondisabling. In August 1995, claimant requested that SAIF reclassify the claim to disabling on the ground that she had become entitled to temporary disability compensation. SAIF responded by letter, informing claimant that she would have to file a claim for an aggravation, which she did in September 1995. In November 1995, SAIF issued an aggravation denial on the ground that claimant's condition had not worsened. On November 22, 1995, SAIF stopped paying temporary disability benefits, which had been authorized through December 4, 1995.

Claimant requested a hearing on SAIF's denial and sought penalties and attorney fees. Before the hearing was held, SAIF determined that it should not have treated claimant's request for reclassification as an aggravation claim because the request was filed within one year of claimant's date of injury. As SAIF acknowledged, under ORS 656.277 (1995),[1] it should have either reclassified the claim as disabling or referred it to the Director pursuant to ORS 656.268 (1995). Consequently, SAIF advised claimant that it was withdrawing its aggravation denial as a "procedural nullity" and that it would reclassify the claim as disabling.

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[1] ORS 656.277 provides:

"Claims for nondisabling injuries shall be processed in the same manner as claims for disabling injuries, except that:

"(1) If within one year after the injury, the worker claims a nondisabling injury originally was or has become disabling, the insurer or self-insured employer, upon receiving notice or knowledge of such a claim, shall report the claim to the Director of the Department of Consumer and Business Services for determination pursuant to ORS 656.268.

"(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."

153 Or App 637> A hearing was held on the issues of penalties and attorney fees. The ALJ awarded claimant a penalty for SAIF's "unreasonable resistance to the payment of compensation" based on SAIF's termination of claimant's temporary disability benefits from November 14, 1995, through December 4, 1995. However, the ALJ denied claimant's request for a penalty for SAIF's failure to process the reclassification claim properly, concluding that "by virtue of the lack of processing, no amounts are due claimant [because] there is nothing upon which penalties can attach * * * even though defendant failed to process the request to reclassify." The ALJ also denied claimant's request for attorney fees under ORS 656.382(1), and ORS 656.386(1).

Claimant sought Board review. The Board affirmed the penalty but reversed the ALJ on the issue of attorney fees, awarding attorney fees of $1,000 under ORS 656.382(1) and $1,000 under ORS 656.386(1). The Board concluded that SAIF's failure to process claimant's reclassification request involved a violation of ORS 656.277 and that its termination of temporary disability payments violated ORS 656.262. It concluded that, because SAIF's error in processing the reclassification request was a separate event from SAIF's termination of temporary disability benefits, an award of attorney fees under ORS 656.382(1) (1995) in addition to the penalty under ORS 656.262(11)(a) (1995) was appropriate. The Board also awarded claimant attorney fees under ORS 656.386(1) concluding that there was a "denied" claim when SAIF issued its denial of the aggravation claim and that SAIF "rescinded" the denial before hearing when it "withdrew" the denial.

SAIF assigns error to the Board's award of attorney fees under ORS 656.382(1)[2] and ORS 656.386(1).[3] With **<153 Or App 637/638>** respect to the award of fees under ORS 656.382(1), SAIF argues that the Board erred in awarding both a penalty under ORS 656.262(11)(a)[4] and an attorney fee under ORS 656.382(1) (1995).[5] SAIF notes that under ORS 656.262(11)(a), a penalty for unreasonable resistance to the payment of compensation is to be paid "in lieu of an attorney fee." SAIF then asserts that in *Corona v. Pacific Resource Recycling*, 125 Or App 47, 865 P2d 407 (1993), this court held that when a penalty is awarded under ORS 656.262(11)(a) (1993), an attorney fee may not be awarded under ORS 656.382(1) (1993) unless there are "two separate acts of misconduct, one of which would not support a penalty[.]" *Id.* at 50. SAIF contends that there was only one act of misconduct here and that, therefore, only the penalty may be imposed. It explains:

> "All of SAIF's actions in this case flowed directly from its initial mistake in treating claimant's request for reclassification as a claim for aggravation. The initial mistake was the only reason SAIF issued an aggravation denial and ceased paying temporary disability compensation. Had the initial action been correct, all of SAIF's actions, including its termination of claimant's temporary disability compensation, would have been proper."

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[2] ORS 656.382(1) provides:

"If an insurer or self-insured employer refuses to pay compensation due under an order of an Administrative Law Judge, board or court, or otherwise unreasonably resists the payment of compensation, except as provided in ORS 656.385, the employer or insurer shall pay to the claimant or the attorney of the claimant a reasonable attorney fee as provided in subsection (2) of this section. To the extent an employer has caused the insurer to be charged such fees, such employer may be charged with those fees."

[3] ORS 656.386(1) provides, in part:

"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."

[4] 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. *Notwithstanding any other provision of this chapter*, the director shall have exclusive jurisdiction over proceedings regarding solely the assessment and payment of the additional amount described in this subsection. The entire additional amount shall be paid to the worker if the worker is not represented by an attorney. If the worker is represented by an attorney, the worker shall be paid one-half the additional amount and the worker's attorney shall receive one-half the additional amount, *in lieu of an attorney fee*." (Emphasis supplied.)

[5] SAIF does not challenge the penalty imposed for its termination of claimant's temporary disability benefits.

SAIF's recitation of the applicable law is correct. A penalty under ORS 656.262(11)(a) is awarded "in lieu of an attorney fee." Misconduct that is subject to a penalty cannot **<153 Or App 638/639>** also be the basis for an attorney fee under ORS 656.382(1). *Oliver v. Norstar, Inc.*, 116 Or App 333, 336, 840 P2d 1382 (1992). Further, if there are two separate acts of misconduct, one of which would not support a penalty, attorney fees may be awarded in addition to a penalty. *Corona*, 125 Or App at 50.

The critical question here is whether substantial evidence supports the Board's conclusion that SAIF's actions amounted to two separate acts of misconduct. SAIF acknowledges that it made two mistakes. First, it failed to process claimant's reclassification request correctly in August 1995. Second, it improperly terminated claimant's temporary disability benefits in November 1995. However, as discussed above, it is SAIF's position that these acts are not separate acts of misconduct because its second mistake "flowed directly from its initial mistake."

While it may be true that, "but for" its first mistake, SAIF would not have made the second, it does not automatically follow that SAIF's actions should not be considered separate acts of misconduct for purposes of the statute. This is not a case, such as *Britton v. Board of Podiatary Examiners*, 53 Or App 544, 632 P2d 1273, *rev den* 292 Or 109 (1981), and *Jensen v. Board of Dental Examiners*, 53 Or App 50, 630 P2d 912 (1981), on which SAIF relies, where a single act of misconduct is being converted into two or more acts of misconduct by affixing different labels to the act. Here, as the Board found, although SAIF's second act of improperly terminating benefits may not have occurred "but for" its initial mistake, SAIF's actions involved separate processing requirements. SAIF's mishandling of the reclassification request was a separate act from the termination of benefits in November 1995. Consequently, because SAIF's conduct in misprocessing the reclassification request in August did not subject it to a penalty and because, as we concluded above, this was a separate act of misconduct, the Board did not err in awarding claimant attorney fees under ORS 656.382(1).

SAIF next argues that the Board erred in awarding attorney fees under ORS 656.386(1). The Board concluded **<153 Or App 639/640>** that when SAIF issued its aggravation denial, there was a "denied claim" and that SAIF rescinded the denial before the hearing when it withdrew the denial.

SAIF argues that there was no "denied claim" for purposes of the statute here, because it did not assert that claimant's condition was not compensable. SAIF explains:

> "[T]he aggravation denial in this case did not result in a 'denied claim' within the meaning of ORS 656.386(1). ORS 656.386(1) defines a 'denied claim' as one in which the insurer or self-insured employer asserts that the claimant's condition is 'not compensable or otherwise does not give rise to an entitlement to any compensation.' SAIF's aggravation denial did not assert that claimant's condition was not compensable, only that the compensable condition had not worsened."

SAIF, however, raises this argument for the first time on judicial review. Consequently, we do not address it.

SAIF also argues that, even assuming that its withdrawal of the denial of the aggravation claim was a "denied claim" under ORS 656.386(1), the Board erred in concluding that SAIF rescinded the denial. SAIF asserts, relying in part on our decision in *Jones v. OSCI*, 107 Or App 78, 810 P2d 1318, *modified on recon* 108 Or App 230, 814 P2d 558 (1991), that a "'rescission of a denial' occurs only when the denial is withdrawn *and* the previous claim is accepted." (SAIF's emphasis.)

Jones does not aid SAIF. As an initial matter on reconsideration, this court withdrew its first opinion, and the modified opinion dealt with an amendment to ORS 656.386(1) that predates the current version of that statute. The language on which attorney fees are based in this case was added in 1995. ORS 656.386(1) now provides that attorney fees are to be awarded where "an attorney is instrumental in *obtaining a rescission of the denial* prior to a decision by the Administrative Law Judge[.]" The change in the language eliminated the requirement that the attorney assist in obtaining compensation and replaced it with language requiring that the attorney be instrumental in obtaining a rescission of a denial. Compensation is no longer the focus of that portion of the statute. Instead, the focus is on obtaining **<153 Or App 640/641>** a rescission of a denial. Accordingly, our decision in *Jones* did not resolve the question presented here.

