# VAN NATTA'S
# WORKERS' COMPENSATION REPORTER

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(Pages 1-632)



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.

JANUARY-MARCH 1998

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50 Van Natta ____ (1998)

In the Matter of the Compensation of
**RICHARD O. BURKE, Claimant**
WCB Case No. 97-01574
ORDER ON REVIEW
Thomas J. Dzieman, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Moller and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that found that the self-insured employer's termination of claimant's temporary disability was authorized. In his brief, claimant contends that, because the employer's (Barrett Business Services') claim processing was unreasonable, he is entitled to penalties and attorney fees. On review, the issues are temporary disability, penalties and attorney fees.

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

Barrett Business Services (BBS) terminated claimant's temporary disability pursuant to ORS 656.268(3)(c) when claimant failed to begin modified work offered by BBS. At hearing, claimant contended that temporary disability was improperly terminated because he was solely employed by West Coast Logging, not jointly by BBS and West Coast Logging, at the time of the compensable February 8, 1995 injury and, thus, his failure to begin modified employment offered by BBS could not properly terminate temporary disability.[1]

The ALJ found that BBS's offer of modified employment was an appropriate and valid condition precedent for termination of temporary disability under ORS 656.268(3)(c) when claimant failed to begin such employment. In reaching this conclusion, the ALJ determined that claimant was not, at the time of injury, a separate direct employee of West Coast Logging, but continued to be an employee of BBS.

On review, claimant contends that he terminated his employment with BBS in October 1994 and became an employee solely of West Coast Logging in January 1995. Arguing that he was free to enter into an employment agreement with whomever he chose after he quit employment for BBS in October 1994, claimant asserts he had a right to sell labor as he desired and that he entered into an exclusive employment relationship with West Coast logging in 1995.

Claimant's contentions notwithstanding, we agree with the ALJ's reasoning and conclusion that claimant never communicated an intention to quit BBS in October 1994. In the absence of such communication, we further agree with the ALJ that claimant continued his employment relationship with BBS at the time of injury. See Roylee Marlow, 28 Van Natta 325, 328 (1970) (the claimant could not terminate employment relationship without prior notice to the employer), aff'd Marlow v. Dexter Wood Products, 47 Or App 811 (1980). Moreover, because we agree with the ALJ's analysis and conclusion that claimant did not make a separate employment contract with West Coast Logging at the time of injury, we affirm the ALJ's decision that BBS could terminate claimant's temporary disability when he failed to begin modified employment.[2]

ORDER

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

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[1] At the time of injury, there was an employee leasing agreement in effect between BBS and West Coast Logging, which provided that West Coast and BBS were joint employers of West Coast personnel, that West Coast would obtain its workers from BBS, and that BBS would provide a variety of services for West Coast, including providing workers' compensation coverage. (Ex. 1). Claimant concedes that, if he was a joint employee of BBS at the time of injury, his refusal to begin modified employment would justify termination of temporary disability.

[2] Claimant raises for the first time the issue of unreasonable claim processing by BBS. We generally do not address issues raised for the first time on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). However, even if the issue were properly raised, we would decline to award penalties or attorney fees in light of our decision on the merits of the temporary disability issue.

In the Matter of the Compensation of
**TIMOTHY K. BUTSKY, Claimant**
WCB Case No. 96-06363
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Neal's order that declined to award temporary disability for the period from May 26, 1995 until July 17, 1995. On review, the issue is temporary disability. We reverse.

## FINDINGS OF FACT

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

As of May 26, 1996, claimant was at least partially disabled due to his worsened compensable right knee condition.

## CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the relevant facts.

Claimant suffered a compensable right knee injury on June 4, 1993. His claim was closed on March 7, 1994, with time loss and permanent disability awards. Claimant eventually received a total award of 11 percent permanent disability for this injury. He was released to light work when his initial claim was closed.

Claimant was laid off from work in June 1994 and he has not worked since.

In February 1995, claimant sought treatment for worsening right knee symptoms. On May 26, 1995, Dr. Puziss reported that claimant could only perform sedentary work.

On August 7, 1995, Dr. Puziss performed arthroscopic surgery on claimant's right knee. Thereafter, the employer amended its acceptance to include the right knee loose body which Dr. Puziss had discovered and removed.

A June 7, 1996 Determination Order closed claimant's aggravation claim with an award of temporary disability for the period from July 17, 1995 through May 9, 1996 and a total award of 17 percent scheduled permanent disability for loss of use or function of claimant's right leg (knee). A July 24, 1996 Order on Reconsideration affirmed the Determination Order.

Claimant requested a hearing, seeking additional temporary disability for the period from May 26, 1995 until July 17, 1995.

The ALJ concluded that claimant was not entitled to temporary disability beginning on May 26, 1995, reasoning that claimant was not disabled due to his compensable condition until July 17, 1995. We disagree.

Claimant's substantive entitlement to temporary disability benefits is established by a preponderance of evidence in the entire record showing that he was at least partially disabled due to his compensable right knee condition (before he became medically stationary), under ORS 656.210 and ORS 656.212. See SAIF v. Taylor, 126 Or App 658 (1994); Kenneth P. Bundy, 28 Or App 2501 (1996).

Here, claimant argues that he is entitled to at least temporary partial disability compensation for the period between May 26, 1995 and July 17, 1995, because he was limited to light work upon initial claim closure (in 1994) and Dr. Puziss, treating physician, has since limited him to sedentary work only beginning May 26, 1995. (See Exs. 54-1, 60, 63, 65). We agree.

On May 26, 1995, Dr. Puziss opined that claimant "really cannot do any kind of work at this time using his legs and is totally disabled from his original job. He can only work sedentarily at this time." (Ex. 60-4). On June 13, 1995, Dr. Puziss reiterated that claimant had been limited to "sit down work only" as of May 26, 1995. (Ex. 63).

On August 1, 1995, Dr. Puziss stated:

> "Although I disabled the patient as of July 17, 1995, I think actually this patient could return to totally sedentary work, i.e., sit-down work only. The pain in his knee is the only reason he is not employed. It was my understanding that no light duty work was available, however, if such duty is available, then he could work in a sit-down position only." (Ex. 69).

On this uncontradicted evidence, we find that claimant was at least partially disabled due to his worsened compensable right knee condition for the period from May 26, 1995 until July 17, 1995. Consequently, he is entitled to temporary disability benefits for that period.

ORDER

The ALJ's order dated June 27, 1997 is reversed. The Order on Reconsideration is modified. Claimant is awarded temporary disability benefits for the period from May 26, 1995 until July 17, 1995. 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.

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In the Matter of the Compensation of
**MARY A. EGBERT, Claimant**
WCB Case No. 97-00939
ORDER ON REVIEW
Hollander, et al, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Hall and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Herman's order that: (1) set aside its denial of claimant's occupational disease claim for a right shoulder condition; and (2) awarded an assessed fee under ORS 656.386(1). On review, the issues are compensability and attorney fees.

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

The employer contends that the most reliable opinion concerning causation is from Dr. Wilson, examining neurologist, in part because he was the only physician to see a videotape depicting claimant's work place. Although Dr. Wilson apparently was the only physician to view the videotape, we do not consider this factor as sufficient to overcome the persuasiveness of the opinion of Dr. Tilson, examining orthopedist.

In rendering his opinion that work activities were the major contributing cause of claimant's right shoulder condition, Dr. Tilson in part relied on a document outlining claimant's job history that was signed by a number of coworkers. At hearing, claimant's supervisor, Ronald Hiller, testified that he "generally agreed" with the description provided in this document. (Tr. 48). Furthermore, in describing any differences between the videotape and the "work history" document, Mr. Hiller stated only that the number of striped cars was less and that employees did not work 12-hour days until the previous year. (Id. at 41-42).

Based on this evidence, we find that the "work history" document upon which Dr. Tilson relied accurately depicted claimant's work activities. Consequently, we find no adverse affect on Dr. Tilson's opinion in failing to view the videotape. Moreover, for the reasons stated by the ALJ, we agree that Dr. Tilson's opinion carries claimant's burden of proof under ORS 656.802(2)(b).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,900, 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 her counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated June 24, 1997 is affirmed. For services on review, claimant's attorney is awarded an assessed attorney fee of $1,900, to be paid by the self-insured employer.

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In the Matter of the Compensation of
**RAMON HERNANDEZ, Claimant**
WCB Case No. 96-11091
ORDER ON REVIEW
Michael M. Bruce, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen D. Brown's order that set aside its denial of claimant's left hand (fingers) injury claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

In lieu of the first sentence of the ALJ's first finding of fact, we make the following finding:

"Claimant sustained an injury to the fingers of his left hand when he was riding in the bucket of the employer's tractor on September 30, 1996."

We also make the following findings:

"Prior to his injury on September 30, 1996, claimant did not know that he was not allowed to ride in the tractor bucket. (Tr. 14, 17, 128). Claimant rode in the tractor bucket on September 30, 1996, so that he could return to his work site promptly after his lunch break. (Tr. 10). Approximately five other workers rode on the tractor along with claimant. (Tr. 12, 23, 51). Claimant's work site was located approximately one-third to one-half mile from the place where he took his lunch break. (See Tr. 9, 40, 69). Claimant's lunch break was one-half hour. (Tr. 9, 40). Claimant usually rode in a company vehicle when traveling between the work site and the lunch location. (Tr. 10, 20)."

CONCLUSIONS OF LAW AND OPINION

We agree with the ALJ's reasoning and conclusion that claimant's injury arose out of and in the course of his employment. We supplement to address the employer's arguments regarding claimant's alleged "misconduct."

The employer argues that because claimant disobeyed a company policy against workers riding in tractor buckets, claimant had placed himself outside the course and scope of his employment at the time of his injury. We disagree.

In Andrews v. Tektronix, Inc., 323 Or 154, 160, 164 (1996), the Court reiterated that "fault is irrelevant in determining a worker's entitlement to compensation," and rejected a general rule that

would deny compensation for injuries sustained as a result of a worker's failure to follow an employer's instructions. The Court further stated that a worker's failure to follow the employer's instructions is only one of many factors to consider in the overall calculation of work-connectedness. 323 Or at 165. Furthermore, the Court noted that, if a work-defining instruction is taken into consideration, "the manner in which the instruction was conveyed, and the worker's consequent perception of the instruction's purpose and scope, also must be considered." Id. Thus, compensability of an injury depends on whether, considering all relevant factors, the activity causing the injury was sufficiently connected to work. Norpac Foods, Inc. v. Gilmore, 318 Or 363, 366 (1994); Rogers v. SAIF, 289 Or 633, 642 (1980). A determination that a worker has disobeyed the employer's instruction is not a substitute for the analysis of work-connectedness. Andrews, 323 Or at 164.

Here, considering all the circumstances, we are persuaded that claimant's work injury is sufficiently work-connected to be compensable. We are not persuaded that claimant was aware of the employer's policy against riding in tractor buckets prior to his injury. Moreover, even if he were aware of that policy, that fact alone would not determine whether claimant's injury was sufficiently work-connected to be compensable. Rather we consider the totality of the circumstances and agree with the ALJ that claimant's injury occurred in the course of his employment and arose out of his employment.[1]

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

ORDER

The ALJ's order dated April 21, 1997 is affirmed. Claimant is awarded an attorney fee of $1,000 for his counsel's services on review, to be paid by the self-insured employer.

[1] Claimant was injured as he was riding in a company vehicle, returning to his work site after his lunch break. It was common for claimant and other workers to use company vehicles to travel between the work site and the location where workers ate lunch. Other workers had ridden in the tractor buckets before claimant's injury, as had claimant himself. (Tr. 45, 115). Thus, we find that the employer condoned workers riding in company vehicles between the work site and the lunch location. We further find that, prior to claimant's injury, and in light of the language barrier for Spanish-speaking workers, it was reasonable for the workers, including claimant, to assume that the employer also condoned riding on the tractors to travel between the work site and the lunch location. Therefore, we conclude that claimant's injury "arose out of" his work. See Wallace v. Green Thumb, Inc., 296 Or 79, 82 (1983).



In the Matter of the Compensation of
**SHERRY A. JANKE, Claimant**
WCB Case Nos. 96-09064 & 96-09063
ORDER ON REVIEW
Cole, Cary & Wing, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Crumme's order that: (1) set aside its denial of claimant's occupational disease claim for right carpal tunnel syndrome; and (2) upheld Health Future's denial of claimant's occupational disease claim for the same condition. In its respondent's brief, Health Future contests the ALJ's attorney fee award under ORS 656.386(1) for an alleged "pre-hearing" rescission of its alleged compensability denial. Asserting that Health Future cannot raise such an argument in the absence of a cross-request, claimant moves to strike that portion of Health Future's respondent's brief. On review, the issues are the motion to strike, responsibility and attorney fees.

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

In its respondent's brief to the Board, Health Future challenged the ALJ's assessed attorney fee award. Claimant moves to strike this portion of Health Future's brief on the basis that Health Future did not cross-request review of this issue and, consequently, this issue "is not properly before the Board at this time."

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. E.g., Cameron D. Scott, 44 Van Natta 1723, 1724 (1992); Kenneth Privatsky, 38 Van Natta 1015 (1986). Consequently, we deny the motion to strike. Furthermore, we agree with the ALJ that claimant is entitled to an assessed attorney fee under ORS 656.386(1). See Kimberly Quality Care v. Bowman, 148 Or App 292, 294-95 (1997) (carrier's notation on response to claimant's request for hearing stating that the claimant had not sustained a work-related injury or disease constituted an "express denial of compensability" for purposes of ORS 656.386(1)).[1]

We turn to the responsibility issue. In its appellant's brief, SAIF first contested the ALJ's determination that Health Future was not precluded under Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996), from contesting its responsibility for claimant's right carpal tunnel syndrome condition. In its reply brief, SAIF acknowledged the amendment to ORS 656.262(10)[2] and its retroactive application.

We understand SAIF's acknowledgment as an abandonment of its "Messmer argument." Moreover, as we discussed in Keith Topits, 49 Van Natta 1538 (1997), under amended ORS 656.262(10), a carrier's failure to appeal or seek review of determination, reconsideration or litigation orders or notices of closure which award permanent disability does not subsequently preclude that carrier from contesting or denying its liability for a condition rated therein. Consequently, whether or not Health Future failed to appeal a closure order that rated the right carpal tunnel syndrome, it is not now precluded from contesting responsibility. Furthermore, in light of this discussion, we do not adopt that portion of the ALJ's reasoning and application of Messmer.

SAIF also argues that the ALJ wrongly decided that it was responsible under the last injurious exposure rule for the right carpal tunnel syndrome condition. Specifically, SAIF contends that, because there is evidence that claimant sought treatment for such condition (even though wrongly diagnosed) when Health Future was on the risk, Health Future should be found to be initially responsible and that the record is not sufficient for it to shift responsibility to SAIF.

We agree with the ALJ that Dr. Jany provided the most persuasive opinion concerning whether claimant's carpal tunnel syndrome was treated before her employment with SAIF's insured, Oregon Orthopedic. Because he indicated only the possibility of such a result, we find that the preponderance of evidence shows that claimant's right carpal tunnel syndrome was first treated while she worked at Oregon Orthopedic. Furthermore, because we also agree with the ALJ that the record fails to show that: (1) it was impossible for workplace conditions at Oregon Orthopedic to have caused the disease or (2) the disease was caused solely by previous employment conditions, SAIF is responsible for the right carpal tunnel syndrome condition. See Beneficiaries of Strametz v. Spectrum Motorwerks, 325 Or 439, 444-45 (1997).

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[1] In her request for hearing on Health Future's denial, claimant indicated that both compensability and responsibility were at issue. Claimant also sought an attorney fee under ORS 656.386(1). In its response, Health Future denied both that claimant sustained a work-related injury or disease and that the employer was responsible.

[2] The statute now provides, in relevant 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."

ORDER

The ALJ's order dated May 16, 1997 is affirmed.

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In the Matter of the Compensation of
**ROBERT E. JOHNSON, Claimant**
WCB Case No. 97-00558
ORDER ON REVIEW
Pamela A. Schultz, Claimant Attorney
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Podnar's order that declined to award an assessed attorney fee for claimant's counsel's efforts in establishing that the self-insured employer's denial was premature. In its respondent's brief, the employer seeks sanctions under ORS 656.390 for claimant's allegedly frivolous appeal. On review, the issues are attorney fees and sanctions. We affirm the ALJ's decision and decline to impose sanctions.

FINDINGS OF FACT

We adopt the findings in the "Issues" and "Findings of Fact" sections of the ALJ's order, with the exception of the finding at the bottom of page two that "[t]he denial of January 14, 1996 regarding claimant's current condition is a prospective denial and sought to deny claimant's future benefits on an accepted claim."

CONCLUSIONS OF LAW AND OPINION

We adopt and affirm the ALJ's decision and analysis on the attorney fee issue with the following supplemental analysis.

We begin with a recitation of the pertinent facts. Claimant sustained a compensable injury to his right shoulder and neck, and the employer ultimately issued an acceptance of a right shoulder strain, neck strain and adhesive capsulitis. Claimant was found medically stationary, and the claim was closed. After claim closure, the employer issued its January 14, 1997 denial of claimant's "current need for treatment."

The ALJ concluded that the employer's denial was "premature and a nullity" because no claim had been made for any post-closure treatment. The ALJ further concluded that claimant was not entitled to an assessed attorney fee because he had not "prevailed" over a denied claim within the meaning of ORS 656.386(1). That provision authorizes an assessed fee in "cases involving denied claims where the claimant prevails finally" in a hearing before an Administrative Law Judge. In declining to award an assessed fee, the ALJ relied on the Board's decision in Robert W. Stephenson, 48 Van Natta 2287, on recon 48 Van Natta 2442 (1996). The carrier in Stephenson issued a premature denial of a new medical condition for which no claim had been filed. The Stephenson Board concluded that an assessed attorney fee was not authorized under ORS 656.386(1) because the claimant received no compensation as a result of its decision that the carrier's denial was a nullity and, therefore, did not "prevail" over a denied claim.

On review, claimant argues that the present case is distinguishable from Stephenson because: the employer's denial and responsive pleadings in the present case required claimant's attorney to litigate the premature denial issue; claimant's attorney was instrumental in establishing the premature denial and, as a result, claimant's right to future treatment for his accepted conditions was protected; the employer intended to deny benefits on the express ground that the claimed condition is not compensable; and the denial in the present case can be construed as a "back-up denial" of a previously accepted condition and/or a prospective denial of future treatment.

After the parties submitted their arguments on review, our decision in Stephenson was affirmed by the court in Stephenson v. Meyer, 150 Or App 300 (1997). In affirming the Board's order, the court relied on ORS 656.005(6), which defines "claim" as a "written request for compensation from a subject worker or someone on the worker's behalf[.]" Consistent with that definition, the court concluded that the term "denied claim" in ORS 656.386(1) means an insurer's refusal to pay in response to a written request for compensation. The court reasoned that the legal predicate for an award of attorney fees under ORS 656.386(1) did not exist because no claim was ever made within the meaning of ORS 656.005(6). The court rejected the claimant's argument that the phrase "denied claim" in ORS 656.386(1) must be read broadly enough to allow attorney's fees "when insurers force litigation by issuing a formal express denial without first having received a claim." The court noted that neither it nor the Board had the authority to expand the language of ORS 656.386(1) to embrace circumstances not covered by it, even though an inequity could result.

We conclude that the court's decision in Stephenson is controlling in the present case. We reject claimant's argument that the employer's denial is a "back-up denial" of a previously accepted condition or a prospective denial of future treatment. It is, instead, a premature denial of treatment for which a claim has not been filed. As the employer's premature denial is a "nullity" and without effect, it has no preclusive effect on claimant's future treatment. Moreover, even assuming that claimant's litigation of the premature denial was necessary to protect claimant's interests, that is not a basis for an award of attorney fees under ORS 656.386(1). The authority to award an assessed fee under that provision is limited to situations where the claimant has prevailed over a "denied claim." An assessed fee is not authorized in the present case because claimant has not made a "claim" for post-closure treatment within the meaning of ORS 656.005(6).

Accordingly, pursuant to the court's decision in Stephenson, we affirm the ALJ's decision that claimant is not entitled to an assessed attorney fee.

We turn to the employer's request for sanctions under ORS 656.390(1). Pursuant to that provision, the Board may impose an appropriate sanction upon claimant's attorney if claimant's request for review was frivolous or was filed in bad faith or for the purpose of harassment. Pursuant to ORS 656.390(2), "frivolous" means the matter is not supported by substantial evidence or is initiated without reasonable prospect of prevailing.

Here, the employer argues that claimant's request for review was frivolous. In support of that argument, the employer contends that there is well-settled Oregon case law adverse to claimant's position on review. The employer also contends that sanctions are warranted for claimant's improper attempt to raise a "back-up" denial issue for the first time on review, and claimant's allegedly frivolous assertion that the establishment of the premature denial protected claimant's right to reimbursement for post-denial treatment. The employer argues that the latter assertion is frivolous because the record does not establish that a claim for the treatment has been filed or that the treatment is compensably related to claimant's accepted injury.

We are not persuaded that claimant's request for review warrants sanctions under ORS 656.390. Claimant's "back-up denial" assertion could be characterized as merely a different theory in support of an assessed attorney fee, rather than a separate and new issue. Given these circumstances, claimant's "back-up denial" argument is not frivolous. Accord William J. Slayton, 49 Van Natta 496, 498 (1997). Furthermore, claimant has presented colorable arguments on review that are sufficiently developed so as to create a reasonable prospect of prevailing on the merits. Moreover, at the time claimant submitted his argument on review, the court had not yet issued its order affirming our decision in Stephenson. 48 Van Natta at 2287, on recon 48 Van Natta at 2442. Thus, while claimant's arguments on review did not ultimately prevail, we cannot say they are "frivolous." Jack B. Hooper, 49 Van Natta 669 (1997); Donald M. Criss, 48 Van Natta 1569 (1996). Accordingly, we deny the employer's request for sanctions.

Finally, we note that the parties' briefs on review include additional documentary evidence on the sanctions issue that is not part of the hearings record. Our consideration of this new evidence would not cause us to reach a different decision in this matter. For this reason, we do not consider this new evidence or otherwise address whether the Board could properly consider it in reaching its decision on review.

## ORDER

The ALJ's April 30, 1997 order is affirmed. The employer's request for sanctions is denied.

In the Matter of the Compensation of
**ALFREDO MARTINEZ, Claimant**
WCB Case No. 96-09312
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that declined to award temporary disability compensation for the period from October 16, 1995 through January 9, 1996. The self-insured employer moves to strike portions of claimant's argument which refer to a prior ALJ's factual findings. On review, the issues are motion to strike (evidence) and temporary disability.

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

The ALJ found that claimant's temporary disability benefits were properly terminated on July 19, 1995 because claimant had returned to his regular work. Further finding that claimant was performing his regular work when he was laid off for reasons unrelated to his compensable claim, the ALJ concluded that claimant was not entitled to reinstatement of temporary disability benefits as of his October 16, 1995 lay-off.

Claimant argues that he was performing modified work only when he was laid off, based solely on a prior ALJ's factual findings. (See Ex. 18). The employer moves to strike claimant's references to the prior findings, contending that these findings are not evidence in this record. The employer argues that the prior ALJ's order has since been reversed by the Board. Claimant responds that we should not rely on our prior order, Alfredo Martinez, 49 Van Natta 67 (1997), because it was not part of the reconsideration record in the present case.

We need not resolve this procedural matter because, even if the prior ALJ's findings could be properly considered, they would not be controlling or persuasive. Furthermore, (without considering the prior findings), we find that the record as developed does not support additional temporary disability, as explained by the ALJ and supplemented herein.

On the merits, we agree with the ALJ that claimant's work after July 19, 1995 was "modified" for noninjury-related reasons. In doing so, we note that all employees performing similar work were similarly restricted. Accordingly, in the absence of persuasive evidence of injury-related lost wages on or after October 16, 1995, we also agree with the ALJ that claimant has not established entitlement to temporary disability benefits for the period from October 16, 1995 through January 9, 1996 (when he became medically stationary). See ORS 656.210; Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992) (A claimant's substantive entitlement to temporary disability is established by a preponderance in the record showing that he was disabled due to the compensable condition before becoming medically stationary).

ORDER

The ALJ's order dated June 6, 1997 is affirmed.

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

On December 26, 1996, in response to claimant's request for reconsideration, we abated our December 6, 1996 Own Motion Order, 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. The self-insured employer submitted its response to claimant's request for reconsideration of the work force issue. However, subsequently, claimant requested that we continue to hold the own motion matter in abeyance pending a decision by Administrative Law Judge (ALJ) Nichols regarding whether claimant's aggravation rights had expired on this claim. By letter dated February 19, 1997, we granted claimant's request. By order dated April 27, 1997, ALJ Nichols 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. Claimant requested Board review of ALJ Nichols' order. On today's date, the Board adopted and affirmed ALJ Nichols' order. Accordingly, the jurisdictional issue having been decided,[1] we proceed with our reconsideration.

After reconsidering the work force issue, we republish our December 6, 1996 Own Motion Order with the following supplementation.

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 argues that an October 18, 1994 CT scan and myelogram and letters dated October 17, 1994 and November 3, 1994 from Dr. Franks, treating surgeon, establish that his compensable injury made it futile for claimant to seek work from the date of his retirement on October 22, 1994, until the date of his cervical surgery on December 13, 1994. We disagree.

Relating to claimant's neck condition, the October 18, 1994 myelogram showed "[s]ignificant and virtually circumferential extradural defects at C5-6, most of which are probably bony" and "[c]entral and possibly right-sided extradural defect at C3-4[.]" The CT scan showed disc annular bulging at C3-4 and

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[1] 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, such benefits are limited to temporary disability compensation. Id.; Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988).

C4-5, spinal stenosis at C5-6, and bony neural foraminal narrowing at C6-7 with disc bulging. Claimant invites us to infer from these findings that it would have been futile for claimant to seek work after he retired. However, we are without the medical expertise to make such an inference.

Moreover, Dr. Franks does not render an opinion regarding claimant's ability to work. In his October 17, 1994 letter, Dr. Franks indicates disagreement with an examining physician's opinion regarding causation of claimant's current neck condition and opines that a 1968 work-related neck injury caused "an accelerated change of degenerative nature that is now causing spinal cord compression." We note that claimant worked for the employer for more than 25 years at the time of his retirement on October 22, 1994, and both the 1968 and 1987 neck injuries occurred while claimant was working for this employer. However, it is the law of the case that claimant's current cervical condition is compensable under claimant's November 11, 1987 injury claim with the employer. John B. Shaw, Sr., 48 Van Natta 2207 (1996). Nevertheless, notwithstanding Dr. Franks' comments about the 1968 injury claim, he does not indicate that it would be futile for claimant to work due to his compensable neck condition. In fact, claimant was working at the time of Dr. Franks' October 17, 1994 letter.

In his November 3, 1994 letter, Dr. Franks reports the results of the October 17, 1994 myelography and CT scan. He indicates that claimant has "significant extradural nerve root compression at the levels C5-6 and C6-7" and recommends surgery. He also notes that claimant is anxious to proceed with surgery as soon as it is authorized. However, Dr. Franks does not indicate that would be futile for claimant to seek work due to his compensable neck condition. Claimant invites us to infer such futility from Dr. Franks' statement that claimant had significant nerve root compression and the fact that claimant wanted to proceed with surgery as soon as possible. However, we are without the medical expertise to infer such an opinion, especially considering that Dr. Franks did not render such an opinion or make any statements from which we can draw such an opinion. Furthermore, the fact that claimant was anxious to proceed with surgery does not establish that his compensable condition rendered a work search futile.

Finally, claimant contends that it was "unnecessary" for Dr. Franks to write an off-work authorization because claimant retired on October 22, 1994. However, there is no indication that Dr. Franks was aware of claimant's retirement. In any event, it is claimant's burden to prove he was in the work force at the time of his disability. ORS 656.266. As discussed above and in our initial order, the record does not meet claimant's burden of proof.

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. The parties' right of appeal shall begin to run from the date of this order. We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
**BRETT D. WILSON, Claimant**
WCB Case No. 96-03297
ORDER ON REVIEW (REMANDING)
Floyd H. Shebley, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Galton's order that: (1) "quashed" SAIF's request that claimant attend an insurer-arranged medical examination; (2) set aside SAIF's denial of claimant's low back injury claim; (3) assessed a penalty for an allegedly untimely denial; and (4) awarded a $7,500 insurer-paid attorney fee. On review, the issues are the ALJ's procedural ruling, compensability, penalties, and attorney fees. We vacate and remand.

## FINDINGS OF FACT

On March 20, 1996, SAIF denied claimant's "alleged occupational disease" claim on the basis that his work activities were not the major cause of his condition. On June 7, 1996, SAIF issued an amended denial which denied claimant's November 15, 1995 "injury" claim on the basis that the work incident was not the major cause of claimant's condition.

By letter dated June 14, 1996, SAIF notified claimant of an insurer-arranged medical examination (IME) scheduled for June 24, 1996 at Columbia Medical Consultants. Following receipt of this letter, claimant's counsel moved for an order excusing claimant from attending the June 24, 1996 examination. On June 21, 1996, the ALJ issued an Interim Order granting claimant's "Motion to Quash" the June 24, 1996 IME.

## CONCLUSIONS OF LAW AND OPINION

Concluding that SAIF was not entitled to a "post-denial" IME, the ALJ granted claimant's motion to "quash" the June 24, 1996 medical examination. We disagree.

Subsequent to the ALJ's order, we issued our decision in Ronald C. Fuller, 49 Van Natta 2067 (1997). There, we held that a carrier's motion to postpone a hearing should have been granted because the claimant refused to attend a "post-denial" IME. Between the issuance of the carrier's aggravation denial and the convening of the scheduled hearing, the carrier made arrangements for an IME. When the claimant refused to attend the "post-denial" IME, the carrier moved for postponement of the hearing. The ALJ denied the motion, held the hearing, and set aside the carrier's denial. The carrier requested Board review, contending that extraordinary circumstances beyond its control justified postponement of the hearing.