To ascertain the meaning of the statute, we first look to its text and context. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610, 859 P2d 1143 (1993). The term "rescission" is not defined in the statute. "Rescind," the root word for "rescission," is defined in the dictionary as

> "1: to do away with: take away: remove * * * 2a: to take back: ANNUL, CANCEL * * * b: to abrogate (a contract) by tendering back or restoring to the opposite party what one has received from him * * * 3: to vacate or make void (as an act) by the enacting or a superior authority: REPEAL * * *." *Websters Third New Dictionary*, 1930 (unabridged ed 1993).

As can be seen from this definition, a rescission does not require replacing that which has been rescinded with something else. It is simply the act of doing away with, taking away or removing something.

In addition, there is nothing in the text or context of the statute that imposes a requirement that anything must be given in exchange for a rescission to have occurred. We conclude that it is not necessary that a rescission of a denial be accompanied by an acceptance of the denied claim in order for attorney fees to be awarded under ORS 656.386(1).

We also conclude that the Board was correct in holding that there was a "rescission" of a denied claim here. SAIF did not discover its mistake until after it had issued a denial. Upon making that discovery, it withdrew, or "took back" the denial. That action satisfies the requirement of ORS 656.386(1).[6] The Board properly awarded attorney fees to claimant under ORS 656.386(1) for her attorney's assistance in obtaining a rescission of the denial of the aggravation claim.

Affirmed.

[6] SAIF argues that, if we hold that what occurred here was a rescission of a denial, insurers will be encouraged to take claims to hearings rather than simply correct clerical errors, which it asserts, and we agree, would be inefficient and costly. However, such an outcome is not mandated by our decision today. If SAIF had discovered its error before issuing the denial, claimant would not have been entitled to attorney fees.

Cite as 153 Or App 662 (1998) April 29, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

OREGON DRYWALL SYSTEMS, INC., *Petitioner,*
v.
The filings of the **NATIONAL COUNCIL ON COMPENSATION INSURANCE**, *Respondent below,*
and SAIF CORPORATION, *Respondent.*
(INS 95-02-006; CA A96891)

Judicial Review from Department of Consumer and Business Services.
Submitted on record and briefs November 25, 1997.
Janice C. Goldberg and Hershner, Hunter, Andrews, Neill & Smith, LLP filed the brief for petitioner.
Hardy Myers, Attorney General, Virginia L. Linder, Solicitor General, and Denise G. Fjordbeck, Assistant Attorney General, filed the brief for respondent.
Before De Muniz, Presiding Judge, and Deits,* Chief Judge, and Haselton, Judge.
DE MUNIZ, P. J.
Reversed.

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* Deits, C. J., *vice* Rossman, S.J.

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153 Or App 664> Oregon Drywall Systems, Inc., (Oregon Drywall) seeks judicial review of a final order of the Insurance Division of the Department of Consumer and Business Services (DCBS) upholding premium audit billings for audit periods January 1, 1992, through December 31, 1993, and January 1, 1994, through December 31, 1994, performed by SAIF Corporation. We conclude that DCBS erred in holding that drywall subcontractors who perform services for Oregon Drywall are workers under the Workers' Compensation Law and reverse.

Oregon Drywall is a drywall contractor for residential and commercial buildings. It is also licensed as a general contractor for the building of homes and other structures, for which it performs the drywall work and subcontracts out other work. Oregon Drywall has employees who do drywall work, including hanging and finishing. If a general contractor has more drywall work than Oregon Drywall can do with its own employees, it contracts with drywall subcontractors. During the relevant audit periods, Oregon Drywall contracted with approximately 18 different drywall subcontractors.

At the relevant time, SAIF Corporation provided workers' compensation insurance coverage to Oregon Drywall. To determine an appropriate workers' compensation premium rate, SAIF uses the business classifications and rates of the National Council on Compensation Insurance (NCCI), a licensed rating organization for workers' compensation insurance. NCCI's classifications and rates have been filed with and approved by DCBS. In its audit of the periods in question, SAIF determined that the drywall subcontractors were actually employees of Oregon Drywall and, as a result of the audit, billed Oregon Drywall for premiums owed for each of the audit periods. Oregon Drywall seeks review of an order of DCBS upholding the results of the premium audit.

William Peterman, the sole shareholder and operator of Oregon Drywall, testified generally concerning the relationship of Oregon Drywall with the subcontractors. He testified that he prefers to use Oregon Drywall employees on **<153 Or App 664/665>** a job to save the additional cost of a subcontractor but that he will hire subcontractors as necessary to meet the needs of the general contractor. Initially, subcontractors contact Peterman to let him know that they are available to do subcontract work. Peterman then contacts the subcontractors when he has more work than Oregon Drywall employees can complete within the time requirements of the general contractor.

During the relevant time, there usually was no written contract between Oregon Drywall and the subcontractor. Subcontractors would bid on a project by the square foot or by the hour if square footage was not a reasonable means of payment because of the nature of the job. The payment method was at the discretion of the subcontractor. Subcontractors would bill Oregon Drywall on completion of

the job and would be paid 30 days from the completion date, usually by the 10th of the following month. Peterman testified that he generally did not question a subcontractor's bid or a billing and that he placed his trust in the subcontractors to bill him fairly.

Peterman testified that he would not presume to tell the subcontractors how to do their work, as he regarded them as equals, with the same training, licensing and ability to bid for any job for which Oregon Drywall bids. He testified that all subcontractors had their own businesses, were separately bonded and registered with the Construction Contractors Board and carried their own liability insurance. The subcontractors were free to hire their own workers if their licensing permitted it. They frequently worked with other subcontractors on jobs and split the fees. Oregon Drywall had no interest or concern in any arrangement subcontractors might make to work with others.

Within the time frame established by the general contractor, subcontractors could set their own hours and days of work. They could decline to take a job with no adverse consequence. Most subcontractors worked for other contractors as well. Peterman testified that subcontractor jobs were generally separate from jobs for which Oregon Drywall used employees. Oregon Drywall usually supplied the drywall material, tape and mud. Subcontractors supplied their own **<153 Or App 665/666>** tools and equipment, mostly hand tools, ladders and scaffolding. Oregon Drywall would visit sites to determine work progress and to inspect the work on completion but would not tell a subcontractor how to do the work. Oregon Drywall had the right not to contract with any subcontractor. Peterman testified that he once replaced a subcontractor who did not show up for a job.

S-W Floor Cover Shop v. Natl. Council on Comp. Ins., 318 Or 614, 872 P2d 1 (1994), sets forth the method for determining whether an individual is a person entitled to benefits under the Workers' Compensation Law. First, it must be determined whether the individual is a "worker" as defined in ORS 656.005(30). If the person is a worker, then a determination must be made as to whether the person is a *subject* worker under ORS 656.023 or a nonsubject worker under ORS 656.027. As defined in ORS 656.005(30), a worker is a person who engages to furnish services for remuneration, "subject to the direction and control of an employer." It is the right to control, not actual control, that is dispositive. *Id.* at 622. Factors involved in determining the right to control include: (1) direct evidence of a right to control; (2) furnishing of tools and equipment; (3) the method of payment; and (4) the right to discharge without liability. *Id.* If the right to control factors are inconclusive, then it is appropriate to consider the "relative nature of the work" test, which considers such factors as whether the work is a regular part of the employer's business, whether the work is continuous or intermittent and whether its duration is sufficient to amount to the hiring of continuing services as distinguished from contracting for the completion of a particular job. *Woody v. Waibel*, 276 Or 189, 192 n 3, 554 P2d 492 (1976) (quoting 1A Larson, *Workmen's Compensation Law* § 43.51 (1973)).

The question of worker status for purposes of the Workers' Compensation Law is one of law if the basic facts are not in dispute. The employer has the burden of disproving SAIF's determination as to who is a worker. *Salem Decorating v. Natl. Council on Comp. Ins.*, 116 Or App 166, 170, 840 P2d 739 (1992), *rev den* 315 Or 643 (1993). We review the findings of DCBS for substantial evidence and to determine whether its conclusion is correct as a matter of law. *Id.* at 171.

153 Or App 667> Nine subcontractors testified at the hearing. With regard to those who testified, the hearings officer determined that the "right to control" test did not conclusively show that they were workers, but that under the "nature of the work" test they were workers, because the work that they performed was a regular, integral and continuing part of Oregon Drywall's business. The evidence concerning those subcontractors who did not testify was the general testimony of Peterman concerning his relationship with the subcontractors and the documentation contained in the audit report. With respect to those nine, the hearings officer concluded that Oregon Drywall had failed to meet its burden to show that they were not workers under ORS 656.005.