We agreed with the carrier's contention. Citing Ring v. Paper Distribution Services, 90 Or App 148 (1988), and Gary E. Frazier, 47 Van Natta 1313, on recon 47 Van Natta 1401, second recon 47 Van Natta 1508 (1995), we acknowledged that, when a claim has been denied, there is no compensation to be paid and, thus, no sanctions (i.e., there is no compensation for the Director to suspend) are available under ORS 656.325(1) for a claimant's failure to attend an IME. Nonetheless, as noted by the Ring court, we stated that a claimant's failure to attend an IME could result in dismissal of the claimant's hearing request if such a failure constituted an unjustified delay under its dismissal rules. Consistent with that rationale, we determined that a claimant's failure to attend a "post-denial" IME may be grounds for a postponement of a scheduled hearing under OAR 438-006-0081(4).

In reaching our conclusion, we found it unnecessary to decide whether the "investigation cooperation" requirements of ORS 656.262(14) were limited to "pre-denial" investigations. In doing so, we reasoned that, even if the statute was so limited, it did not affect the precedential authority of such "pre-262(14)" decisions as David M. Foote, 45 Van Natta 270 (1993), Myron E. Blake, 39 Van Natta 144 (1987), and Victoria Napier, 34 Van Natta 1042 (1982), which had granted postponements based on a claimant's failure to attend an IME. Consistent with "the modest level of cooperation" required by ORS 656.325(1), the statutory policy directive of ORS 656.012 to provide a "fair and just administrative system," and in the interests of achieving substantial justice under ORS 656.283(7), we continued to adhere to our long-standing holdings that a claimant's failure to attend a "post-denial" IME may be grounds for a postponement of a scheduled hearing.

Inasmuch as the sole basis for the claimant's objection to the carrier's postponement motion was his position that he was not required to attend the IME, we vacated the ALJ's order and remanded with instructions to reconvene the hearing once claimant attended the IME. Because no other objection had been raised, we emphasized that, in that particular case, there was no need for the ALJ to determine whether the carrier had exercised due diligence in arranging for the IME. In this regard, we noted that, under OAR 438-006-0081(4), incomplete case preparation is not grounds for a postponement unless the ALJ finds that completion of the record could not be accomplished with due diligence.

Here, in addition to his contention that there was no statutory authority for a post-denial IME, claimant also challenged the timing and scheduling of the IME. OAR 438-006-0081(4) provides that incomplete case preparation is not grounds for a postponement unless the Administrative Law Judge finds that completion of the record could not be accomplished with due diligence. We interpret claimant's arguments as a contention that SAIF did not demonstrate "due diligence" under OAR 438-006-0081(4). Because the ALJ did not take evidence on whether SAIF exercised due diligence warranting a postponement, we find the record incompletely developed concerning this issue.[1] Consequently, we conclude that remand is appropriate. ORS 656.295(5).

In light of our holding in Fuller, and because we find the record incompletely developed regarding whether due diligence has been established under OAR 438-006-0081(4) to justify a postponement, we vacate the ALJ's order and remand this case to ALJ Galton. Accordingly, the ALJ's order dated November 5, 1996 is vacated. This matter is remanded to ALJ Galton for further proceedings consistent with this order. Specifically, the ALJ should reopen the record and take evidence regarding whether due diligence has been shown under OAR 438-006-0081(4), such that a postponement should be granted. If the ALJ finds that a postponement is not warranted, the ALJ shall issue a final appealable order addressing the issues. If the ALJ finds that a postponement is warranted, a hearing will presumably be rescheduled after claimant's attendance at a reasonably scheduled IME. Following the completion of the hearing and the closure of the record, the ALJ shall issue a final appealable order addressing the issues. The further proceedings may proceed in any manner that the ALJ deems achieves substantial justice. ORS 656.283(7).

IT IS SO ORDERED.

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[1] It is questionable whether the Hearings Division has the authority to "quash" a request for an IME or issue a "protective order." The Hearings Division does have the authority to postpone or dismiss a case if a party's actions are prejudicial to the other party or result in an unwarranted delay of the scheduled hearing. See OAR 438-006-0071, 438-006-0081. However, given our decision to remand this matter to the ALJ, we need not resolve this question.

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In the Matter of the Compensation of
**BEVERLY B. PIERCE, Claimant**
WCB Case No. 97-02531
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order which affirmed an Order on Reconsideration that did not award any scheduled permanent disability for a compensable right elbow condition. On review, the issue is extent of scheduled permanent disability.

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

At hearing, claimant's counsel called claimant to testify. Counsel for the SAIF Corporation objected to claimant's testimony on the basis that it was inadmissible pursuant to ORS 656.283(7) and

SAIF's objection. On review, claimant asserts that the ALJ's evidentiary ruling violates her constitutional "due process" rights. We have previously rejected claimant's constitutional argument 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).

Finally, inasmuch as we have affirmed the ALJ's order, claimant's request for an attorney fee pursuant to ORS 656.382(2) is moot.

ORDER

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

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In the Matter of the Compensation of
**BOBBI J. BLAKELY, Claimant**
Own Motion No. 97-0529M
OWN MOTION ORDER OF ABATEMENT
Martin J. McKeown, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant submits additional evidence[1] regarding the work force issue, we consider this submission to be a request for reconsideration of our December 1, 1997 Own Motion Order, as reconsidered on December 16, 1997. In our prior orders, we declined to reopen claimant's 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 this regard, we found that, although claimant established that her compensable injury rendered her unable to work during the period in question, she failed to establish that she was willing to work.

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

IT IS SO ORDERED.

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[1] This evidence consists of a cover letter and a statement signed by Dr. Mohler, M.D., on December 17, 1997, addressing claimant's ability to work since her bilateral knee arthroscopy on November 19, 1996. Because it is not apparent that claimant sent a copy of this evidence to the SAIF Corporation, we are attaching a copy of the evidence to SAIF's copy of this Own Motion Order of Abatement. Pursuant to OAR 438-012-0016, a copy of any document in an own motion proceeding directed to the Board must be simultaneously mailed to all other parties. In the future, claimant is requested to copy SAIF with any documentation or correspondence she submits to the Board.

In the Matter of the Compensation of
**ERIC DIAZ, Claimant**
WCB Case No. 96-02280
ORDER ON REVIEW (REMANDING)
Peter O. Hansen, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) admitted a medical report (Ex. 79A) from claimant's treating physician; (2) declined to award an attorney fee under ORS 656.382(1) for an allegedly untimely acceptance of claimant's thoracolumbar strain; (3) upheld the insurer's denial of claimant's levoscoliosis condition; (4) found that claimant's somatic dysfunction was encompassed within his accepted lumbar strain; and (5) declined to award an attorney fee under ORS 656.382(1) for allegedly unreasonable claim processing. On review, the issues are the ALJ's evidentiary ruling, compensability, claim processing and attorney fees. We vacate and remand.

Claimant contends that the ALJ erred in admitting Exhibit 79A without allowing cross-examination or rebuttal. For the following reasons, we agree.

Exhibit 79A is a February 4, 1997 summary of a telephone conversation between the insurer's counsel and Dr. Takacs, claimant's attending physician, who indicated his agreement with the contents of the letter on February 6, 1997. The insurer's counsel received Dr. Takacs' report on May 30, 1997 and then submitted the report at the June 2, 1997 hearing. Claimant's counsel objected to admission of the medical report in the absence of the opportunity to either cross-examine Dr. Takacs or obtain a rebuttal report.

Noting that the parties had deposed Dr. Takacs on May 12, 1997, the ALJ concluded that the February 6, 1997 report had no probative or evidentiary value because Dr. Takacs had been cross-examined regarding all items discussed in the written report. Although giving it no "weight," the ALJ admitted the medical report and declined to allow claimant to obtain rebuttal evidence.

To begin, the ALJ properly admitted Exhibit 79A at hearing because the insurer submitted the report within seven days of receipt. See OAR 438-007-0015(4); Edward D. Swor, 45 Van Natta 1690 (1993). 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 with 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).

Here, concluding that the evidence contained in admitted Exhibit 79A was the same evidence as found in Dr. Takacs deposition, the ALJ did not allow post-hearing cross-examination or rebuttal of Exhibit 79A. We conclude that the ALJ abused his discretion.

Inasmuch as claimant had the burden of proving the compensability of his lumbar somatic dysfunction and levoscoliosis conditions, he had the right of "last presentation of evidence" on the compensability issues. See OAR 438-007-0023; Robert D. Sloan, 46 Van Natta 87 (1994). Because the insurer submitted Exhibit 79A at the hearing, we are persuaded that claimant could not, with due diligence, present the final medical evidence at hearing. Under these circumstances, we conclude that the ALJ abused his discretion in not continuing the hearing to allow claimant to present the final rebuttal evidence.[1] See OAR 438-006-0091(3); James D. Brusseau II, 43 Van Natta 541 (1991).

[1] Although the ALJ determined that the deposition of Dr. Takacs addressed all points raised in Exhibit 79A, claimant's attorney obviously did not have Dr. Takacs' report when the deposition occurred. Thus, claimant's attorney did not have the opportunity to inquire regarding its contents. While this may ultimately prove not to be significant, we, nevertheless, conclude that it is in the interests of substantial justice and consistent with Board procedural rules that claimant's request for cross-examination or rebuttal be granted.

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); Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem, 80 Or App 152 (1986).

Here, because the ALJ improperly refused to hold the record open for cross-examination or rebuttal, and because claimant could not have obtained rebuttal evidence with due diligence at the time of hearing, we find that the record has been incompletely or otherwise insufficiently developed, and that claimant has established a compelling reason to grant the motion for remand. Edward D. Swor, 45 Van Natta at 1690.

Therefore, we remand this matter to ALJ Podnar to allow claimant an opportunity to cross-examine Dr. Takacs or rebut the late-produced evidence. The submission of this additional evidence shall be made in any manner which ALJ Podnar determines will achieve substantial justice.

Accordingly, the ALJ's order dated June 13, 1997 is vacated. This matter is remanded to ALJ Podnar for further proceedings consistent with this order. Following these further proceedings, ALJ Podnar shall issue a final, appealable order.[2]

IT IS SO ORDERED.

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[2] The ALJ determined that claimant's thoracic levoscoliosis condition was not compensable because it was not caused or worsened by claimant's injury. On remand, the ALJ should address the affect of SAIF v. Nehl, 148 Or App 101 (1997) and Gregory C. Noble, 49 Van Natta 764 (1997), on the compensability issue. In addition, the ALJ concluded that, because claimant did not raise the issue of an attorney fee under ORS 656.382(1), such issue could not be addressed. The ALJ on remand should also consider the affect of the Board's rule on the amendment of issues at hearing (OAR 438-006-0031) with respect to the issue of whether claimant's counsel is entitled to an attorney fee under ORS 656.382(1).

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In the Matter of the Compensation of
**RONALD C. FULLER, Claimant**
WCB Case No. 96-04233
ORDER OF ABATEMENT
Pozzi, Wilson, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Claimant requests reconsideration of our December 4, 1997 Order on Review which: (1) found that the SAIF Corporation was entitled to a postponement of a scheduled hearing in order to obtain a "post-denial" insurer-arranged medical examination; and (2) remanded this case to Administrative Law Judge Tenenbaum for further proceedings. Specifically, claimant contends that our decision neglected to address the effect of OAR 436-060-0135 on our reasoning.

In order to further consider claimant's motion, our December 4, 1997 order is withdrawn. SAIF is granted an opportunity to respond. To be considered, SAIF's response must be filed within 14 days from the date of this order. Thereafter, this matter will be taken under advisement.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**KEITH FAIGEN, Claimant**
WCB Case No. 97-00943
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Davis' order that: (1) found that diagnostic medical services for a noncompensable urological condition were compensable; (2) set aside the insurer's partial denial of claimant's increased high blood pressure condition; and (3) awarded an attorney fee of $1,000 for services at hearing regarding the diagnostic medical services issue. On review, the issues are medical services, compensability and attorney fees. We affirm in part and reverse in part.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact. We do not adopt the third paragraph of the findings of ultimate fact.

## CONCLUSIONS OF LAW AND OPINION

### Compensability of Diagnostic Services for Urological Condition[1]

We adopt and affirm the ALJ's opinion in regard to this issue, with the following comment.

In Counts v. International Paper Co. 146 Or App 768 (1997), the court held that, if diagnostic services are necessary to determine the cause or extent of a compensable injury, the tests are compensable whether or not the condition that is discovered as a result of them is compensable. After de novo review of the record, we agree with the ALJ's conclusion that the diagnostic procedures were initially conducted because Dr. McWeeney was concerned that claimant's compensable low back injury had caused claimant's urological problem. Consequently, even though claimant's urological condition is not compensable, diagnostic medical services provided by Drs. Jamison and Burke through December 4, 1996, are compensable.

### Compensability of Hypertension

We begin with a brief summary of the facts. Claimant was diagnosed with borderline high blood pressure in April 1996, prior to his August 1996 low back injury. (Exs. 15A, 18, Tr. 2). On November 8, 1996, claimant reported an increase in his blood pressure that was noted by Dr. Inman on October 29, 1996, to Dr. McWeeney. Dr. McWeeney referred claimant to Dr. Jamison, a neurologist, for evaluation to see whether claimant needed hypertensive medication.

Dr. Jamison found baseline hypertension with an asymptomatic orthostatic drop, which, he opined, was suggestive of autonomic nerve dysfunction. Dr. Jamison also observed anxious behaviors by claimant and opined that claimant's anxiety might be playing a role in the maintenance or exacerbation of his high blood pressure. Dr. Jamison also noted a family history of hypertension. (Ex. 32). On November 21, 1996, Dr. Jamison prescribed Procardia (an anti-hypertensive) to control claimant's high blood pressure. Claimant did not fill the Procardia prescription for monetary reasons. (Exs. 34, 38-2).

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[1] We note that the court has held that the Director has jurisdiction over disputes that concern only the compensability of medical services. ORS 656.245(6); SAIF v. Shipley, 147 Or App 26 (1997). Here, however, the dispute concerned the insurer's compensability denial of the underlying urological condition claim. (Ex. 43). Accordingly, we have jurisdiction over this dispute. Jacqueline J. Rossi, 49 Van Natta 1184, on recon 49 Van Natta 1844 (1997); see also Charles Bertucci, on recon 49 Van Natta 1833 (1997) (Hearings Division has jurisdiction over medical services dispute where the claimant was seeking to establish compensability of a new condition).

On December 20, 1996, Dr. McWeeney recommended that claimant obtain a second opinion regarding his back condition, as it was not improving with conservative care and Dr. McWeeney did not consider surgery to be an option. (Ex. 38). In February 1997, Dr. Rosenbaum, a neurological surgeon, examined claimant and recommended surgery. As a result of pre-surgical screening on March 11, 1997, claimant was referred to Dr. Bowman, a primary care physician, for evaluation of his high blood pressure condition. Dr. Bowman provided medication and authorized surgery. (Ex. 44C, Tr. 28). On March 12, 1997, Dr. Rosenbaum performed a left lumbosacral laminectomy.

Relying on Dr. Bowman's opinion, the ALJ found that claimant's preexisting high blood pressure (hypertension) condition combined with the compensable injury. The ALJ concluded that claimant's increased high blood pressure was compensable. On review, the insurer contends that there is no persuasive medical evidence that claimant's high blood pressure condition combined with his compensable low back injury or was caused or worsened by his accepted low back condition. We agree that claimant's hypertension is not compensable, but for the following reasons.

The medical evidence indicates that claimant has a preexisting high blood pressure condition which combined with his low back injury. (Exs. 15A, 45). Therefore, ORS 656.005(7)(a)(B) applies to his claim.[2]

It is claimant's burden to prove the compensability of his claim by a preponderance of the evidence. ORS 656.266. In order to establish compensability under ORS 656.005(7)(a)(B), claimant must show that the work injury was the major contributing cause of the disability or need for treatment of the combined condition. SAIF v. Nehl, 148 Or App 101, mod 149 Or App 309, 311 (1997); Gregory C. Noble, 49 Van Natta 764, 767 (1997). Determining the "major contributing cause" involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause. Dietz v. Ramuda, 130 Or App 397 (1994), rev dismissed 321 Or 416 (1995); Gregory C. Noble, 49 Van Natta at 765-66.

Because a determination of major contributing cause requires the assessment of the relative contribution of different causes, it is necessary to consider the effect of all possible causes of a condition. In this case, that includes assessing the relative contribution to the need for treatment of claimant's elevated high blood pressure of claimant's autonomic dysfunction, anxiety, the normal course of untreated high blood pressure, the effect of a family history of hypertension, and the compensable injury, each of which was alluded to in the medical reports as having an effect on claimant's hypertension. (Exs. 31, 32, 34, 37, 38, 42, 45).

Dr. Bowman, who examined claimant on only one occasion, provides the only affirmative support for claimant's position.[3] However, Dr. Bowman's report does not discuss the relative contribution of any of the above-mentioned factors. Rather, Dr. Bowman's conclusory report states only that "the pain which [claimant] experienced following his August 9, 1996 injury is more than 50 percent responsible for the combined condition and pathological worsening of the hypertension." (Dr. Bowman also predicted that claimant's blood pressure would diminish subsequent to surgery. However, claimant did not return for further evaluation or treatment.) In the absence of any explanation of his opinion, we do not find Dr. Bowman's report persuasive regarding the cause of claimant's need for treatment of his increased high blood pressure. Somers v. SAIF, 77 Or App 259 (1986).

On this record, claimant has not established that his 1996 work injury was the major contributing cause of his disability or need for medical treatment for his combined condition. While Dr. Bowman prescribed Procardia to diminish claimant's high blood pressure immediately prior to surgery, Dr. Jamison, who opined that claimant's back condition did not contribute to his increased high blood pressure, had prescribed the same medication at an earlier time. Under these circumstances, claimant

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[2] The insurer contends that claimant's increased high blood pressure should be analyzed as a consequential condition under ORS 656.005(7)(a)(A). We disagree. Claimant was diagnosed with elevated blood pressure prior to his injury. A consequential condition is a separate condition that arises from the compensable injury. Because claimant's claim did not involve two different injuries (one caused by another), but rather involved a preexisting high blood pressure condition and an accepted low back injury, ORS 656.005(7)(a)(A) is not applicable. E.g., Fred Meyer, Inc. v. Crompton, 150 Or App 531 (1997).

[3] Dr. McWeeney and Dr. Jamison, as well as the insurer's panel, each opined that claimant's high blood pressure was unrelated to his low back condition. (Exs. 34, 41, 42-3).

has not established that his need for treatment of his increased high blood pressure is compensably related to his 1996 work injury. Accordingly, we must uphold the insurer's denial. Nehl, 149 Or App at 313.

Attorney Fees

The ALJ awarded claimant a $1,000 attorney fee, to be paid by the insurer, for his counsel's services in overturning the denial of diagnostic medical services for the urological condition. On review, the insurer contends that the attorney fee awarded was excessive, particularly in light of the lack of evidence regarding the value of the diagnostic services.

An attorney fee award is not established solely by the value of the services. We consider the amount of claimant's counsel's attorney fee for services at 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 issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

As compared to typical medical services cases, the issue here was of somewhat above-average complexity. The claim's value and the benefits secured are of less than average proportions, consisting of the payment of medical bills to a date certain. The transcript consists of 36 pages and claimant was the sole witness to testify. The hearing lasted one hour. Finally, although there was a decided risk that claimant's counsel's efforts might have gone uncompensated, counsel's skill and time was spent in reducing that risk through preparation. See Schoch v. Leupold & Stevens, 144 Or App 259 (1996) (the risk in a particular case that an attorney's efforts may go uncompensated is a factor to be considered in setting a reasonable attorney fee under OAR 438-015-0010(4)).

After considering these factors, we conclude that the ALJ's award of $1,000 is a reasonable assessed attorney fee for claimant's counsel's services at hearing. Moreover, based on similar considerations, we find that $700 is a reasonable assessed fee for claimant's counsel's efforts in defending on the issue of medical services on Board review.[4]

ORDER

The ALJ's order dated July 31, 1997, is affirmed in part and reversed in part. That portion of the order that set aside the insurer's denial of claimant's claim for a high blood pressure condition and awarded an assessed attorney fee of $2,000 is reversed. The insurer's denial is reinstated and upheld. The remainder of the order is affirmed. For services on Board review regarding the diagnostic services issue, claimant's attorney is awarded an assessed fee of $700, payable by the insurer.

[4] Claimant is not entitled to an attorney fee on review for his counsel's services in defending on the attorney fee issue. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).



In the Matter of the Compensation of
**ELIZABETH NIMMO-PRICE, Claimant**
WCB Case No. 95-00779
SECOND ORDER ON RECONSIDERATION
Gatti, Gatti, et al, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

On December 19, 1997, we republished our August 21, 1997 Order on Review that had: (1) reversed that portion of an Administrative Law Judge's (ALJ's) order that had set aside the self-insured employer's partial denial of claimant's thoracic outlet syndrome, rotator cuff tear, and cerebral hematoma conditions; (2) affirmed those portions of the ALJ's order that had set aside the employer's partial denial of claimant's left arm condition, thoracic strain/sprain, left hip pain, and generalized pain complaints (with related myospasms); (3) affirmed an ALJ's $1,750 attorney fee award for the employer's

"pre-hearing" acceptance of a headache and post-concussion syndrome; (4) modified the ALJ's $3,000 attorney fee award to $2,300; and (5) awarded a $1,200 attorney fee for claimant's counsel's services on Board review.

We took this action in response to the employer's counsel's request that our August 21, 1997 order be "affirmed." We have now received the parties' "Stipulation and Order of Dismissal" and Disputed Claim Settlement Agreement," which purport to resolve all issues raised or raisable between the parties. The parties' submission is treated as a motion for reconsideration of our December 19, 1997 order. The motion is granted and our prior orders are withdrawn.

Pursuant to the stipulation, the parties agree that the Board's August 21, 1997 Order on Review "is affirmed in all respects and will forever remain in force and effect." The parties' settlement provides that the employer's denial, as supplemented in the agreement, "shall forever remain in full force and effect." The settlement further states that "the claimant's Request for Hearing thereon shall be dismissed with prejudice as to all issues raised or raisable between the parties."

We have approved the parties' stipulation and 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] In granting this approval, we note that the stipulation states that our August 21, 1997 order is "affirmed in all respects." Our order affirmed that portion of the ALJ's order that had set aside part of the employer's January 10, 1995 partial denial insofar as it pertained to claimant's left arm condition, thoracic strain/sprain, left hip pain, and generalized pain complaints (with related myospasms). In contrast to their stipulation and the aforementioned portion of our "affirmed" order, the parties' settlement provides that the employer's January 10, 1995 denial, as supplemented in the agreement, "shall forever remain in full force and effect."

In light of the parties' stipulation (which refers to their "companion Disputed Claim Settlement Agreement"), we have interpreted the parties' settlement in the following manner. With the exception of that portion of the employer's January 10, 1995 denial set aside as a result of our August 21, 1997 order, the remaining portions of the employer's denial, as supplemented in the settlement, "shall forever remain in full force and effect." Based on this interpretation of the parties' agreements, we have granted our approval. In the event that our understanding of the parties' intentions is incorrect, they should immediately seek reconsideration of our decision.

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January 6, 1998 Cite as 50 Van Natta 20 (1998)

In the Matter of the Compensation of
**RAIMO TILA, Claimant**
Own Motion No. 97-0586M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable L4-5 disc herniation injury. Claimant's aggravation rights expired on January 4, 1978. SAIF opposes authorization of temporary disability compensation, contending that: (1) surgery or hospitalization requested is not compensably related to the accepted condition in the 1971 claim; and (2) claimant was not in the work force at the time of disability.

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

On December 12, 1997, SAIF submitted its recommendation to deny claimant's request for Own Motion time loss benefits. SAIF contended the current need for surgery is reasonable and necessary but disputed its compensability. The Board wrote to SAIF requesting further clarification of its recommendation and requesting a copy of the denial if one had issued. SAIF responded on December 29, 1997, restating its position that claimant's current need for surgery was not compensably related to the accepted condition in the 1971 claim and that there was no need to issue a formal denial at this time. No response has been received from claimant.

Thus, the issue of whether claimant's current need for surgery at L4-5 and L5-S1 is related to his accepted L4-5 disc herniation injury remains a compensability question which is undetermined at this time.

Inasmuch as the dispute between the parties remains unresolved, we are not authorized to reopen claimant's 1971 injury claim for payment of temporary disability benefits. See ORS 656.278(1)(a). Should claimant's circumstances change, and the surgery subsequently be determined to be compensably related to the accepted condition in the 1971 claim, 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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In the Matter of the Compensation of
**WILLIAM D. BRIZENDINE, Claimant**
WCB Case Nos. 95-09476, 95-06006 & 95-04929
ORDER ON REVIEW
Greg Noble, Claimant Attorney
Garrett, et al, Defense Attorneys
Nancy J. Meserow, Defense Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Marshall's order that: (1) set aside its back-up denial of claimant's lumbar strain injury claim; and (2) set aside its denial of claimant's injury claim for an L5-S1 disc condition. On review, the issues are back-up denial and 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

### Back-up Denial

We adopt the ALJ's opinion and conclusions concerning the back-up denial issue, from the second full paragraph on page 6 through the first full paragraph on page 7. In addition, we offer the following comment.

The employer argues that its back-up denial should be upheld because its acceptance of claimant's lumbar strain was induced by fraud or misrepresentation. See ORS 656.262(6)(a). We are not inclined to address this contention, because it was not raised at hearing. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). Moreover, because we agree with the ALJ that claimant suffered a January 21, 1995 lumbar strain at work, we would not find that the employer's acceptance of the claim for a lumbar strain was obtained by fraud, misrepresentation, or other illegal activity. See Boeing Co. v. Young, 122 Or App 591 (1993); see also David F. Lemus, 49 Van Natta 815 (1997); Charles A. Tureaud, 47 Van Natta 306 1995).

### Compensability

The ALJ found that claimant established that the compensable lumbar strain injury was a material contributing cause[1] of claimant's current L5-S1 disc condition, based on the opinion of Dr. Collada, treating physician. We disagree.

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[1] The employer argues that the ALJ should have applied the "major contributing cause" standard of proof because claimant had preexisting low back degeneration. See ORS 656.005(7)(a)(B). We need not determine whether claimant has a "combined" condition and is therefore subject to the "major contributing cause" standard, because we find the evidence supporting a "material contributing cause" relationship unpersuasive.

We generally rely on the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983). In this case, we find such reasons.

First, we find no indication that Dr. Collada saw claimant more than once, eight months after the work injury. (See Exs. 30A, 36, 40, 51). Under these circumstances, we cannot say that Dr. Collada was in an advantageous position to render an opinion regarding the relationship between the January 1995 strain injury and the current disc condition. 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)). Moreover, we cannot say that Dr. Collada's causation opinion should be accorded deference due to firsthand exposure to and knowledge of claimant's condition. Compare Givens v. SAIF, 61 Or App 490, 494 (1983).

Second, we find Dr. Collada's conclusion relating claimant's L5-S1 disc bulge to the fall at work inadequately explained. "With regards to the lumbar problem," Dr. Collada acknowledged claimant's degenerative changes "throughout different regions." (Ex. 51). "Despite the degenerative changes which have been preexisting," Dr. Collada stated that he could "easily" relate claimant's bulging disc to the fall, because claimant's post-injury symptoms were consistent with a bulging disc. (Id). Considering the extent of claimant's preexisting lumbar degeneration, we do not find the doctor's causal conclusion, which is based solely on the nature and timing of claimant's post-injury symptoms, to be persuasive. See Barbara J. James, 44 Van Natta 888 (1992), aff'd mem James v. O'Rourke, 117 Or App 594 (1993).

Finally, the record indicates that claimant has had long-standing low back problems and there is no indication that Dr. Collada had a complete history regarding the extent of these problems. (See Exs. 1, 8-1, 16-1; 1Tr. 27, 75-78; see also 1Tr. 30-31, 71, 123-24; 127-28). Under these circumstances, we cannot say that Dr. Collada's opinion is based on an accurate and complete history. See Somers v. SAIF, 77 Or App 259 (1986). Accordingly, in the absence of persuasive medical evidence relating claimant's L5-S1 disc condition to his work injury, we conclude that the claim must fail.

Claimant's attorney is 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 concerning the back-up denial is $1,200 payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

## ORDER

The ALJ's order dated June 5, 1997 is reversed in part and affirmed in part. That portion of the order that set aside the self-insured employer's denial of claimant's claim for an L5-S1 disc condition is reversed. That portion of the denial is reinstated and upheld. The ALJ's related $2,000 attorney fee is reversed. For services on review regarding the back-up denial, claimant is awarded a $1,200 attorney fee, payable by the employer. The remainder of the order is affirmed.

In the Matter of the Compensation of
**JAMES A. HANSON, Claimant**
WCB Case No. 97-00643
ORDER ON REVIEW
Malagon, 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) Michael V. Johnson's order that increased claimant's scheduled permanent disability award for loss of use or function of his right wrist from 5 percent (7.5 degrees), as awarded by an Order on Reconsideration, to 19 percent (28.5 degrees). On review, the issue is extent of scheduled permanent disability. We reverse.

## FINDINGS OF FACT

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

Claimant, age 54 at the time of hearing, compensably injured his right wrist on June 25, 1995. He sought emergency treatment and was diagnosed with a contusion of the right wrist. The condition was accepted by SAIF on July 26, 1995.

Claimant continued to experience right wrist pain and an August 10, 1995 arthrogram indicated probable ligamentous injury and triangular fibrocartilage tear. In early October 1995, claimant began treating with Dr. Zirschky, an orthopedic surgeon.

On May 14, 1996, claimant underwent a physical capacity evaluation (PCE). Over the course of the examination, the evaluators noted swelling in claimant's right upper extremity. Claimant's right wrist strength was measured at 4+/5. The evaluators also concluded that claimant was unable to repetitively grasp with his right hand.