We have reviewed the record with regard to all 18 subcontractors, and, contrary to the conclusions of the hearings officer, we do not find the record on these undisputed facts to be inconclusive as to the right to control. All direct evidence of a right to control shows that the relationship of Oregon Drywall and its subcontractors was not one of employment: subcontractors could accept or refuse a job; they could set their own hours within the time frame of the general contractor; they could use their own methods to reach the intended result; and they were not subject to monitoring

in the method of doing their work, but only in their progress. The right to control the work refers to the right to control the manner and means of accomplishing the result, not the right to control the details of the desired result. *Reforestation General v. Natl. Council on Comp. Ins.*, 127 Or App 153, 167, 872 P2d 423 (1994). As we held in *Cy Investment, Inc. v. Natl. Council on Comp. Ins.*, 128 Or App 579, 583, 876 P2d 805 (1994), the monitoring of progress towardjob completion does not amount to the exercise of direction and control over the means and method of doing the work. The testimony of Peterman and the subcontractors indicates that in drywalling there are many acceptable methods and techniques for reaching the same desired result and that subcontractors were not instructed as to the details of how to complete the job. *Compare HDG Enterprises v. Natl. Council on Comp. Ins.*, 121 Or App 513, 518-19, 856 P2d 1037 (1993) (carpet installers were provided with suggested positions for seams and other details of installation). We conclude that the evidence shows **<153 Or App 667/668>** that Oregon Drywall had no right to control the methods chosen by the subcontractors.

The method of payment also indicates a nonemployment relationship. Subcontractors submitted bids and billings based on square footage or hours, depending on *their own* assessment of the job, its difficulty and the time involved. Oregon Drywall did not dispute billings and did not question bids that were within the range of acceptable charges for the nature and size of the job. Subcontractors were paid for each job within 30 days of completion, rather than by a regular pay schedule, also indicating that the relationship was not one of employment.

The record shows that drywall installers used their own tools for their work whether they were employed by someone else or self-employed. Thus, although it might otherwise be indicative of a nonemployment relationship, the furnishing of tools factor does not weigh on either side of the equation.

With regard to the right to terminate, the record shows that, although Oregon Drywall could choose not to enter into a new contract with a particular drywaller without liability to the subcontractor, the termination of a subcontractor mid-job without good reason would be regarded by all parties as a breach of contract. As we said in *Henn v. SAIF*, 60 Or App 587, 592-93, 654 P2d 1129 (1982), *rev den* 294 Or 536 (1983),

> "An unqualified right to fire, indicative of an employer-employe[e] relationship, must be distinguished from the right to terminate the contract of an independent contractor for bona fide reasons of dissatisfaction. The exercise of such a right is still consistent with the idea that a satisfactory end result is all that is aimed for by the contract." (Citations omitted.)

The fact that a party could terminate a contract only for bona fide reasons of dissatisfaction is indicative, in this circumstance, that the relationship is other than one of employment.

153 Or App 669> Because the factors relevant to the right to control test show conclusively that there was no employment relationship between Oregon Drywall and its subcontractors, we do not reach the relative nature of the work test and conclude that the subcontractors were not workers for purposes of the Workers' Compensation Act. *Reforestation General*, 127 Or App at 169; *Premsingh & Assoc. v. Natl. Council on Comp. Ins.*, 111 Or App 624, 627, 826 P2d 120, *rev den* 313 Or 300 (1992). For this reason, we need not consider the parties' arguments concerning the applicability of a 1995 legislative amendment to ORS 656.027(7) that establishes conclusively that contractors registered with the Construction Contractors Board are nonsubject workers. Or Laws 1995, ch 216, § 3(7)(b).

Reversed.

Cite as 154 Or App 89 (1998) May 27, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

DENNIS TROUT, Appellant,

v.

LIBERTY NORTHWEST INSURANCE CORPORATION, an Oregon corporation, Respondent.

(9603-01667; CA A95626)

Appeal from Circuit Court, Multnomah County.

Andrew Chenoweth, Judge pro tempore.

Argued and submitted March 9, 1998.

Meagan Flynn argued the cause for appellant. On the opening brief was Kimberley Chaput and Pozzi Wilson Atchison.

Kathryn Reynolds Morton argued the cause for respondent. With her on the brief was Thomas H. Johnson.

Before Warren, Presiding Judge, and Edmonds and Haselton, Judges.

EDMONDS, J.

Affirmed.

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154 Or App 91> Plaintiff filed a complaint in his own right and as the assignee of defendant's insured, Charles B. Harris III, dba C.B.H. Company (Harris). He seeks a judgment for $70,000 and a declaration that defendant has waived or is otherwise not entitled to assert a lien for workers' compensation benefits that defendant paid to plaintiff against plaintiff's recovery from Harris. Defendant counterclaimed for foreclosure of the lien. Plaintiff and defendant filed cross-motions for summary judgment. ORCP 47. The trial court denied plaintiff's motion and granted defendant's motion. Plaintiff appeals, and we affirm.

Plaintiff was injured on May 31, 1990, while working within the course and scope of his employment for Kenneth J. Haney, dba Sun Valley Construction (Haney). Haney was a subcontractor on a construction job on which Harris was the general contractor. Because Haney was a noncomplying employer, defendant, as Harris' workers' compensation insurer, paid workers' compensation benefits to plaintiff under ORS 656.029.[1] Plaintiff later brought a third-party action pursuant to ORS 656.578 against Haney and Harris. He alleged claims for negligence and for violation of the Employer's Liability Act (ELA). ORS 654.305 *et seq.* Defendant's insurance policy with Harris also provided "Employers Liability Insurance" to Harris.

Harris tendered the defense of plaintiff's action to defendant, who refused to defend or indemnify him. After a trial to the court, the court found that "plaintiff was performing duties as a carpenter on an apartment project under construction in Washington County under the joint supervision and control of [Harris] and [Haney]." The court then ruled that Harris had violated the ELA "in failing to use every **<154 Or App 91/92>** device, care and precaution which is practical for the protection and safety of employees, and in failing to provide a protective device to employees working at heights ten feet or higher above the ground." It entered judgment for plaintiff against Harris in the amount of $210,000. Harris' other insurers paid a combined total of $140,000 on the judgment. Harris declared bankruptcy and assigned his rights against defendant to plaintiff in consideration of a covenant not to execute on the judgment against Harris personally.

Plaintiff then filed this action against defendant. On his own behalf, he alleges that defendant is liable as Harris' insurer for the unpaid portion of the judgment. As Harris' assignee, he alleges that defendant breached its contract of insurance with Harris by refusing to defend or indemnify him in the underlying action. Finally, plaintiff alleges that defendant's breach of contract waived its right to assert a workers' compensation lien against the $210,000 judgment for the benefits it paid to plaintiff.

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[1] ORS 656.029(1) provides:

"If a person awards a contract involving the performance of labor where such labor is a normal and customary part or process of the person's trade or business, the person awarding the contract is responsible for providing workers' compensation insurance coverage for all individuals, other than those exempt under ORS 656.027, who perform labor under the contract unless the person to whom the contract is awarded provides such coverage for those individuals before labor under the contract commences."

Defendant contends that it is not liable for the judgment because plaintiff's injury was not covered by the policy that it issued to Harris. Under the section entitled "Part Two -- Employers Liability Insurance," the policy provides:

> "A. * * * * *
>
> "This employers liability insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting in death.
>
> "1. The bodily injury must arise out of and in the course of *the injured employee's employment by you.*
>
> "* * * * *
>
> "B. * * * * *
>
> "We will pay all sums you legally must pay as damages because of bodily injury to *your employees*, provided the bodily injury is covered by this Employers Liability Insurance.
>
> "The damages we will pay, where recovery is permitted by law, include damages:
>
> **154 Or App 93>** "1. for which you are liable to a third party by reason of a claim or suit against you by that third party to recover the damages claimed against such third party as a result of injury to your employee;
>
> "* * * * *
>
> "provided that these damages are the direct consequence of bodily injury that arises out of and in the course of the injured employee's employment by you." (Emphasis supplied.)

Initially, defendant moved to dismiss plaintiff's claim for a declaration that defendant had waived its lien on the ground that the claim failed to state ultimate facts sufficient to constitute a claim for relief. ORCP 21(A)(8). The trial court granted that motion. Plaintiff repleaded that claim, and defendant renewed its motion. The trial court again granted defendant's motion, and plaintiff did not replead. The parties then filed cross-motions for summary judgment. The trial court denied plaintiff's motions for summary judgment, granted defendant's motions for summary judgment, including judgment on its counterclaim, and entered judgment for defendant accordingly. In regard to plaintiff's claim under the ELA, the trial court ruled:

> "I'm going to grant [defendant's] motion, and my thinking is while the ELA treats plaintiff as if he were an employee for purposes of that statutory scheme, he was not the employee of the insured under the policy and did not qualify under your employee provisions.
>
> "I am aware in this legal community of defenses being provided to employers under that liability portion of the policy, and in my own experience, that's not - - it's not frequent, but it's not infrequent either. It happens routinely.
>
> "* * * * *
>
> "And finally, under the common meaning of the word employee, plaintiff would not qualify as the employee of Harris, the general."