Dr. Zirschky declared claimant medically stationary as of June 14, 1996. Dr. Zirschky reviewed the PCE and agreed with the findings, although he believed that the evaluators overestimated claimant's capacity to perform medium duty work. He opined that claimant could not repetitively grip or strong twist with his right hand, and that this restriction would be permanent.

On August 8, 1996, Dr. Zirschky reported that claimant had a 5 percent loss of active ulnar deviation, though other range of motion in the right forearm was normal. He further noted that, although claimant showed definite muscle weakness in the right wrist and decreased pinch strength, he could not find objective evidence of a nerve damage.

A September 10, 1996 Determination Order awarded claimant 15 percent scheduled permanent disability, consisting of loss of range of motion and loss of strength in the right wrist. A week later, claimant was approved for an authorized training program.

Claimant requested reconsideration, seeking additional scheduled permanent disability for a chronic condition of the right wrist.[1] SAIF also requested reconsideration, and claimant was required to attend a medical arbiter examination. On December 14, 1996, claimant was examined by a panel of three arbiters, Drs. Ballard, Kho and Neumann. Among other things, the panel measured claimant's wrist range of motion, sensation, and muscle strength. They found 5/5 strength in all muscle groups in both upper extremities, normal range of motion, normal sensation and no objective evidence to support a chronic condition.

On January 17, 1997, an Order on Reconsideration issued, which reduced claimant's scheduled permanent disability award to 5 percent. The Appellate Review Unit concluded that, although claimant did not establish loss of motion or loss of strength related to his compensable injury, a preponderance of the evidence established that he was significantly restricted in the repetitive use of his right wrist due to his injury.

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[1] Claimant did not disagree with the impairment findings used to rate disability.

CONCLUSIONS OF LAW AND OPINION

Based on the results of the PCE testing and the findings of claimant's attending physician, the ALJ found that claimant was entitled to a scheduled permanent disability award of 19 percent, consisting of the following combined values: 1 percent for loss of motion, 14 percent for loss of strength and 5 percent for a chronic condition. On review, SAIF contends that the ALJ erred in relying on the findings of claimant's attending physician over those of the medical arbiter panel, who examined claimant closer in time to the reconsideration order and found no objective evidence of permanent impairment related to the compensable injury. Specifically, SAIF asserts that the PCE results regarding loss of strength and Dr. Zirschky's finding of reduced motion do not constitute evidence of permanent disability. SAIF also contends that there is no persuasive evidence that claimant is significantly limited in the repetitive use of his right hand.

Evaluation of a worker's disability is as of the date of issuance of the reconsideration order. ORS 656.283(7). Where a medical arbiter is used, impairment is determined by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. 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). We have previously held that we do not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment but, rather, rely on the most thorough, complete, and well-reasoned evaluation of the claimant's injury-related impairment. See Kenneth W. Matlack, 46 Van Natta 1631 (1994).

In this case, claimant's attending physician noted a loss of wrist strength and reduced ulnar deviation when he declared claimant medically stationary in June 1996.[2] Six months later, the medical arbiter panel specifically tested claimant's muscle strength and wrist range of motion and found no ratable permanent impairment. The fact that the arbiter examination is performed closer in time to the reconsideration order is not always decisive. See, e.g., Charlene L. Vinci, 47 Van Natta 1919 (1995). However, a medical arbiter's report may be more probative where there is a significant time gap between the claimant's closing evaluation and the medical arbiter's examination. See, e.g., Ronald L. Tipton, 48 Van Natta 2521 (1996); David Gonzalez, 48 Van Natta 376 (1996). This is especially true where the record establishes an improvement in claimant's impairment between the time claimant was declared medically stationary and the time of the medical arbiter examination several months later. See, e.g., Maureen E. Bradley, 49 Van Natta 2000 (1997); Kyle L. Ellis, 49 Van Natta 557 (1997).

Here, we agree with SAIF that the medical arbiter panel provided the most persuasive opinion concerning claimant's wrist strength and range of motion. The arbiters performed a complete and thorough examination of claimant's injury-related impairment at a point much closer in time to the reconsideration order. The arbiters specifically opined that their range of motion and muscle strength findings were valid. Because claimant's permanent disability must be rated as of the January 17, 1997 Order on Reconsideration, we consider the medical arbiter panel's December 1996 evaluation of claimant's wrist strength and motion to be more probative than the findings of the PCE and the reports of Dr. Zirschky, who last examined claimant in June 1996.[3]

Although the arbiters also found no objective evidence to support a chronic condition related to claimant's compensable injury, we, like the Appellate Review Unit and the ALJ, conclude that a preponderance of the evidence establishes otherwise. Pursuant to OAR 436-035-0010(5), a claimant is entitled to 5 percent permanent scheduled disability for a chronic and permanent medical condition that significantly limits his ability to repetitively use his right hand and/or wrist. In this case, both the PCE evaluators and Dr. Zirschky found objective evidence (in the form of swelling) of claimant's inability to

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[2] Although Dr. Zirschky wrote to SAIF regarding claimant's wrist impairment on August 8, 1996, it is not apparent that he examined claimant on or around that date. (Ex. 12A). In fact, the record establishes that Dr. Zirschky last examined claimant's wrist injury on June 12, 1996, when he declared claimant medically stationary. (Ex. 10B).

[3] Although Dr. Zirschky noted in August 1996 that claimant exhibited signs of muscle weakness during his May 1996 PCE, the doctor related this weakness to pain and deconditioning rather than any nerve injury. (Ex. 12A). Also, Dr. Zirschky did not specifically opine that this weakness would be permanent, as he did with regard to claimant's inability to use his right hand in a repetitive fashion. Under these circumstances, we decline to rely on Dr. Zirschky's opinion regarding claimant's wrist strength and range of motion.

repetitively grip and twist with his right hand. (Exs. 9, 10). Although the arbiters did not find such evidence during their examination, they did not have the opportunity evaluate claimant performing repetitive activities with his right hand over the course of a five hour examination, as did the PCE evaluators.[4] After reviewing the PCE report, Dr. Zirschky specifically opined that claimant was limited in the repetitive use of his right hand, and that this restriction on repetitive use was permanent. Dr. Zirschky also agreed with the PCE evaluators that claimant was unable to return to his job as a welder/layout fabricator because of his compensable injury. (Exs. 10, 16A). 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 condition arising out of his compensable injury.

ORDER

The ALJ's order dated June 2, 1997 is reversed. The ALJ's attorney fee award is also reversed. The Order on Reconsideration, awarding 5 percent (7.50 degrees) scheduled permanent disability for loss of use or function of the right forearm (wrist), is reinstated and affirmed.

[4] The PCE evaluators noted significant swelling in the right hand and wrist (an increase of 75 ml. of water displacement using a volumeter) during the course of the five hour evaluation, in which claimant was asked to perform repetitive tasks involving overhead reaching, power grasping and vertical ladder climbing. (See Ex. 9). Notwithstanding the considerable time gap between May 1996 PCE and the January 1997 Order on Reconsideration, we find the PCE results regarding claimant's ability to repetitively use his right hand more probative than the findings of the medical arbiters because of the nature of this particular function. In other words, the PCE evaluators had the opportunity to measure the objective effects of repetitive use during the course of a lengthy physical capacities examination.



In the Matter of the Compensation of
**RANDY D. JACKSON, Claimant**
WCB Case No. 96-11252
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
Steve T. Maher, Defense Attorney

Reviewed by Board Members Hall, Bock, and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that: (1) declined to award temporary disability benefits for the period beginning December 16, 1996; and (2) declined to award a penalty based on the insurer's failure to pay those benefits. On review, the issues are temporary disability and penalties. We reverse.

FINDINGS OF FACT

Claimant suffered a twisting traction-type injury to his left upper extremity on February 26, 1996. His initial diagnosis was a strain of the left trapezius, deltoids, and brachioracialis muscles. About a month later, Dr. Adams added a left wrist strain diagnosis. By May 1, 1996, left carpal tunnel syndrome was also diagnosed. By February 1997, left shoulder adhesive capsulitis was suspected. (Ex. 34A; see Exs. 30B, 32).

Dr. Stoessl, treating physician, released claimant to his regular work as of June 17, 1996. Claimant did not return to work.

On August 15, 1996, Dr. Stoessl concurred with an examining physician's opinion that claimant's left shoulder and elbow strain conditions were medically stationary.

On December 9, 1996, the insurer accepted claimant's left shoulder, elbow and wrist strains.

On December 16, 1996, Dr. Stoessl examined claimant for chronic left arm and elbow symptoms and wrote a note indicating that claimant had "not been released to work yet." (Ex. 29-2). The same day, claimant's counsel wrote to the insurer, requesting commencement of time loss benefits, enclosing Dr. Stoessl's note. (Ex. 29-1).

The insurer did not pay time loss compensation for the period beginning December 16, 1996.

Claimant's February 26, 1996 injury claim remained open as of December 16, 1996.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant was not entitled to the requested temporary disability benefits, because claimant was medically stationary on August 15, 1996, he remained medically stationary thereafter, and his inability to work beginning December 16, 1996 was not injury-related. We disagree.

We first note that the insurer's opinion as to claimant's alleged medically stationary status while the claim is open is not relevant to the claim for temporary disability.[1] In addition, because there is no contention that claimant's previous temporary disability benefits were improperly terminated, the provisions of ORS 656.268(3) are inapplicable.[2]

The sole issue in this case is whether claimant is entitled to resumption of temporary disability under his open claim, based on information received by the insurer after December 16, 1996. We conclude that the answer is yes.

A worker whose temporary disability has been properly terminated becomes procedurally entitled to resumption of temporary total disability payments if, prior to claim closure, the attending physician again authorizes time loss. See Rodgers v. Weyerhaeuser Company, 88 Or App 458, 460 (1987); Robert L. Fawcett, 47 Van Natta 139, 140 (1995); Robert D. Gudge, 42 Van Natta 812 (1990); see also Doris S. Klager, 44 Van Natta 982, 986 (1992) (Although the claimant was not procedurally entitled to temporary disability while her claim was open and she was released to regular work, she was entitled to resumption of temporary disability thereafter, when her doctor released her from work again while the claim remained open).

Claimant's compensable conditions involve his left upper extremity, specifically his left shoulder, elbow and wrist. Various diagnoses have been considered since the February 1996 traction injury. However, carpal tunnel syndrome (CTS) and adhesive capsulitis are the only diagnoses/conditions which have not been accepted and directly related to the compensable injury by examining and treating physicians alike at all times relevant to this claim. (See Exs. 32-1, 34A; see also Exs. 23, 30B). With this background in mind, we evaluate claimant's entitlement to temporary disability.

On December 16, 1996, Dr. Stoessl, treating physician, examined claimant for "chronic pain, inflammation and decreased range of motion in the left arm and elbow," noting that claimant's injury had involved his left shoulder and elbow. (Ex. 25A). He reported that claimant had "vastly decreased range of motion in the arm, elbow and shoulder" and referred to claimant's "on-the-job-injury claim" as "recently reopened." (Id). Dr. Stoessl also authored a "prescription" which stated that claimant "has not been released to work yet." (Ex. 29-2). The same day, claimant's counsel wrote to the insurer requesting commencement of time loss benefits, enclosing a copy of Dr. Stoessl's "off work" note. (Ex. 29-1). Claimant did not work thereafter. (See Exs. 33A, 34A).

In our view, Dr. Stoessl's December 16, 1996 chart and prescription notes establish that claimant's contemporaneous inability to work resulted from his ongoing left upper extremity problems and these problems are primarily (if not solely) injury-related.[3] Under these circumstances, we find that claimant has established entitlement to resumed temporary disability compensation for the period beginning December 16, 1996.

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[1] "Medically stationary" status is first determined upon claim closure, not before. See Rodger M. Hanson, 41 Van Natta 1744, 1746 (1989) (The issue of whether claimant was medically stationary was not ripe at the time of the hearing because the claim was open and ORS 656.268(2) & (3) required the insurer to either obtain a Determination Order or issue a Notice of Closure before the authority of the Hearings Division could be invoked to determine the effective date that claimant became medically stationary.); see also Lindon E. Lewis, 46 Van Natta 237, 239 (1994) ("The closure order determines a worker's entitlement to temporary benefits through the date of claim closure, including a determination of claimant's medically stationary date.").

[2] The insurer argues that entitlement to temporary disability benefits ceases once a claimant became medically stationary, citing Lebanon Plywood v. Seiber, 113 Or App 651 (1992) and Benjamin G. Santos, 48 Van Natta 1516, 1517 n.2 (1996). However, because neither of these cases addressed a claim for resumed temporary disability while the claim is open, they are neither controlling nor instructive.

[3] Regardless of whether the material or major contributing cause standard applies, claimant's temporary disability is attributable to his compensable injury.

Penalties may be assessed when a carrier "unreasonably delays or unreasonable refuses to pay compensation." ORS 656.262(11)(a). The reasonableness of a carrier's delay or refusal must be gauged based upon the information available to the carrier at the time of the conduct. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988); Price v. SAIF, 73 Or App 123, 126 n.3 (1985). A carrier's "refusal to pay is not unreasonable if it has a legitimate doubt about its liability." International Paper Co. v. Huntley, 106 Or App 107, 110 (1991) (citing Castle & Cook, Inc. v. Porras, 103 Or App (1990)).

Here, the insurer contends that it had a legitimate doubt concerning its liability for temporary disability compensation, because claimant's disability on and after December 16, 1996 could have resulted from causes other than the compensable injury. However, we find no evidence suggesting that possibility. Under these circumstances, in the absence of evidence supporting a legitimate doubt, we conclude that the insurer's failure to pay temporary disability benefits was unreasonable and a penalty is appropriate. See Carolyn S. Farmer, 45 Van Natta 839 (1993) (The insurer cannot have a legitimate doubt based on lack of knowledge of facts that would have been disclosed by a reasonable investigation); Kenneth A. Foster, 44 Van Natta 148, aff'd mem SAIF v. Foster, 117 Or App 543 (1992).

ORDER

The ALJ's order dated April 11, 1997, as reconsidered May 6, 1997, is reversed. The insurer is directed to pay temporary disability benefits for the period beginning December 16, 1996 until termination is authorized by law. Claimant's attorney is awarded 25 percent of increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney. The insurer is also directed to pay a penalty equal to 25 percent of temporary disability due for the period beginning December 16, 1996, to be divided equally between claimant and his attorney.

**Board Member Moller dissenting.**

The majority holds that claimant is entitled to temporary disability, based on Dr. Stoessl's December 16, 1996 chart note which stated that claimant had "not been released to work yet." (Ex. 22). The ALJ found the record insufficient to establish that claimant's December 16, 1996 off-work status was the result of the compensable injury, considering claimant's non-work conditions and his substantial functional interference. I would find that claimant is not entitled to temporary disability for the reasons set forth by the ALJ. Moreover, regardless of the entitlement issue, I would find that the insurer had a legitimate doubt regarding its liability for temporary disability on this record and conclude that penalties are therefore inappropriate. For these reasons, I must respectfully dissent.

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January 7, 1998 Cite as 50 Van Natta 27 (1998)

In the Matter of the Compensation of
**JAMES D. ORTNER, Claimant**
Own Motion No. 96-0543M
OWN MOTION ORDER
Welch, Bruun, et al, Claimant Attorneys

Johnston & Culberson initially submitted claimant's request for temporary disability compensation for his compensable right knee pain, right medial meniscus injury. Claimant's aggravation rights on that claim expired on January 19, 1993.