Summary judgment is appropriate when "there is no genuine issue as to any material fact and * * * the moving party is entitled to judgment as a matter of law." ORCP 47 C. **<154 Or App 93/94>** In *Anderson v. Jensen Racing, Inc.*, 324 Or 570, 575-76, 931 P2d 763 (1997), the court said:

> "'As a general rule the construction of a contract is question of law for the court.' *Hekker v. Sabre Construction Co.*, 265 Or 552, 555, 510 P2d 347 (1973).
>
> "'Unambiguous contracts must be enforced according to their terms; whether the terms of a contract are ambiguous is, in the first instance, a question of law.' *Pacific First Bank v. New Morgan Park Corp.*, 319 Or 342, 347, 876 P2d 761 (1994) (citation omitted).

> "Additionally, in deciding whether the terms of a contract are ambiguous and in deciding what those terms mean, the court must consider the context in which they appear. *Id.* at 348, 353-54. * * * The court's goal is to give effect to the intention of the contracting parties." (Citations omitted.)

Questions of coverage under an insurance policy are subject to the above rules. *Hoffman Construction Co. v. Fred S. James & Co.*, 313 Or 464, 469, 836 P2d 703 (1992). In this case, the term "employee" is not defined in the policy. Defendant argues that, when an insurance policy contains undefined terms, the courts have consistently held that such words should be given their plain, ordinary meaning. *Twilleager v. N. A. Accident Ins. Co.*, 239 Or 256, 259-60, 397 P2d 193 (1964). It asserts that plaintiff is not an employee of Harris as contemplated by common law or by the ordinary usage of the term because Harris did not provide plaintiff with remuneration. *See Webster's Third New Int'l Dictionary* 743 (unabridged ed 1993) (defining employee as "one employed by another usu[ally] below the executive level and usu[ally] for wages"); *see also Jylha v. Chamberlain*, 168 Or 171, 175, 121 P2d 928 (1942) (defining employee under the ELA as "one who renders service for another for wages or salary"). Plaintiff does not contend that he was Harris' direct employee, and he concedes that Harris did not directly provide remuneration to him. Plaintiff also concedes that under the common law definition, he was not Harris' employee. Thus, if defendant's interpretation of the term "employee" is correct, then it was entitled to summary judgment as a matter of law.

154 Or App 95> Instead, plaintiff argues that, because defendant specifically wrote the insurance policy to provide coverage for a statutory ELA claim, the term "employee" in the policy is defined by the statutory definition of an "employee" under the ELA. In *Anderson*, the court interpreted the term "prevailing party" in a contract by using a statutory definition. It held that "in the absence of evidence that the parties had a different intention, the court will ascribe to the term 'prevailing party' (or a similar one) in a contract 'the statutory meaning of "prevailing party," which is defined in ORS 20.096(5).'" *Anderson*, 324 Or at 579. By analogy, plaintiff asserts that, "[u]nder the [ELA], * * * [he] was Harris' employee, because * * * Harris had charge of or was responsible for plaintiff's work." It follows, according to plaintiff, that because the policy is intended to provide coverage for ELA claims, the statutory definition of "employee" in the ELA is also the definition of "employee" in the policy. Plaintiff then asserts that the ELA contains a different definition of employee apart from the common law definition of the word. He relies on *Thomas v. Foglio*, 225 Or 540, 545, 358 P2d 1066 (1961), in support of that argument:

> "At the juncture where we held that a plaintiff could recover under the Employers' Liability Law against one who did not employ him, the word 'employer' took on a special and broader meaning embracing situations in which the defendant would not be considered an employer of the plaintiff workman as that term is ordinarily understood. * * * The plaintiff becomes, in effect, an adopted employee to carry out the work project in which plaintiff's actual employer and his adoptive employer are participating. To draw the defendant into the employer-employee relationship in this sense, it must be shown that the defendant was one 'having charge of, or responsible for the work.'"

Before deciding whether the term "employee" in the insurance policy contemplates an ordinary meaning or a statutory meaning, it is first necessary to determine whether plaintiff is correct when he asserts that the term "employee" has a broader meaning under the ELA than under the common law definition. We begin with the text of the applicable statute. ORS 654.305 provides:

> **154 Or App 96>** "Generally, all owners, contractors or subcontractors and other persons having charge of, or responsibility for, any work involving a risk or danger to *the employees or the public* shall use every device, care and precaution that is practicable to use for the protection and safety of life and limb[.]" (Emphasis supplied.)

Thus, the statute contemplates a risk of danger to two classes of individuals: "employees" and "the public."

In *Sacher v. Bohemia, Inc.*, 302 Or 477, 481, 731 P2d 434 (1987), the court explained what the legislature contemplated in ORS 654.305 when it distinguished between "employee" and "the public." The court first examined the history of the ELA. The ELA was originally enacted in 1911, and its purpose was to impose a higher standard of care on employers engaged in lines of work involving risk or danger than the common law had provided. Or Laws 1911, ch 3, sect. 1. The court explained:

> "From 1913 to 1965, employers that would otherwise be subject to the ELA for injuries to their employees (*i.e.*, those in charge of, or responsible for work involving risk or danger to their employees) could opt into the Worker's Compensation Act which would immunize them from liability under the ELA, or opt not to participate in the Worker's Compensation Act and to remain subject to the ELA. * * *
>
> "Initially, the ELA was held to allow both members of the general public and employees of employers engaged in 'work involving risk or danger' to recover for injuries sustained from inherently dangerous instrumentalities under the control of the employer. * * * Two years later * * * the court limited *Clayton[v. Enterprise Electric Co.*, 82 Or 149, 161 P 411 (1916)] and held that members of the general public, as such, could not recover under the ELA. * * *
>
> "This court held in *Byers v. Hardy*, 216 Or 42, 48, 337 P2d 806 (1959), that *an action against a third-party employer could only be maintained because of the reference in ORS 654.305 to a risk or danger to 'the public.'*" *Sacher*, 302 Or at 482 (emphasis supplied; citations omitted).

In other words, "[t]he purpose [of the word 'public' in the ELA] was to give protection to persons working for others." *Saylor v. Enterprise Electric Co.*, 106 Or 421, 439, 212 P 477 **<154 Or App 96/97>** (1923). Thus, protection, under the ELA, was provided to "employees" in the ordinary sense of the word *and* to certain members of "the public."

The *Sacher* court then defined what workers were included in the definition of the phrase "the public." It explained that "the public" included workers when the defendant and the worker's employer "are simultaneously engaged in carrying out work on a common enterprise." *Sacher*, 302 Or at 483. It held that, under a common enterprise test, third-party employers may be liable to "adopted employees," "intermingled employees," or "an employee of an independent contractor hired by the defendant employer where the defendant employer retains or exercises a right to control the risk-creating activity or instrumentality."[2] *Id.* at 486. In that light, we conclude that the statutory scheme does not expand the definition of "employees" but rather provides for additional coverage for certain members of "the public" who work under particular circumstances. Accordingly, plaintiff is incorrect when he argues that the term "employees" in ORS 654.305 has a broader meaning than its ordinary definition. Rather, plaintiff's purported expanded definition is found within the phrase "the public" in ORS 654.305.

Turning to the language of the policy, it provides that "[t]he bodily injury must arise out of and in the course of *the injured employee's employment by you.*" (Emphasis supplied.) Moreover, it also provides that "[defendant] will pay all sums you legally must pay as damages because of bodily injury to *your employees.*" (Emphasis supplied.) By its express terms, the policy language does not extend coverage to the statutory classification of workers who are included under the definition of "the public" under ORS 654.305. The policy covers injuries to those employees employed by the insured and not to those members of the public who are also **<154 Or App 97/98>** furnished protection under the ELA. Because plaintiff concedes that he was not Harris' employee in the ordinary sense, his injury is not covered by the language of the policy.[3]

Next, plaintiff argues that the trial court erred when it ruled that defendant was entitled, as a matter of law, to foreclose its workers' compensation lien against the proceeds of plaintiff's judgment against Harris. ORS 656.580(2) provides, in part:

> "The paying agency has a lien against the cause of action as provided by ORS 656.591 or 656.593, which lien shall be preferred to all claims except the cost of recovering such damages."

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[2] The courts have consistently held that only "employees," either directly against their own employer or indirectly through the common enterprise test, may maintain an action under the ELA. *See Groves v. Max J. Kuney Company*, 303 Or 468, 471-75, 737 P2d 1240 (1987) (holding that an independent contractor may not bring an action under the ELA); *see also Jylha v. Chamberlain*, 168 Or 171, 175, 121 P2d 928 (1942) (holding that volunteers are not employees under the ELA).

[3] In *Jylha*, the court held that "the word 'employee' * * * must be considered in its ordinary acceptation and meaning." 168 Or at 175. The Workers' Compensation Act now provides the exclusive remedy for most employees. ORS 656.018. Thus, only employees not covered by the Workers' Compensation Act, such as "casual" employees, may now bring an action under the ELA against their employer. *See* ORS 656.027 (defining workers who are not "subject workers" under the Act).

> "Paying agency" means "the self-insured employer or insurer paying benefits to the worker or beneficiaries." ORS 656.576. ORS 656.593(1) provides:
>
> "The proceeds of any damages recovered from an employer or third person by the worker or beneficiaries shall be subject to a lien of the paying agency for its share of the proceeds as set forth in this section."