Johnston & Culberson denied the responsibility for claimant's current right knee strain condition. Claimant requested a hearing. (WCB Case No. 97-00996). Thereafter, the Board received a request for consent to issue an order designating a paying agent pursuant to ORS 656.307. On February 14, 1997, the Board issued an Interim Own Motion Order Consenting to the Designation of a Paying Agent (ORS 656.307). The Board received a Motion for Abatement/Reconsideration of Interim Order on March 3, 1997 from Johnston & Culberson. On March 11, 1997, the Board issued a Second Interim Own Motion Order Consenting to Designation of Paying Agent Under ORS 656.307, which adhered to and republished our February 14, 1997, order in its entirety. On May 13, 1997, the Board postponed action on the own motion matter pending resolution of that litigation

On May 6, 1997, Administrative Law Judge (ALJ) Neal set aside Johnston & Culberson's January 14, 1997, denial which denied responsibility for claimant's current condition. Johnston & Culberson

requested Board review of the ALJ's order, and, by an order issued on today's date, the Board reversed that portion of the ALJ's order which found Johnston & Culberson responsible, and found SAIF responsible for claimant's current compensable condition under his 1974 injury claim.

Under ORS 656.278(1)(a), we may exercise our own motion authority to reopen a claim for additional temporary disability compensation when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization.

Here, the current condition for which claimant requests own motion relief, remains in denied status, and is the responsibility of SAIF. As a result, we are not authorized to grant claimant's request for own motion relief under his 1987 injury claim with Johnston & Culberson. See Id.

Accordingly, claimant's request for own motion relief in his 1987 claim is denied.

IT IS SO ORDERED.

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January 7, 1998 Cite as 50 Van Natta 28 (1998)

In the Matter of the Compensation of
**JAMES D. ORTNER, Claimant**
Own Motion No. 96-0544M
OWN MOTION ORDER
Welch, Bruun, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation initially submitted claimant's request for temporary disability compensation for his compensable right knee strain injury. Claimant's aggravation rights on that claim expired on March 24, 1981.

SAIF denied the responsibility for claimant's current right knee strain condition. Claimant requested a hearing. (WCB Case No. 97-00893). Thereafter, the Board received a request for consent to issue an order designating a paying agent pursuant to ORS 656.307. On February 14, 1997, the Board issued an Interim Own Motion Order Consenting to the Designation of a Paying Agent (ORS 656.307). The Board received a Motion for Abatement/Reconsideration of Interim Order on March 3, 1997 from Johnston & Culberson. On March 11, 1997, the Board issued a Second Interim Own Motion Order Consenting to Designation of Paying Agent Under ORS 656.307, which adhered to and republished our February 14, 1997, order in its entirety. On May 13, 1997, the Board postponed action on the own motion matter pending resolution of that litigation

On May 6, 1997, Administrative Law Judge (ALJ) Neal upheld that portion of SAIF's December 19, 1996 denial which denied responsibility for claimant's current condition, and found Johnston & Culberson responsible. Johnston & Culberson requested Board review of the ALJ's order, and, by an order issued on today's date, the Board reversed that portion of the ALJ's order which found Johnston & Culberson responsible. The Board also found SAIF responsible for claimant's current compensable condition under his 1974 injury claim.

Under ORS 656.278(1)(a), we may exercise our own motion authority to reopen a claim for additional temporary disability compensation when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization.

On November 5, 1996, Dr. Wyman, claimant's treating physician, recommended claimant undergo total knee surgery. Thus, we are persuaded that claimant's compensable injury worsened requiring surgery.

Accordingly, we authorize the reopening of claimant's 1974 injury claim with SAIF to provide temporary disability compensation beginning the date claimant was hospitalized for the 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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In the Matter of the Compensation of
**JAMES D. ORTNER, Claimant**
WCB Case Nos. 97-00996 & 97-00893
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Thaddeus J. Hettle, Defense Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

Tri-Met, Inc., as a self-insured employer, requests review of Administrative Law Judge (ALJ) Neal's order[1] that: (1) set aside its denial of responsibility of claimant's right knee condition; and (2) upheld the SAIF Corporation's denial of responsibility for the same condition. On review, the issue is responsibility. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" and provide a summary of those facts.

Claimant works as a bus driver for the employer. In 1974, SAIF, the carrier for the employer at that time, accepted a claim for right knee sprain/strain. (Ex. 2). Claimant subsequently underwent an open arthrotomy and lateral meniscectomy. In 1987, while self-insured, the employer accepted a claim for "right knee pain." (Ex. 21A). Claimant underwent arthroscopic surgery on a torn medial meniscus.

In October 1996, claimant filed claims for the 1974 and 1987 injuries. In November 1996, claimant underwent a third right knee surgery. The employer and SAIF denied responsibility for claimant's right knee condition. In February 1997, the Director issued an order pursuant to ORS 656.307(1) designating SAIF as the paying agent.

## CONCLUSIONS OF LAW AND OPINION

Although finding that the employer was not precluded from denying responsibility under Georgia-Pacific v. Piwowar, 305 Or 494 (1988), the ALJ concluded that the employer was precluded from doing so pursuant to Deluxe Cabinet Works v. Messmer, 140 Or App 548, rev den 324 Or 305 (1996). Consequently, the ALJ found the employer responsible for claimant's current knee condition. The ALJ also noted that the employer "might have successfully rebutted the presumption" of responsibility established under Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1983), and Raymond H. Timmel, 47 Van Natta 31 (1995).

The employer challenges the ALJ's order, first contending that, because the current version of ORS 656.262(10) effectively overruled the court's holding in Messmer, it is not precluded on this basis from denying responsibility. The employer further challenges the Board's analysis in Timmel and also asserts that it successfully rebutted the "Kearns presumption."

After the ALJ's order issued, the 1997 legislature amended ORS 656.262(10). Or Laws 1997, ch. 605, § 1. As amended, the statute now provides:

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[1] We note that the caption of the ALJ's order identifies it as an "Arbitration Order." Under former ORS 656.307(2), an ALJ acted as an "arbitrator" and conducted an "arbitration proceeding" when parties litigated an order issued under subsection (1). That law was amended in 1995, however, and now provides that an ALJ conducts such proceedings "in the same manner as any other hearing * * * pursuant to ORS 656.295[.]" Or Laws 1995, ch 332, § 36(2).

> "Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability, nor shall mere acceptance of such compensation be considered a waiver of the right to question the amount thereof. Payment of permanent disability benefits pursuant to a determination order, notice of closure, reconsideration order or litigation order or the failure to appeal or seek review of such an order or notice of closure shall not preclude an insurer or self-insured employer from subsequently contesting the compensability of the condition rated therein, unless the condition has been formally accepted." (Emphasis added).[2]

In Keith Topits, 49 Van Natta 1538 (1997), we concluded that the newly amended statute effectively overruled the Messmer decisions. Specifically, we held that a carrier's failure to appeal a prior Order on Reconsideration permanent disability award based on an unaccepted condition did not preclude the carrier from subsequently contesting the compensability of the condition. Consequently, whether or not the employer awarded permanent disability for claimant's current condition, it is not precluded from now denying it under the Messmer rationale.

We next address whether the employer is precluded from denying responsibility under Piwowar. In that case, the carrier accepted a claim for a "sore back." Subsequent medical evidence showed that a preexisting disease (ankylosing spondylitis) caused the sore back, and the carrier denied compensability of that condition. The Supreme Court explained that an employer is required "to compensate the claimant for the specific condition in the notice of acceptance regardless of the cause of that condition." 305 Or at 501. In other words, the cause of the original injury does not determine the scope of the employer's acceptance. Instead, "the scope of acceptance corresponds to the condition specified in the acceptance notice[.]" Id. The Court then concluded that, because the carrier had accepted a claim for a symptom of the underlying disease, and not a separate condition, its denial of the preexisting condition constituted a "back-up" denial. Id.

Here, the record shows that the condition for which claimant received medical treatment in 1996 was arthritis in the lateral compartment of the right knee. (Exs. 38-3, 39, 59-2). Thus, we examine whether the employer's acceptance of "right knee pain" in 1987 encompassed the arthritis condition.

The record shows that claimant was treated for a knee strain and medial meniscus tear following the 1987 injury. (Exs. 17, 19). After the employer issued its acceptance, claimant's treating surgeon reported that claimant's "pre-existing degenerative changes in his knee [] do not [] in any way materially contribute to his injury of April 14, 1987[.]" (Ex. 22). Because this evidence shows that arthritis (or degenerative disease) did not cause claimant's "right knee pain," we conclude that the employer's acceptance did not encompass the underlying condition. Piwowar, 305 Or at 501. Thus, the employer's denial does not constitute a "back-up" denial.

We turn to the application of the "Kearns presumption." In Kearns, the court examined responsibility in the context of successive accepted injuries involving the same body part. The court held that there was a rebuttable presumption that the last carrier with an accepted claim remains responsible for subsequent conditions involving the same body part. 70 Or App at 585-87. As we discussed in Raymond H. Timmel, encompassed in the "Kearns presumption" is the "last injury rule," which fixes responsibility based on the last injury to have independently contributed to the claimant's current condition. 47 Van Natta at 31. The carrier with the last accepted injury can rebut the "Kearns presumption" by establishing that there is no causal connection between the claimant's current condition and the last accepted injury. 70 Or App at 588. In Timmel, we decided that the enactment of former ORS 656.308(1)[3] did not overrule Kearns and, where a claimant has several accepted claims for injuries

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[2] Section 2 provides that the amendments to ORS 656.262 by section 1 of the Act "apply to all claims or causes of action existing or arising on or after the effective date of this Act, regardless of the date of injury or the date a claim is presented, and this Act is intended to be fully retroactive." Or Laws 1997, ch. 605, § 2. Thus, amended ORS 656.262(10) is fully retroactive and applies to this claim. See Bay Area Hospital v. Landers, 150 Or App 154, 157 (1997).

[3] That statute provided:

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

involving the same body part, but not the same condition as that for which the claimant currently seeks compensation, Kearns remained valid law. 47 Van Natta at 32.

In this case, as stated above, claimant has two successive injuries to the same body part (right knee) but the condition for which he currently seeks compensation (arthritis of the lateral compartment) is different from his prior injuries (right knee strain/sprain, right knee pain). Dr. Lee, osteopath, began treating claimant in November 1994. He stated that claimant's "[r]ight knee pain related to [his] initial injury in 1975." (Ex. 37).

Dr. Marble, examining orthopedic surgeon, diagnosed "[p]ost-traumatic arthritis right knee" and reported that the "major factor" was the "1975 injury since it consisted of an open lateral meniscectomy" and such a procedure "is associated with a more rapid progression of post-traumatic arthritis than a partial medical meniscectomy." (Ex. 38-4). Dr. Marble also indicated that claimant's surgery in 1987 "did aggravate the pre-existing problem[.]" (Id.) Dr. Lee concurred with Dr. Marble's report.

Dr. Wyman, orthopedic surgeon, saw claimant at Dr. Lee's request. Dr. Wyman found that claimant's condition was "end stage arthritis directly as a result of an on the job lateral meniscus injury with total open lateral meniscectomy." (Ex. 47-2). Dr. Wyman further stated that claimant required a "total knee arthroplasty" and that such need "is directly related to his on the job injury." (Id.)

After Dr. Wyman performed the recommended surgery, he concurred with a "check-the-box" report from the employer's attorney stating that he had reviewed claimant's prior medical record and that claimant's "right knee condition and resultant need for treatment for a full knee replacement was 'wholly due' to the 1974 injury." (Ex. 59-2). The report further stated that "the 1987 industrial injury did not contribute to [claimant's] right knee condition for which you performed a full knee replacement" and that Dr. Wyman based his opinion on "the injury sustained in 1974; the open type of surgery performed in 1975; and claimant's 'end stage arthritis' being located in the lateral compartment of the right knee, the same location as the 1974 lateral torn meniscus." (Id. at 2-3) (emphasis in original).

After evaluating the medical opinions, we find Dr. Wyman's to be most persuasive. First, Dr. Wyman treated claimant and performed the surgery, in contrast to Dr. Marble, who saw claimant one time, and Dr. Lee, who concurred with Dr. Marble's opinion. See Argonaut Insurance Company, 93 Or App 698 (1988); Weiland v. SAIF, 64 Or App 810 (1983). Furthermore, Dr. Wyman explained the basis for his opinion and relied on an accurate understanding of claimant's history. See Somers v. SAIF, 77 Or App 259 (1986).

Relying on Dr. Wyman's opinion, we find that claimant's current condition is caused by the 1975 injury with no contribution from the 1987 injury. Consequently, the employer successively rebutted the "Kearns presumption" by establishing that there is no causal connection between the claimant's current condition and its last accepted injury. 70 Or App at 588. Consequently, SAIF, as the carrier for the 1974 injury, is responsible for claimant's current need for treatment and disability.

Finally, we note that claimant's attorney submitted a statement of services (SOS) requesting a fee of $1,000 for services on review. Such a fee is not available under ORS 656.307(5). See Lynda C. Prociw, 46 Van Natta 1875 (1994). Claimant could be awarded an assessed attorney fee for services on review pursuant to ORS 656.382(2) if our order results in no disallowance or reduction in compensation. Id. Inasmuch as claimant's aggravation rights under both claims have expired, no temporary disability is at risk in this proceeding. Thus, the record does not establish that claimant's compensation is at risk. Under such circumstances, claimant is not entitled to an attorney fee under ORS 656.382(2). See Paul J. LaFrance, 45 Van Natta 1991 (1993). Moreover, the record shows that claimant's temporary disability rate was lower under SAIF's claim than the employer's claim. (See Ex. 57). Consequently, because our order finds SAIF responsible, we find that our order results in a reduction in compensation and claimant is not entitled to an attorney fee for services on review.

## ORDER

The ALJ's order dated May 6, 1997 is reversed. The self-insured employer's denial of responsibility is reinstated and upheld. The SAIF Corporation's denial of responsibility is set aside and the claim is remanded to SAIF for processing according to law. SAIF also is liable for the ALJ's attorney fee award.

In the Matter of the Compensation of
**JANE M. SPENCER, Claimant**
WCB Case No. 97-01486
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Peterson's order that awarded an assessed attorney fee under ORS 656.382(1). On review, the issue is entitlement to attorney fees. We reverse.

## FINDINGS OF FACT

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

## CONCLUSIONS OF LAW AND OPINION

In August 1996, the insurer accepted a claim for "mild cervical and left shoulder strain/contusion." In January 1997, claimant's attorney wrote to the insurer requesting that the condition of left shoulder tendonitis also be accepted. In February 1997, claimant requested a hearing concerning a "de facto" denial of left shoulder tendonitis. The insurer then accepted the left shoulder tendonitis condition immediately before the commencement of the hearing. The insurer had paid all compensation due, including benefits for the left shoulder tendonitis condition.

Claimant proceeded to hearing, asserting that she was entitled to an assessed attorney fee. Although deciding that claimant was not entitled to an attorney fee under ORS 656.386(1), the ALJ concluded that claimant should be awarded a fee under ORS 656.382(1).

ORS 656.382(1) in part provides that, when a carrier "unreasonably resists the payment of compensation," the carrier shall pay a reasonable attorney fee to the claimant's attorney. As the court explained in SAIF v. Condon, 119 Or App 194, 196, rev den 317 Or 163 (1993), a carrier cannot unreasonably resist the payment of compensation that has been paid. In such a situation, therefore, the award of an attorney fee under ORS 656.382(1) is "wrong as a matter of law." 119 Or App at 196.

Here, because the insurer paid compensation, ORS 656.382(1) is not a basis for awarding an assessed attorney fee.[1] Consequently, we reverse the ALJ's award of an assessed attorney fee.

## ORDER

The ALJ's order dated May 16, 1997 is reversed. The ALJ's attorney fee award is reversed.

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[1] Based on the insurer's payment of compensation, we find this case distinguishable from Gustavo Cantu-Rodriguez, 46 Van Natta 1801 (1994), which the ALJ relied on in awarding an assessed attorney fee under ORS 656.382(1).

In the Matter of the Compensation of
**ROLLIN R. BRADFORD, Claimant**
WCB Case Nos. 96-02027 & 96-01849
ORDER ON REVIEW
Thomas C. Howser, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) directed SAIF to pay claimant's counsel's costs relating to the deposition of Dr. Courash; (2) set aside SAIF's denial of claimant's aggravation claim for a right ankle condition; and (3) upheld Sedgwick James & Company's denial of claimant's "new injury" claim for the same condition. On review, the issues are attorney costs, compensability and responsibility. We reverse in part and affirm in part.

## FINDINGS OF FACT

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

## CONCLUSIONS OF LAW AND OPINION

### Attorney Costs

The ALJ directed SAIF to pay for claimant's counsel's travel costs for attending the deposition of Dr. Curoush in Portland. We disagree.

The Board is authorized to award a fee payable to an attorney for legal services. See ORS 438-015-0005(4). An attorney's preparation for, travel to, and attendance at a deposition represents hours of legal services rendered on behalf of a party and that time is considered in awarding a reasonable attorney fee. See Marilyn M. Keener, 49 Van Natta 110 (1997). However, costs incurred by an attorney in pursuing a matter on a party's behalf are not amounts that the Board or Hearings Division can authorize an opposing party to pay. See Tom Goodpaster, 46 Van Natta 936 (1994); Jeffrey P. Keimig, 41 Van Natta 1486 (1986).

Here, the costs awarded by the ALJ represent lodging, meal, and mileage expenses incurred by claimant's counsel in attending the deposition of Dr. Courash. (Ex. 76). As noted above, there is no authority by which a party may be awarded such costs. Marilyn M. Keener, 49 Van Natta at 113. Accordingly, we reverse the ALJ's award of costs to claimant's counsel.

### Compensability/Responsibility

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

Claimant's attorney is entitled to an assessed fee for services on review concerning the denial issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the denial issue is $1,500, payable by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We have not considered the time devoted to the attorney costs issue.

## ORDER

The ALJ's order dated June 19, 1997 is reversed in part and affirmed in part. That portion of the ALJ's order which directed SAIF to pay claimant's counsel $101.72 for expenses is reversed. The remainder of the order is affirmed. For services on review, claimant's counsel is awarded $1,500 as a reasonable attorney fee, payable by the SAIF Corporation.

In the Matter of the Compensation of
**GARY W. HOLMES, Claimant**
Own Motion No. 950441M
OWN MOTION ORDER
Glenn M. Feest, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation initially submitted claimant's request for temporary disability compensation for his compensable low back strain injury. Claimant's aggravation rights expired on December 27, 1979.

SAIF opposed reopening of claimant's claim for the payment of temporary disability compensation, contending that: (1) claimant's current L3-4 and L4-5 instability and stenosis was not causally related to his compensable injury; (2) it was not responsible for claimant's current condition; and (3) surgery or hospitalization was not reasonable and necessary for claimant's compensable injury. In addition, on August 29, 1995, SAIF issued a partial denial that denied claimant's current L3-4 and L4-5 instability and stenosis conditions. Claimant requested a hearing. (WCB Case No. 95-10941). As a result of the pending litigation, we postponed action on the own motion matter on October 31, 1995.

On December 20, 1996, Administrative Law Judge (ALJ) Menashe upheld SAIF's August 29, 1995 denial. Claimant requested review, contending that, by virtue of a March 14, 1988 stipulation, SAIF had accepted low back conditions which were the major contributing cause of his need for treatment in 1995. By order dated July 18, 1997, the Board found the March 14, 1988 stipulation ambiguous as a matter of law and the record insufficient to determine the parties' intentions regarding what conditions were accepted by the stipulation. Consequently, the Board vacated ALJ Menashe's December 20, 1996 order and remanded the case to ALJ Menashe with instructions to allow both parties the opportunity to submit additional evidence to explain what they intended with the stipulation.

By Opinion and Order on Remand dated November 7, 1997, ALJ Menashe found that, via the March 14, 1988 stipulation, SAIF had accepted claimant's L4-5 instability and the discopathy at L4-5. The ALJ further found that the major contributing cause of claimant's need for treatment in 1995 was the accepted L4-5 instability. Therefore, the ALJ set aside SAIF's August 29, 1995 denial. That order was not appealed and has become final by operation of law. The pending litigation having been resolved, we proceed with our determination of the own motion matter.

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

On November 15, 1995, claimant underwent a decompressive laminectomy at L3, L4, and L5. As discussed above, this treatment has been found compensably related to the accepted injury. Thus, we are persuaded that claimant's compensable injury has worsened requiring surgery. In addition, 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, SAIF agrees that claimant was in the work force at the time of disability. (December 23, 1997 letter from SAIF).

Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning November 15, 1995, the date claimant 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
**DORIS KELSCH, Claimant**
WCB Case No. C703233
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Robert Guarrasi, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

On December 23, 1997, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for her compensable injury. We approve the proposed disposition.

The first page of the proposed disposition agreement provides that the total due claimant is $12,525 and the total due claimant's attorney is $3,475, for a total consideration of $16,000. However, on page 2, line 23, the total consideration has been omitted. Thus, based on the first page of the document, we correct page 2, line 23 of the agreement to reflect that the total consideration is $16,000.

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. See ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved. An attorney fee of $3,475, 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
**BRADLEY R. PIERCE, Claimant**
WCB Case No. C703066
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Jolles, et al, Attorneys

Reviewed by Board Members Biehl and Bock.

On December 8, 1997, the Board acknowledged receipt of the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for his compensable injury. We approve the proposed disposition.

The first page of the proposed CDA indicates that claimant is making a full release of "permanent disability including aggravations" and vocational assistance. The body of the CDA does not contain a provision confirming the type of release (full or partial) or the type of benefits released. The agreement provides only that claimant retains his rights to medical services. Therefore, based on the first page of the document, we interpret the agreement as providing that only permanent disability, including aggravation, and vocational assistance benefits are fully released. All other benefits are retained.

The agreement, as interpreted herein, is in accordance with the terms and conditions prescribed by the Board. See ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
**RICHARD T. SHERMAN, Claimant**
Own Motion No. 66-0448M
OWN MOTION ORDER OF ABATEMENT
Welch, Bruun, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our September 19, 1997 Own Motion Order, as reconsidered on December 24, 1997, in which we ultimately declined to authorize reopening his 1962 low back injury claim for medical services and temporary disability benefits. Claimant requests that we abate our prior orders and allow him 30 days to gather additional medical information to support his position.

In our September 19, 1997 order, we authorized reopening of claimant's 1962 claim for the requested medical services and payment of temporary disability compensation. Subsequently, the SAIF Corporation requested reconsideration of that order. With its request for reconsideration, SAIF submitted additional medical evidence consisting of a copy of the operative report for claimant's December 6, 1962 L4-5 disc surgery and a copy of a December 16, 1996 report from Dr. Malos, the surgeon who performed claimant's January 3, 1997 low back surgery. On October 17, 1997, we abated our order and granted claimant an opportunity to respond to SAIF's motion. On December 24, 1997, after receiving claimant's response and reconsidering the record, we issued our Own Motion Order on Reconsideration in place of our initial order and found that claimant failed to meet his burden of proving his current low back condition which required surgery was causally related to his compensable 1962 low back injury claim. Consequently, we declined to reopen his claim for medical services and temporary disability.

In his current request for reconsideration, claimant contends that we changed our decision based on identical medical evidence. We disagree. As noted above, with its request for reconsideration, SAIF submitted additional medical evidence regarding claimant's medical condition at the time of his 1962 surgery and his condition at the end of 1996, just prior to his January 3, 1997 surgery.

Nevertheless, because more than 30 years passed between claimant's low back surgeries, the medical causation issue in this case is a complex one which must be resolved on the basis of expert medical evidence. Additional medical evidence may further clarify the medical causation issue. Therefore, we grant claimant's request and abate our prior orders. We implement the following supplemental evidence and briefing schedule.

Claimant's opening submission shall be due 30 days from the date of this order. The insurer's responding submission shall be due within 30 days from the date of mailing of claimant's submission. Claimant's reply shall be due 14 days from the date of mailing of the insurer's response. Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
**WARREN G. THOMSON, Claimant**
Own Motion No. 66-0315M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

On November 19, 1997, the SAIF Corporation submitted claimant's request for medical benefits relating to his compensable June 4, 1957 injury claim. This claim was accepted for severe contusions to the left shoulder, left neck musculature and skull and ultimately resulted in claimant undergoing spinal fusion at L5-S1. SAIF recommends against the payment of the requested benefits on the ground that claimant's need for treatment was not related to the compensable injury.

Inasmuch as claimant sustained a compensable industrial injury prior to January 1, 1966, he does not have a lifetime right to medical benefits pursuant to ORS 656.245. William A. Newell, 35 Van Natta 629 (1983). However, for conditions resulting from a compensable injury occurring before January 1, 1966, the Board may authorize the payment of medical services. See ORS 656.278(1)(b). Claimant has the burden of proving that the requested medical services are causally related to the compensable injury. ORS 656.266; OAR 438-012-0037.

By letter dated December 1, 1997, we advised claimant of his burden of proof and requested his response within 14 days. The time allowed for response has passed and no response has been received from claimant. Therefore, we proceed with our review.

On June 30, 1997, claimant underwent low back surgery performed by Dr. Hubbard and consisting of left L2-3 partial hemilaminectomies, partial foraminotomy over L3 root, and removal of extruded disc herniation. (Operative report dated June 30, 1997). Dr. Hubbard provides the only evidence in the record regarding the cause of claimant's need for that surgery. Dr. Hubbard states that he "cannot relate claimant's current need for surgery to his old fusion treatment." (Letter from Dr. Hubbard dated October 27, 1997). Instead, Dr. Hubbard opined that "the major contributing cause of [claimant's] need for surgery was that of spontaneous degenerative disc disease, no obvious trauma or other accident intervened by history." Id.

Based on Dr. Hubbard's unrebutted opinion, we find that claimant has failed to prove that his June 1997 low back surgery is causally related to his June 1957 work injury. Accordingly, claimant's request to reopen his claim for medical services allegedly related to the 1957 work injury is denied. We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
**PHYLLIS J. WOODS, Claimant**
WCB Case No. 96-02347
ORDER ON REVIEW (REMANDING)
W. Todd Westmoreland, Claimant Attorney
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Spangler's order that: (1) declined to postpone claimant's scheduled hearing to compel claimant to attend a "post-denial" medical examination; and (2) set aside SAIF's denial of claimant's current low back condition. On review, the issues are postponement and compensability. We vacate and remand.

## FINDINGS OF FACT

We adopt the "Stipulated Facts" and "Findings of Fact" as set forth in the ALJ's order with the following supplementation.

On December 19, 1995, Dr. Grewe, claimant's treating physician, responded to an inquiry by SAIF stating that claimant's current complaints were not related to the 1975 compensable injury or resulting fusion surgery. By letter dated January 15, 1996, SAIF denied claimant's current low back condition.

In early March 1996, claimant requested a hearing contesting SAIF's denial. The hearing was initially scheduled for May 15, 1996, but was subsequently postponed when claimant was unable to attend due to illness. The hearing was rescheduled for November 13, 1996.

Dr. Grewe treated claimant with steroid injections which reduced claimant's symptoms. By letter dated September 5, 1996, Dr. Grewe reported that claimant's current low back symptoms were at the site of the bone removal that was used to perform the compensable 1977 fusion surgery.

By letter dated September 24, 1996, SAIF informed claimant that it had scheduled a medical examination for October 11, 1996. On October 8, 1996, claimant's counsel informed SAIF that claimant would not attend the October 11, 1996 medical examination on the basis that it was referred to as a "closing examination" and also because SAIF had denied claimant's current condition.

Thereafter, SAIF requested the Compliance Section of the Workers' Compensation Division to suspend claimant's compensation for failure to attend the October 11, 1996 medical examination. By order dated October 18, 1996, the Compliance Section denied SAIF's request on the basis that its notification letter to claimant was technically flawed.

By letter dated October 23, 1996, SAIF notified claimant that the medical examination had been rescheduled for November 12, 1996. On November 8, 1996, claimant's counsel informed SAIF that claimant would not attend the rescheduled medical examination because her claim was in denied status.

## CONCLUSIONS OF LAW AND OPINION

Prior to the scheduled hearing, SAIF moved for postponement until claimant attended the insurer-arranged medical examination (IME). The ALJ found that since claimant's claim had been denied, she was not obligated under ORS 656.325(1) to attend the requested IME. Because claimant was not obligated to attend the IME, the ALJ concluded that there was no basis to postpone the hearing and denied SAIF's motion. We disagree.

Subsequent to the ALJ's order, we issued our decision in Ronald C. Fuller, 49 Van Natta 2067 (1997). There, we held that a carrier's motion to postpone a hearing should have been granted because the claimant refused to attend a "post-denial" IME. Between the issuance of the carrier's aggravation denial and the convening of the scheduled hearing, the carrier made arrangements for an IME. When the claimant refused to attend the "post-denial" IME, the carrier moved for postponement of the hearing. The ALJ denied the motion, held the hearing, and set aside the carrier's denial. The carrier requested Board review, contending that extraordinary circumstances beyond its control justified postponement of the hearing.

We agreed with the carrier's contention. Citing Ring v. Paper Distribution Services, 90 Or App 148 (1988), and Gary E. Frazier, 47 Van Natta 1313, on recon 47 Van Natta 1401, second recon 47 Van Natta 1508 (1995), we acknowledged that, when a claim has been denied, there is no compensation to be paid and, thus, no sanctions (i.e., there is no compensation for the Director to suspend) are available under ORS 656.325(1) for a claimant's failure to attend an IME. Nonetheless, as noted by the Ring court, we stated that a claimant's failure to attend an IME could result in dismissal of the claimant's hearing request if such a failure constituted an unjustified delay under its dismissal rules. Consistent with that rationale, we determined that a claimant's failure to attend a "post-denial" IME may be grounds for a postponement of a scheduled hearing under OAR 438-006-0081(4).