Thus, the statutes establish the procedure for determining the extent to which a "paying agency" may receive a share of any sum recovered if a worker elects under ORS 656.578 to seek damages from the employer or a third person who has caused a compensable injury. In this case, plaintiff sought to recover under the ELA from Harris, who is the "third person" who caused his injury.

Plaintiff does not dispute that defendant is the paying agency; however, he first argues that common law subrogation principles preclude subrogation by an insurer against an insured. Specifically, he contends

> "[n]o right of subrogation can arise in favor of the insurer against its own insured, since by definition subrogation arises only with respect to rights of the insured against a **<154 Or App 98/99>** third person to whom the insurer owes no duty. *Couch on Insurance*, Sect. 61:136; *see also Jackman v. Jones*, 198 Or 564, 576, 258 P2d 133 (1953)."

However, defendant did not seek to subrogate its rights against Harris. Instead, it sought to invoke a statutory lien against plaintiff's recovery from Harris. The applicable statute specifically provides for a "paying agency" to recover against such proceeds, regardless of whether the paying agency was the actual insurer of the "third person."

Plaintiff also argues that the insurance policy provides only for "Recovery from Others" and that that limitation prohibits recovery of monies that the insurer has paid to an insured. In particular, the policy provides:

> "We have your rights, and the rights of persons entitled to the benefits of this insurance, to recover a payment from anyone liable for the injury. You will do everything necessary to protect those rights for us and to help us enforce them."

Plaintiff contends that that provision only gives defendant the right to recover from non-insureds. We disagree. The policy provision does not conflict with the statutory language; rather, it provides for other types of recoveries that may not be provided for by statute. Defendant did not invoke the subrogation provision in the policy. Instead, it sought to enforce a statutory lien under the statute that specifically contemplates recovery of paid workers' compensation benefits from proceeds recovered from a third party. Thus, the trial court did not err when it granted defendant summary judgment and ruled that defendant was entitled to enforce its statutory lien.

Plaintiff's third assignment of error is that the trial court erred when it dismissed plaintiff's claim that defendant waived its right to assert its lien against the workers' compensation benefits because defendant failed to defend or indemnify Harris. Also, plaintiff alleges that defendant is equitably estopped from asserting its lien because of the same conduct. Our holding that the policy did not provide **<154 Or App 99/100>** coverage to Harris regarding plaintiff's claims disposes of that assignment of error.

Affirmed.

Cite as 154 Or App 149 (1998) May 27, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Serafin C. Lopez, Claimant.

SERAFIN C. LOPEZ, Petitioner,

v.

AGRIPAC, INC., and LIBERTY NORTHWEST INSURANCE CORPORATION, Respondents.

(95-13600; CA A98380)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 16, 1998.

Dale C. Johnson argued the cause for petitioner. With him on the brief was Malagon, Moore, Johnson & Jensen.

John M. Pitcher argued the cause and filed the brief for respondents.

Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.

ARMSTRONG, J.

Affirmed.

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154 Or App 151> Claimant seeks review of an order of the Workers' Compensation Board that reduced his scheduled award of permanent partial disability for loss of use or function of his left knee from 19 percent to five percent. We review for substantial evidence and errors of law, ORS 183.482(7), (8), and affirm.

The Board made the following findings, which claimant agrees "are sufficient for the purposes of this review": In 1989, claimant injured his left knee in a non-work-related car accident. His doctor diagnosed "internal derangement of the left knee," and claimant underwent arthroscopic correction of a rim tear of the lateral meniscus. During his rehabilitation for that knee injury, claimant's physical therapist noted that claimant required "aggressive rehab intervention" to both knees. The thereapist continued, "[Claimant] has significant joint noise in [his] right knee and apparently has at least as much pain in [his] right knee as he does [in his] left." The therapist diagnosed claimant with "right knee disfunction" [*sic*].

In June 1994, claimant sustained another left knee injury when he stepped on a cob of corn in employer's food-processing plant, which caused him to twist his knee. In March 1995, he underwent left knee arthroscopy and medial meniscectomy. Following claimant's closing examination, his attending physician, who had performed that surgery, concluded, "On physical examination [claimant] has full ROM and no effusion. There is no medial joint line tenderness any longer. * * * He is medically stationary. The only impairment he has is [a] loss of a portion of his medial meniscus." In July 1995, a determination order awarded claimant five percent disability because of the 1995 surgery on his left knee. Claimant sought reconsideration of that order.

In October 1995, a medical arbiter examined claimant. The arbiter noted that claimant was working full time without restrictions, that he was not receiving any specific treatment for the knee and that he was taking no medications. He also noted claimant's 1989 injury to his left knee and that claimant had stated that he thought that his knee **<154 Or App 151/152>** had "improved to the status of his knee just prior to the injury of September 6, 1994." In response to a question about whether claimant had a chronic limiting condition, the medical arbiter stated that, because claimant had stated that his knee had returned to its condition before the 1994 injury, claimant did "not have any limited or partial loss of ability to repetitively use his knee [from] the incident of September 1994. Limited use of the knee is present, but it is basically based on history, and is apparently related to his injury of March 29, 1989." The arbiter found that claimant's range of motion for each of his knees was 120 degrees of flexion and zero degrees of extension. There was not an "indication in the arbiter's examination report that * * * claimant's right knee was injured at any time prior to the medical arbiter examination."[1] In December 1995, an order on reconsideration affirmed the determination order.

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[1] The arbiter found that claimant "has mild crepitus in the *right* and left knee, with patellofemoral click noted bilaterally." (Emphasis supplied.) Crepitus is joint noise. Claimant does not challenge, however, the Board's finding that the arbiter's report does not indicate that claimant had suffered a past injury or disease to the right knee, so we accept that finding.

Claimant sought a hearing and the ALJ reversed the order on reconsideration, awarding claimant 19 percent permanent partial disability. Under OAR 436-035-0007(22), to determine a claimant's range of motion for a joint, the injured joint's range of motion is compared with that of the contralateral joint, unless the contralateral joint has a history of injury or disease. Because claimant's knees both have 120 degrees of flexion, when the two knees are compared, claimant has no compensable range of motion impairment. The ALJ concluded, however, that the physical therapist's 1989 notes constituted evidence of an injury or disease to claimant's right knee. Therefore, the ALJ did not compare the two knees but simply compared claimant's 120 degrees of flexion to the relevant chart, OAR 436-035-0220, and determined that claimant's impairment for his range of motion was 11 percent. The ALJ also concluded that claimant was entitled to a five percent award for his chronic condition, because employer had not affirmatively proven that claimant had a pre-existing impairment that caused the chronic condition. When those two awards were **<154 Or App 152/153>** combined with (not added to) claimant's five percent award, the ALJ concluded that claimant was entitled to 19 percent impairment.

Employer sought review and the Board reversed the ALJ. It concluded that the ALJ had erred in concluding that claimant had established a history of injury or disease to his right knee sufficient to preclude comparison of the two knees under OAR 436-035-007(22):

> "[I]n the absence of persuasive medical evidence indicating that claimant's right knee does have a history of injury or disease, we find the therapist's 1989 report, without more, is insufficient to establish that claimant's right knee 'has a history of injury or disease' for purposes of rating his left knee impairment under OAR 436-035-007(22)."

As a result, when determining claimant's range of motion impairment, the Board compared claimant's knees and concluded that claimant was not entitled to an impairment award for his left knee's limited range of motion. The Board also concluded that the ALJ had erred in concluding that claimant had a chronic condition related to the 1994 injury. It agreed, however, that claimant was entitled to a five percent impairment award, so it affirmed the order on reconsideration.

On review, claimant assigns error to the Board's conclusion that OAR 436-035-0007(22) requires comparison of the contralateral joint unless there is medical evidence establishing a history of injury or disease to the contralateral joint. OAR 436-035-0007(22) provides, in relevant part:

> "The range of motion or laxity (instability) of an injured joint shall be compared to and valued proportionately to the contralateral joint except when the contralateral joint has a *history of injury or disease* or when either joint's range of motion is zero or is ankylosed. * * *
>
> "* * * * *
>
> "(b) When the contralateral joint has *a history of injury or disease*, the findings of the injured joint shall be valued based upon the values established under these rules."

154 Or App 154> (Emphasis supplied.) Claimant argues that the reference to "a history of injury or disease" means that he is required only to submit evidence that provides an "account" of an injury or disease to the contralateral joint. The plain language of the rule, claimant argues, does not require a claimant to submit medical evidence of that injury or disease.

Employer disagrees, arguing that, under the relevant rules and statutes, the account of an injury or disease to the contralateral joint must be established by medical evidence. Considering the text and context of OAR 436-035-0007(22), we agree with employer. The authority of the director of the Workers' Compensation Division to promulgate OAR 436-035-0007(22) is derived from ORS 656.726(3)(f), which permits the director to adopt rules for the evaluation of disabilities. In adopting those rules, the director had to adhere to the principle that "[i]mpairment is established by a preponderance of medical evidence based upon objective findings." ORS 656.727(3)(f)(B). That proposition is stated more generally in ORS 656.283(7), which provides that "*[a]ny* finding of fact regarding the worker's impairment must be established by medical evidence that is supported by objective findings." (Emphasis supplied.) While OAR 436-035-0007(22) does not specifically refer to that requirement, the director echoed those statutory provisions in OAR 436-035-0010(1), which provides that "[a]ll physical disability ratings in these rules

shall be established on the basis of medical evidence that is supported by objective findings from the attending physician or as provided in OAR 436-035-0007." Those provisions anticipate that any finding about a claimant's condition that bears on a determination of impairment will be supported by medical evidence. Whether an injured joint should be compared to its contralateral joint is such a finding. Therefore, we conclude that OAR 436-035-0007(22) requires that a "history of injury or disease" to the contralateral joint be established by medical evidence.[2]

Claimant argues that even if that interpretation of the rule is correct, the Board's conclusion that claimant has <154 Or App 154/155> not established a history of injury or disease in this case cannot stand in the light of the physical therapist's 1989 report. We disagree. Medical findings relating to a claimant's permanent impairment must be made by the claimant's attending physician or a medical arbiter. ORS 656.245(2)(b)(B); ORS 656.268(7). Evidence relating to the impairment from other sources is admissible only if those findings are ratified by the attending physician or the medical arbiter. *Simon v. PIE Nationwide, Inc.*, 142 Or App 411, 414 n 5, 921 P2d 421 (1996). Therefore, even if we assume that the physical therapist's report supports claimant's position that he has a history of injury or disease to his right knee, that evidence is inadmissible unless it is ratified by either the attending physician or the arbiter. Claimant concedes that it was not. Therefore, on this record, claimant failed to establish that he had a history of injury or disease to his right knee and the Board did not err in comparing claimant's knees in determining his impairment to his right knee.[3]

Affirmed.

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[2] We agree with claimant that OAR 436-035-0007(22) does not require that the claimant establish that he or she currently has an injury or disease that affects the contralateral joint. It requires only that the claimant establish a *history* of such injury or disease. To the extent that the Board's opinion indicates otherwise, it is incorrect.

[3] Claimant does not challenge the Board's conclusion that he is not entitled to an award for a chronic condition. Hence, we do not consider that ruling.

Cite as 154 Or App 244 (1998) June 3, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Barbara Brown, Claimant.

BARBARA BROWN, Petitioner,
v.
A-DEC, INC., and SAIF CORPORATION, Respondents.
(96-04554; CA A98879)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 22, 1998.
Meagan Flynn argued the cause and filed the brief for petitioner.
David L. Runner argued the cause and filed the brief for respondents.
Before Riggs, Presiding Judge, and Landau and Wollheim, Judges.
WOLLHEIM, J.
Affirmed.

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154 Or App 246> Claimant seeks review of an order of the Workers' Compensation Board affirming an Administrative Law Judge's (ALJ) order holding that the symptoms and treatment of claimant's degenerative cervical condition are not compensable as an occupational disease. The medical record shows that claimant's cervical symptoms were brought on by her work as a dental parts assembler but that her current condition requiring treatment combines with a preexisting age-related degenerative disc condition also known as osteoarthritis or cervical spondylosis. The Board, in adopting the ALJ's order, ruled that claimant's cervical spine condition was a preexisting condition as defined in ORS 656.005(24) and that claimant could prove the compensability of her cervical symptoms only by satisfying the test set out in ORS 656.802(2)(b) and showing that her employment conditions were the major contributing cause of a pathological worsening of her underlying condition. We affirm.

ORS 656.802 provides, in part:

> "(1)(a) As used in this chapter, 'occupational disease' means any disease or infection arising out of and in the course of employment caused by substances or activities to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein, and which requires medical services or results in disability or death * * *.
>
> "* * * * *
>
> "(2)(a) The worker must prove that employment conditions were the major contributing cause of the disease.
>
> "(b) If the occupational disease claim is based on the worsening of a preexisting disease or condition pursuant to ORS 656.005(7), the worker must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease.
>
> "(c) Occupational diseases shall be subject to all of the same limitations and exclusions as accidental injuries under ORS 656.005(7).
>
> " * * * * *
>
> **154 Or App 247>** "(e) Preexisting conditions shall be deemed causes in determining major contributing cause under this section."

Claimant does not contend that her underlying degenerative cervical condition was caused or worsened by her employment, and she apparently does not seek to have the underlying cervical condition accepted as an occupational disease. Rather, she contends that work activities caused her to experience cervical symptoms, which required her to seek medical care, and that those symptoms and their treatment are compensable as an occupational disease. Because claimant's claim is not precisely based on a worsening of a preexisting condition, she contends that the Board erred in pplying the test for compensability set out in ORS 656.802(2)(b).

Even assuming that claimant is correct that the test set out in ORS 656.802(2)(b) is not the provision under which this claim should be analyzed, the Board nevertheless applied the correct standard of proof. It is conceded that claimant suffers from a degenerative cervical condition that contributes to her symptoms and need for treatment. ORS 656.802(2)(c) provides that the provisions of ORS 656.005(7) apply in determining the compensability of an occupational disease. Under ORS 656.005(7)(a)(B),

> "[i]f 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."

Contrary to claimant's contention, we conclude that claimant's degenerative cervical condition is a "preexisting condition" for purposes of ORS 656.005(7)(a)(B). ORS 656.005(24) defines "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."

154 Or App 248> Claimant contends that, because her degenerative cervical condition is caused by the natural process of aging, it is a mere "physical change," much like gray hair or wrinkles, and not a "disease," per se. From a medical standpoint, however, the degenerative process in claimant's back, although a natural result of the aging process, is a "disease" as characterized by the doctors who examined claimant and as found by the ALJ. Further, there is no indication in ORS 656.005(24) that it was intended to exclude "naturally occurring" diseases. On the contrary, the statute speaks of "any" disease or "similar condition" that contributes or predisposes a worker to disability or a need for treatment. There is no question that claimant's degenerative cervical condition contributes or predisposes claimant to her need for treatment.

Claimant contends that the treatment of a condition brought on by aging as a preexisting condition for purposes of the Workers' Compensation Law is a violation of Article I, section 20, of the Oregon Constitution. That section provides:

> "No law shall be passed granting to any citizen or class of citizens privileges, or immunities, which, upon the same terms, shall not equally belong to all citizens."

Claimant contends she is a member of a class of people, older workers or workers with degenerative changes in the spine, who suffer disparate treatment from other workers who have preexisting non-age-related conditions. We reject that contention. Even if claimant is correct that she is a member of a class distinct from all injured workers who suffer from preexisting conditions, she has failed to establish that that class is treated differently.

Claimant's final argument is that the application of separate requirements to workers who have preexisting conditions conflicts with the Americans with Disabilities Act, 42 USC sect. 12102. We considered and rejected that contention in *Bailey v. Reynolds Metals*, 153 Or App 498, ___ P2d ___ (1998).

Affirmed.

Cite as 154 Or App 259 (1998) June 10, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Conrid J. Paxton, Claimant.

SAIF CORPORATION and SUN STUDS, INC., Petitioners,
v.
CONRID PAXTON, WOOLLEY ENTERPRISES and RLC INDUSTRIES, Respondents.
(WCB 95-00537, 94-13809, 94-10357; CA A93939)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 16, 1998.
Michael O. Whitty argued the cause and filed the brief for petitioners.
William Blitz argued the cause and filed the brief for respondent Woolley Enterprises.
Charles E. Bolen argued the cause for respondent RLC Industries. On the brief was Adam T. Stamper.
No appearance by respondent Conrid Paxton.
Before Edmonds, Presiding Judge, and Armstrong and Wollheim, Judges.
EDMONDS, P. J.
Reversed and remanded.

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154 Or App 261> SAIF and Sun Studs, Inc. (Sun Studs) seek reversal of an order of the Workers' Compensation Board that concluded that Sun Studs is the responsible employer for claimant's hearing loss. Compensability is not an issue in this case. Rather, the only issue is whether there is substantial evidence in the record to support the Board's finding that Sun Studs is the responsible employer. ORS 183.482(8). We reverse.

The Board found the following facts. From 1977 to January 1981, claimant worked for Woolley Enterprises (Woolley). From January 1981 to October 1991, he worked for RLC Industries (RLC). After October 1991, he worked for Sun Studs. Claimant's work for all three employers as a heavy equipment mechanic exposed him to noise. He wore no hearing protection until mid-way through his employment at RLC. Since that time, he has used hearing protection on an as-needed basis. His exposure to loud noise at Sun Studs is infrequent.

The Board relied on reports from two examining medical doctors. Dr. Scott concluded that all of claimant's hearing loss had occurred before June 4, 1981. In reaching his opinion, he relied on a June 4, 1981, hearing test and the fact that since June 1981 claimant's hearing loss has been relatively the same. Dr. Hodgson reported:

"I agree with previous reports that there has been no increase in hearing loss due to occupation noise exposure since 1981. Although I have seen changes at 2,000 Hz in both ears, this has occurred in the face of absolutely no change in hearing at 3,000 to 6,000 Hz, where noise exposure most commonly damages hearing. Therefore, in my opinion, the hearing changes at 2,000 Hz in both ears occurring after 1981 are due to nonoccupational factors. * * *

"[I]t is important to note that the sole cause of occupational hearing loss, in my opinion, is noise exposure prior to June 4, 1981. In my view, I see no evidence of occupational hearing loss occurring in either ear since June 4, 1981."

At the end his report, Hodgson answered specific questions posed by a SAIF claims adjuster.[1] He said:

154 Or App 262> "1. The major contributing factor to the current level of hearing loss is occupational noise exposure prior to June 4, 1981.

"2. The development of hearing loss is not, in major part, related to idiopathic reasons or natural aging effects. It is possible that degenerative changes associated with aging have led to some changes at 2,000 Hz in both ears in recent years, though this represents a minor aspect of his hearing loss. *I feel the major portion of the hearing loss is due to occupational noise exposure, though, as mentioned above, this is due entirely to occupational noise exposure prior to 1981.*

"3. It is unlikely that much or any of the hearing loss is due to avocational activities. These types of activities clearly represent a minor contributing factor, if a factor at all.

"4. There has been no hearing loss due to any cause, aging, degenerative or noise damage, since October 1991. There is no evidence that employment at Sun Studs, Inc. has contributed in any way to the hearing loss." (Emphasis supplied.)

The Board first ruled that, because none of the three employers had accepted the hearing loss claim, the last injurious exposure rule applied. The Board explained:

"That rule provides that when, as here, a worker proves that an occupational disease was caused by work conditions that existed when more than one carrier was on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. *Boise Cascade Corp. v. Starbuck*, 296 Or 238[, 243, 675 P2d 1044] (1984)."

The Board then explained that the last employer, which in this case was Sun Studs,

"can shift responsibility to a prior carrier by showing that claimant's work exposure while a prior carrier was on the risk was the sole cause of claimant's hearing loss condition, or that it was impossible for conditions while SAIF/Sun Studs was on the risk to have caused that condition. *See FMC Corp. v. Liberty Mutual Ins. Co.*, 70 Or App 370, 374, [689 P2d 1046 (1984),] *mod* 73 Or App 223, [698 P2d 551,] *rev den* 299 Or 203 (1985)."

154 Or App 263> Applying those rules, the Board ruled that the sole cause of claimant's hearing loss was his work exposure before June 4, 1981, and that, therefore, Sun Studs was not the responsible employer.

RLC requested reconsideration, and the Board reversed its decision. It reasoned:

"Dr. Hodgson * * * determined that, based on the June 4, 1981 hearing test and the fact that claimant has experienced no increase in hearing loss due to occupational noise exposure after 1981, the major portion of claimant's hearing loss is due entirely to occupational noise exposure prior to June 4, 1981. * * *

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[1] The actual questions are not in the record.

> "Neither physician specifically addressed whether claimant's pre-June 4, 1981 work was the sole cause of his hearing loss, or whether it was impossible for claimant's work conditions at Sun Studs to have caused that condition. Indeed, Dr. Hodgson's statement that the major portion of claimant's hearing loss was due entirely to pre-1981 work noise exposure admits, at least impliedly, that part of his hearing loss was due to post-1981 work noise exposure, which would include claimant's period of employment at Sun Studs."

SAIF requested reconsideration of that decision. It argued that the *sole* cause of claimant's occupational hearing loss was noise exposure before June 4, 1981, and that Hodgson's report could not be reasonably construed to mean that any hearing loss after June 4, 1981, was attributable to industrial exposure. The Board then issued a second order on June 19, 1996, on reconsideration, further explaining:

> "We conclude that, if SAIF's interpretation of Dr. Hodgson's opinion is accepted, then Dr. Hodgson's opinion is inconsistent. That is, Dr. Hodgson found that claimant's current condition consisted of only 'possible' contribution for degenerative changes, and it was 'unlikely' that claimant's hearing loss was due to avocational activities. * * * Accordingly, Dr. Hodgson's opinion that claimant's pre-1981 occupational noise exposure was the major contributing factor to claimant's current hearing loss, when read in conjunction with his statement regarding nonwork contributors, could be construed to mean that post-1981 work **<154 Or App 263/264>** exposure could have partially contributed to claimant's current condition. * * * [W]e find that SAIF's argument that *all* of claimant's industrial noise exposure occurred prior to 1981 is inconsistent with Dr. Hodgson's quantification of claimant's condition in terms of the 'major' contributing cause." (Emphasis in original.)

In *Garcia v. Boise Cascade Corp.*, 309 Or 292, 295, 787 P2d 884 (1990), the court said:

> "[S]ubstantial evidence supports a finding when the record, viewed as a whole, permits a reasonable person to make the finding. ORS 183.482(8)(c). A court must 'evaluate the substantiality of supporting evidence by considering *all* the evidence in the record.' * * * That is, the court must evaluate evidence against the finding as well as evidence supporting it to determine whether substantial evidence exists to support that finding. If a finding is reasonable in light of countervailing as well as supporting evidence, the finding is supported by substantial evidence." (Emphasis in original; citations omitted.)

In this case, the Board's ruling is not supported by substantial evidence. In essence, the Board interpreted Hodgson's opinion to mean that Sun Studs was within the employer risk pool and that Sun Studs could not demonstrate that claimant's prior employer was the sole cause of claimant's hearing loss condition. The Board's interpretation centers around a single sentence in Hodgson's report, which says, "I feel the major portion of the hearing loss is due to occupational noise exposure, though, as mentioned above, this is due entirely to occupational noise exposure prior to 1981." The Board concludes that "Hodgson's statement that the major portion of claimant's hearing loss was due entirely to pre-1981 work noise exposure *admits, at least impliedly,* that part of his hearing loss was due to post-1981 work noise exposure, which would include claimant's period of employment at Sun Studs." (Emphasis supplied.) The Board misunderstands the unambiguous import of the sentence. The sentence first says that a major portion of the hearing loss is due to occupational noise exposure. It then informs the reader that all hearing loss due to occupational noise exposure occurred before 1981. The only reasonable inference from Hodgson's statement is that any hearing loss after 1981 was due only to *nonoccupational* causes.

Moreover, Hodgson also said in his report, "There has been *no hearing loss due to any cause,* aging, degenerative or noise damage, since October 1991. *There is no evidence that employment at Sun Studs, Inc. has contributed in any way to the hearing loss.*" (Emphasis supplied.) When the sentence relied on by the Board is read in context with the rest of the report, it is unreasonable to infer that Sun Studs is responsible for claimant's hearing loss caused by his work activities. The record, viewed as a whole, permits only one reasonable interpretation: all of claimant's hearing loss due to occupational exposure occurred before June 4, 1981; some of claimant's hearing loss was caused by non-work related factors,

but that loss occurred before October 1991; claimant suffered no hearing loss after October 1991 or after he began to work for Sun Studs. Because no hearing loss occurred while claimant was employed by Sun Studs, it cannot legally be the responsible employer on the claim. *See Roseburg Forest Products v. Long*, 325 Or 305, 313, 937 P2d 517 (1997).

Finally, Woolley argues that "[i]f the Court finds that Sun Studs is not responsible, then presumptive responsibility for Claimant's occupational disease shifts to RLC Industries and should remain there." It asks us to make that ruling. However, that issue is not before us to decide. The only order that is before us on review is the second order on reconsideration. That order does not decide whether responsibility shifts to RLC if Sun Studs is not the responsible employer. We remand to the Board for further consideration.

Reversed and remanded.

Cite as 154 Or App 380 (1998) June 10, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Lisa A. Hiner, Claimant.

LISA A. HINER, Petitioner,
v.
CRAWFORD HEALTH & REHABILITATION, Respondent.
(95-11008; CA A96402)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 25, 1997.
James L. Edmunson argued the cause for petitioner. With him on the brief was Cole, Cary & Wing, P.C.
Kevin L. Mannix argued the cause for respondent. On the brief were Patricia Nielsen and Mannix, Nielsen & Crawford, P.C.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
ARMSTRONG, J.
Affirmed.

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154 Or App 382> Claimant seeks review of an order of the Workers' Compensation Board affirming employer's denial of her aggravation claim. We review for substantial evidence and errors of law, *see* ORS 183.482(8), and affirm.

Claimant was involved in a work-related car accident on September 19, 1990. She filed a workers' compensation claim for the accident, which was accepted by employer as a nondisabling injury claim. Claimant received medical services for her injuries during the next year.

In October 1991, claimant also began seeking psychological treatment and, in early 1992, she began seeking medical treatment for chronic neck and back strain, fibromyalgia and thoracic outlet syndrome. On March 9, 1992, and June 25, 1992, employer sent claimant "partial denials" that denied the compensability, "in connection with her September 19, 1990 injury claim," of her "thoracic outlet syndrome, her current neck and back condition, including fibromyalgia and her psychological condition."

Claimant requested a hearing on the denial. At the hearing, claimant agreed that her claim was for nondisabling injuries,[1] but objected to employer's conclusion that the conditions it had denied were

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[1] At the outset of the 1993 hearing, the ALJ noted that claimant's claim had been classified as nondisabling and stated that the issue in the hearing was whether certain conditions were compensably related to the 1990 injury. Claimant's attorney agreed to the ALJ's characterization of the issue. Near the end of claimant's testimony, her attorney again specifically noted that claimant's injuries were nondisabling. He had the following colloquy with the ALJ:

unrelated to her 1990 injury. On **<154 Or App 382/383>** March 31, 1993, the ALJ issued an order concluding that the conditions were compensably related to the 1990 claim:

> "IT IS THEREFORE ORDERED that [employer's] March 9, 1992 and June 25, 1992 partial denials, as clarified at the March 31, 1993 hearing, are set aside. Claimant's September 19, 1990 injury claim with [employer] is hereby remanded to [employer] for acceptance, in connection with said claim, of the compensability of her cervical/lumbar strain conditions, fibromyalgia, and thoracic outlet syndrome, for which she has received medical services since early 1992, and for acceptance, in connection with her 1990 injury claim, of the psychological conditions for which claimant has received medical services since October 1991."

Employer sought review of that decision and the Board affirmed the order of the ALJ. Effective March 17, 1995, this court affirmed, without opinion, the order of the Board. After entry of the appellate judgment, employer began paying, and continued to pay, for the medical services related to the conditions at issue in those proceedings.

Claimant had continued to work and to require medical services throughout the appeal of the partial denials. In May 1995, one of her physicians, Dr. Morris, noted that claimant's conditions seemed to be stabilizing. She continued to be treated by Morris throughout the summer, and on September 11, 1995, he reported that claimant was more comfortable but continued to need treatment. On September 14, 1995, claimant saw another physician, Dr. Carter. At that time, claimant "reported worsening pain in her neck, right shoulder, right arm and low back" and Carter believed that claimant's depression was worse than it had been when he had seen her in September 1993. In late September 1995, claimant's symptoms increased and on October 5, 1995, claimant quit working because of her various chronic conditions. She continued to receive medical services from Morris and Carter.

On December 8, 1995, Morris signed a notice of an aggravation claim. Claimant signed the form on December 21, 1995, and employer received it on or before January 2, 1996. On January 10, 1996, employer sent claimant a letter **<154 Or App 383/384>** denying her aggravation claim. Claimant requested a hearing.

An ALJ upheld the denial of claimant's aggravation claim after a hearing. On Board review of that decision, claimant made several arguments. First, she challenged the initial processing of her claim in 1990. Citing ORS 656.319(6), the Board rejected that argument as time barred. She also argued that employer had failed to process her claim properly after the entry of the appellate judgment. The Board rejected that argument, too.

> Attorney: "We also covered [in the telephone conference that claimant] hadn't taken time off of work for this. It was nondisabling.
>
> ALJ: "Right. I think I mentioned that at the outset of the hearing.
>
> Attorney: "I [didn't] know if you needed further confirmation of it.
>
> ALJ: "That at this point it's still a nondisabling claim."

Claimant's attorney then elicited the following testimony from claimant:

> Attorney: "You haven't taken any time off of work for this?
>
> Claimant: "Not on Workers' Comp[ensation].
>
> Attorney: "What have you taken?
>
> Claimant: "I took sick days and vacation days."

Next, claimant asserted that her claim had become disabling and needed to be reclassified as such. Claimant argued that she did not have to establish an aggravation in order to have her claim reclassified and presented evidence that her claim had been disabling since as early as 1992. She argued that, even if she did have to prove an aggravation, she had established one in the 1993 hearing. The Board concluded that claimant had to prove an aggravation in order to have her claim reclassified. Under ORS 656.277(2) and ORS 656.273(4)(b), it concluded that claimant had to file that aggravation claim within five years of her accident, which meant that the claim had to have been filed by September 19, 1995. The Board found that claimant had not made an aggravation claim at or before the 1993 hearing, nor had she filed any other aggravation claim before her aggravation rights expired. Finally, the Board rejected claimant's argument that it should impose a penalty against employer.

Claimant sought judicial review. On review, she assigns error to the Board's conclusion that she can neither file an aggravation nor get her 1990 nondisabling claim reclassified after September 19, 1995. We review the Board's conclusion for errors of law. *See* ORS 183.484(8)(a).

ORS 656.277 dictates the procedures that a claimant must follow in order to have a claim reclassified as disabling. ORS 656.277(1) provides:

> "If *within one year after the injury*, the worker claims a nondisabling injury originally was or has become disabling, the insurer or self-insured employer, upon receiving notice or knowledge of such a claim shall report the claim to the **<154 Or App 384/385>** Director of the Department of Consumer and Business Services for determination pursuant to ORS 656.268." (Emphasis supplied.)

ORS 656.277(2) provides:

> "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 supplied.) In 1990, claimant's claim for her September 19, 1990, injury was accepted as a nondisabling claim. Although it appears that employer did not process the claim correctly in 1990, at the March 1993 hearing claimant acknowledged that her claim had been classified as nondisabling. She did not object to that classification, nor did she object to employer's processing of her claim. Thus, in 1993, two and a half years after her injury, claimant affirmed that her 1990 claim had been classified as nondisabling and that it had had that status for more than one year. ORS 656.277(2) applies to such claims. Therefore, any attempt by claimant to have her claim reclassified is tied to her ability to establish an aggravation pursuant to ORS 656.273. ORS 656.273 limits the time within which a claimant in claimant's position can file an aggravation claim to five years from the date of injury. ORS 656.273(4)(b).[2] In this case, claimant's injury occurred on September 19, 1990, so claimant had until September 19, 1995, to file an aggravation claim.

Claimant argues that the limitation created by ORS 656.277(2) and ORS 656.273(4)(b) should not apply to her case because employer failed to process her claim properly after the entry of the appellate judgment. We disagree. Even if we assume that employer failed to process claimant's claim properly after the entry of the appellate judgment, that does not affect the application of ORS 656.277(2) to claimant's claim. Her claim for her 1990 injury was accepted as nondisabling in 1990. It had that classification for more than a year. ORS 656.277(2) squarely applies to the reclassification of **<154 Or App 385/386>** that claim. Moreover, claimant was aware of her claim's classification. Unless and until she had affirmative knowledge that her 1990 claim had been reclassified as disabling, she had to operate under the assumption that it remained classified as nondisabling. In other words, she had to operate under the assumption that the five-year limitation for pursuing an aggravation claim, *see* ORS 656.277(2) and ORS 656.273(4)(b), applied to her claim. Any other conclusion would directly conflict with the

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[2] ORS 656.273(4)(b) provides:

> "If the injury has been in a nondisabling status for one year or more after the date of injury, the claim for aggravation must be filed within five years after the date of injury."

legislature's decision, as expressed in ORS 656.277(2), to require a claimant to pursue a reclassification claim as an aggravation if the claimant's injury was considered nondisabling a year or more after the injury. Therefore, we conclude that the Board correctly held that claimant was barred from filing an aggravation claim, or from filing a claim to have her 1990 claim reclassified as disabling, after September 19, 1995.

Claimant argues that, even if ORS 656.277(2) and ORS 656.273(4)(b) apply to her claim, the Board erred when it found that neither the argument that she made in the 1993 hearing nor any of the medical reports that she had submitted to employer through September 1995 constituted an aggravation claim. We review the Board's findings for substantial evidence. *See* ORS 183.484(8)(c). According to the record, the parties, the ALJ, the Board and this court did not consider in the 1993 hearing or the proceedings that followed it whether claimant had suffered an aggravation. Rather, the issue in those proceedings was whether several denied conditions were compensably related to the 1990 injury claim. Moreover, the medical reports that were made prior to the 1993 hearing focus on causation, not aggravation. We conclude that the Board's finding that claimant did not raise an aggravation claim before or at the March 1993 hearing is supported by substantial evidence.

The Board also found that claimant did not file any other aggravation claim between March 1993 and September 1995. Under ORS 656.273(3), "[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."[3] **<154 Or App 386/387>** On review, claimant does not dispute that she did not file an aggravation claim that comports with that statute before September 19, 1995. Until July 1995, however, "[a] physician's report [that established a] worsened condition by written medical evidence supported by objective findings" was sufficient to make an aggravation claim. ORS 656.273(3) (since amended by Or Laws 1995, ch 332, sect. 31).[4] Claimant does dispute the Board's finding that none of the medical reports submitted on her behalf between March 1993 and July 1995 constituted aggravation claims under that standard. After reviewing the record in its entirety, we conclude that the Board's finding is supported by substantial evidence. Therefore, we affirm the Board's finding that claimant failed to file an aggravation claim before September 19, 1995, which was a necessary prerequisite to her request to have her claim reclassified.

We have considered claimant's other assignments of error and reject them without discussion.

Affirmed.

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[3] ORS 656.273(3) 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." (Emphasis supplied.)

[4] The amendments to ORS 656.273(3) changing the manner in which an aggravation claim could be filed became effective June 7, 1995. Or Laws 1995, ch 332, sect. 66(1). However, the director did not adopt a form for filing aggravation claims until July 5, 1995, *see* WCD Bulletin No 284 (July 5, 1995), so, as a practical matter, claimants could not have complied with the change in the law until July 1995.

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