In reaching our conclusion, we found it unnecessary to decide whether the "investigation cooperation" requirements of ORS 656.262(14) were limited to "pre-denial" investigations. In doing so, we reasoned that, even if the statute was so limited, it did not affect the precedential authority of such "pre-262(14)" decisions as David M. Foote, 45 Van Natta 270 (1993), Myron E. Blake, 39 Van Natta 144 (1987), and Victoria Napier, 34 Van Natta 1042 (1982), which had granted postponements based on a claimant's failure to attend an IME. Consistent with "the modest level of cooperation" required by ORS 656.325(1), the statutory policy directive of ORS 656.012 to provide a "fair and just administrative system," and in the interests of achieving substantial justice under ORS 656.283(7), we continued to adhere to our long-standing holdings that a claimant's failure to attend a "post-denial" IME may be grounds for a postponement of a scheduled hearing.

Inasmuch as the sole basis for claimant's objection to the carrier's postponement motion was his position that he was not required to attend the IME, we vacated the ALJ's order and remanded with instructions to reconvene the hearing once claimant attended the IME. Because no other objection had been raised, we emphasized that, in the particular circumstances presented in Fuller, there was no need for the ALJ to determine whether the carrier had exercised due diligence in arranging for the IME. In this regard, we noted that, under OAR 438-006-0081(4), incomplete case preparation is not grounds for a postponement unless the ALJ finds that completion of the record could not be accomplished with due diligence.

Here, in addition to his contention that there was no statutory authority for a post-denial IME, claimant also challenged the timing and scheduling of the IME, as well as the reference to "closing examination" in SAIF's September 24, 1996 letter. OAR 438-006-0081(4) provides that incomplete case preparation is not grounds for a postponement unless the Administrative Law Judge finds that completion of the record could not be accomplished with due diligence. We interpret claimant's arguments as a contention that SAIF did not demonstrate "due diligence" under OAR 438-006-0081(4). Because the ALJ did not take evidence on whether SAIF exercised due diligence warranting a postponement, we find the record incompletely developed concerning this issue. Consequently, we conclude that remand is appropriate. ORS 656.295(5).

In light of our holding in Fuller, and because we find the record incompletely developed regarding whether due diligence has been established under OAR 438-006-0081(4) to justify a postponement, we vacate the ALJ's order and remand this case to ALJ Spangler. Accordingly, the ALJ's order dated December 12, 1996, as amended December 13, 1996 is vacated.

This matter is remanded to ALJ Spangler for further proceedings consistent with this order. These further proceedings may proceed in any manner that the ALJ deems achieves substantial justice. ORS 656.283(7). Specifically, the ALJ should reopen the record and take evidence regarding whether due diligence has been shown under OAR 438-006-0081(4), such that a postponement should be granted. If the ALJ finds that a postponement is not warranted, the ALJ shall issue a final appealable order addressing the issues. If the ALJ finds that a postponement is warranted, a hearing will presumably be rescheduled after claimant's attendance at a reasonably scheduled IME. Following the completion of the hearing and the closure of the record, the ALJ shall issue a final appealable order addressing the issues.

IT IS SO ORDERED.

In the Matter of the Compensation of
**LINDA K. DICKENSON, Claimant**
WCB Case No. 96-05441
ORDER ON REVIEW (REMANDING)
Welch, Bruun, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Moller and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Spangler's order that: (1) declined to postpone/continue claimant's scheduled hearing to compel claimant to attend a "post-denial" insurer-arranged medical examination; and (2) set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. On review, the issues are postponement and compensability. We vacate and remand.

## FINDINGS OF FACT

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

## CONCLUSIONS OF LAW AND OPINION

Prior to the scheduled hearing, SAIF moved for postponement until claimant attended the insurer-arranged medical examination (IME). The ALJ found that, because claimant's claim had been denied, she was not obligated under ORS 656.325(1) to attend the requested IME. After finding that claimant was not obligated to attend the IME, the ALJ concluded that there was no basis to postpone the hearing and denied SAIF's motion. We disagree.

Subsequent to the ALJ's order, we issued our decision in Ronald C. Fuller, 49 Van Natta 2067 (1997). There, we held that a carrier's motion to postpone a hearing should have been granted because the claimant refused to attend a "post-denial" IME. Between the issuance of the carrier's aggravation denial and the convening of the scheduled hearing, the carrier made arrangements for an IME. When the claimant refused to attend the "post-denial" IME, the carrier moved for postponement of the hearing. The ALJ denied the motion, held the hearing, and set aside the carrier's denial. The carrier requested Board review, contending that extraordinary circumstances beyond its control justified postponement of the hearing.

We agreed with the carrier's contention. Citing Ring v. Paper Distribution Services, 90 Or App 148 (1988), and Gary E. Frazier, 47 Van Natta 1313, on recon 47 Van Natta 1401, second recon 47 Van Natta 1508 (1995), we acknowledged that, when a claim has been denied, there is no compensation to be paid and, thus, no sanctions (i.e., there is no compensation for the Director to suspend) are available under ORS 656.325(1) for a claimant's failure to attend an IME. Nonetheless, as noted by the Ring court, we stated that a claimant's failure to attend an IME could result in dismissal of the claimant's hearing request if such a failure constituted an unjustified delay under its dismissal rules. Consistent with that rationale, we determined that a claimant's failure to attend a "post-denial" IME may be grounds for a postponement of a scheduled hearing under OAR 438-006-0081(4).

In reaching our conclusion, we found it unnecessary to decide whether the "investigation cooperation" requirements of ORS 656.262(14) were limited to "pre-denial" investigations. In doing so, we reasoned that, even if the statute was so limited, it did not affect the precedential authority of such "pre-262(14)" decisions as David M. Foote, 45 Van Natta 270 (1993), Myron E. Blake, 39 Van Natta 144 (1987), and Victoria Napier, 34 Van Natta 1042 (1982), which had granted postponements based on a claimant's failure to attend an IME. Consistent with "the modest level of cooperation" required by ORS 656.325(1), the statutory policy directive of ORS 656.012 to provide a "fair and just administrative system," and in the interests of achieving substantial justice under ORS 656.283(7), we continued to adhere to our long-standing holdings that a claimant's failure to attend a "post-denial" IME may be grounds for a postponement of a scheduled hearing.

Inasmuch as the sole basis for claimant's objection to the carrier's postponement motion was his position that he was not required to attend the IME, we vacated the ALJ's order and remanded with instructions to reconvene the hearing once claimant attended the IME. Because no other objection had been raised, we emphasized that, in that particular case, there was no need for the ALJ to determine whether the carrier had exercised due diligence in arranging for the IME. See OAR 438-006-0081(4).

In this case, as in Fuller, the sole basis for claimant's objection to SAIF's postponement motion is her position that she was not required to attend the IME.

Accordingly, ALJ's order dated November 13, 1996 is vacated. This matter is remanded to ALJ Spangler for further proceedings consistent with this order. Under these circumstances, the rescheduling of a hearing will presumably be conducted following claimant's attendance at a reasonably scheduled medical examination arranged by SAIF. In this regard, we note that claimant's failure to attend the insurer-arranged medical examination was based on his position that he was not statutorily required to attend pursuant to ORS 656.325(1). Inasmuch as no other objection to the examination was apparently raised, we do not find it necessary to have the ALJ take further evidence with regard to whether a postponement should be granted. In other words, under the particular facts of this case, there is no need for the ALJ to decide whether SAIF exercised due diligence under OAR 438-006-0081(4)[1] in order to be granted a postponement. Compare Sarah A. Strayer, 49 Van Natta 244 (1997) (record concerning dismissal of hearing request, for failure to attend a "post-denial" insurer-arranged medical examination, was incompletely developed where no documentary evidence, testimony, or stipulation of parties was admitted in record).

These further proceedings may proceed in any manner that the ALJ deems achieves substantial justice. Following the completion of the rescheduled hearing and the closure of the record, the ALJ shall issue a final appealable order addressing the matters that remain at issue.

IT IS SO ORDERED.

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[1] OAR 438-006-0081(4) provides that incomplete case preparation is not grounds for a postponement unless the Administrative Law Judge finds that completion of the record could not be accomplished with due diligence.

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January 9, 1998 Cite as 50 Van Natta 42 (1998)

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

The self-insured employer requests abatement and reconsideration of our December 11, 1997 Order on Review that, in part: (1) reversed the portion of the Administrative Law Judge's (ALJ's) order reducing claimant's scheduled permanent disability for loss of use or function of the left arm from 5 percent (9.6 degrees) to zero; and (2) awarded an attorney fee.

In moving for reconsideration, the employer contends that our order "subverts the intent of the Legislature by ignoring the provisions of ORS 656.262(6)(d)" and also asks us to "reconsider the attorney fee award * * * as the permanent disability award has been previously paid to the claimant following the issuance of an additional Notice of Closure[.]" The employer accompanies the motion with "post-hearing" documents, including correspondence from claimant's attorney, a Notice of Claim Acceptance, a Notice of Closure, and a document from claimant's treating physician.

In order to consider this matter, we withdraw our December 11, 1997 order. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 14 days from the date of this order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**GEOFF McCLELLAN, Claimant**
WCB Case No. 97-02487
ORDER ON REVIEW
Ronald A. Fontana, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Biehl and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Bethlahmy's order that upheld the SAIF Corporation's denial of claimant's injury claim pursuant to ORS 656.262(15) based on his failure to cooperate with its investigation. On review, the issue is whether claimant failed to cooperate with the investigation for reasons beyond his control. We affirm.

## FINDINGS OF FACT

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

Claimant, age 19 at the time of hearing, lives at home with his parents and five siblings. He has worked for the employer for approximately three years. On or about November 2, 1996, he was at work lifting a roll door on a delivery truck when he experienced the onset of low back pain. He sought chiropractic treatment a few days later.

On November 16, 1996, claimant and his treating chiropractor, Dr. Patton, completed a form 827. On November 17, 1996, claimant completed an 801 Form, describing the nature of his injury and the date it occurred.

On November 25, 1996, SAIF wrote to claimant requesting more information. SAIF sent another letter requesting additional information on December 10, 1996. On December 27, 1996, having not heard from claimant, SAIF wrote to the Department of Consumer and Business Services (DCBS) requesting that DCBS send a letter to claimant asking him to cooperate with SAIF's investigation and requesting authorization to suspend benefits until claimant cooperated. Thereafter, on January 2, 1997, DCBS wrote to claimant requesting that he cooperate and advising that his failure to cooperate may lead to the denial of his claim.

On January 10, 1997, DCBS issued an order suspending claimant's compensation pursuant to ORS 656.262(15). This order was sent to claimant via regular and certified mail. On January 11, 1997, claimant's mother signed for and received a certified letter addressed to claimant. She put it on top of the refrigerator with the rest of his mail.

On February 5, 1997, SAIF denied claimant's claim on the basis that he failed to cooperate with the investigation of his claim for more than 30 days following DCBS' January 2, 1997 notice to him.

Claimant's mother has the key to the family's mailbox. She brings the mail into the house and puts the mail addressed to her children on top of the refrigerator. She recalls receiving letters addressed to her son from SAIF and DCBS, which she placed on top of the refrigerator. At one point in about December 1996, claimant's father also signed for a certified letter addressed to claimant which he put on top of the refrigerator with the rest of the mail.

Neither claimant's mother nor his father specifically advised him that he had received mail from SAIF and/or DCBS. Claimant does not usually receive mail and he did not check the mail on top of the refrigerator after he filed his claim.

In late February 1997, claimant was advised by his chiropractor that his treatment bills were not being paid. Claimant went home and advised his parents that the bills were not being paid. Claimant's father then got the mail from on top of the refrigerator, read it and advised claimant to retain an attorney. Claimant got an attorney and requested a hearing under ORS 656.291.

## CONCLUSIONS OF LAW AND OPINION

ORS 656.262(14) and (15) were added to ORS Chapter 656 in 1995 as part of Senate Bill 369. Subsection (14) provides, in pertinent part, that injured workers "have the duty to cooperate and assist the insurer or self-insured employer in the investigation of claims for compensation." Subsection (15) states that if the Director (of DCBS) finds that a worker fails to reasonably cooperate with an investigation concerning an initial claim or an aggravation claim, the Director shall suspend all or part of the compensation after notice to the worker. Subsection (15) also provides that if the worker does not cooperate for an additional 30 days after the notice, the carrier may deny the claim because of the worker's failure to cooperate. In addition, this subsection provides, in pertinent part, as follows:

> "After such a denial, the worker shall not be granted a hearing or other proceeding under this chapter on the merits of the claim unless the worker first requests and establishes at an expedited hearing under ORS 656.291 that the worker fully and completely cooperated with the investigation, that the worker failed to cooperate for reasons beyond the worker's control or that the investigative demands were unreasonable."[1] (Emphasis supplied).

The ALJ found that claimant's failure to cooperate with SAIF's investigation was within his control and declined to set aside SAIF's denial. On review, claimant asserts that his parents were at fault for keeping his mail from him and that his failure to cooperate was beyond his control. We disagree.

Our task in interpreting a statute is to discern the intent of the legislature. PGE v. Bureau of Labor and Industries, 317 Or 606 (1993). At the first level of analysis, we examine both the text and context of the statute. Id. at 610. If the legislative intent is not clear from that inquiry, we then examine the legislative history or other extrinsic aids. Id. at 611-12 . We have previously found that the legislature's intent with regard to an injured worker's "duty to cooperate" with a carrier's claim investigation is apparent from the statutory text and context. See Patti E. Bolles, 49 Van Natta 1943 (1997). In this case, we similarly find no ambiguity in the "reasons beyond the worker's control" standard as used in ORS 656.262(15).[2]

Although there is evidence that claimant's parents did not advise him that he had received several letters from SAIF and DCBS, there is no evidence that claimant's parents affirmatively *prevented* claimant from receiving his mail (i.e., by destroying or disposing of it) so that, had he inquired or looked, he would not have discovered the letters from SAIF and DCBS leading up to SAIF's February 5, 1997 denial. Like the ALJ, we decline to hold claimant's parents responsible for claimant's failure to cooperate with the investigation of his claim. Rather, we find that, as a person over the age of 18 who is capable of maintaining employment and completing the paperwork to make a claim,[3] claimant should

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[1] The remaining part of subsection (15) provides:

> "If the Administrative Law Judge finds that the worker has not fully cooperated, the Administrative Law Judge shall affirm the denial, and the worker's claim for injury shall remain denied. If the Administrative Law Judge finds that the worker has cooperated, or that the investigative demands were unreasonable, the Administrative Law Judge shall set aside the denial, order the reinstatement of interim compensation if appropriate and remand the claim to the insurer or self-insured employer to accept or deny the claim."

[2] This same standard also appears in other provisions of ORS Chapter 656. See, e.g., ORS 656.262(4)(c); 656.268(1)(b); and 656.283(4).

[3] With certain exceptions not relevant in this case, 18 is the age of majority in Oregon. At the age of 18, a person is deemed to have control of his or her own actions and business, and to have all the rights and be subject to all the liabilities of a citizen of full age. See ORS 109.510.

have anticipated that he would thereafter receive some communication about the claim.[4] It was within his control to check whether he received any mail concerning his claim. He did not do so. This lack of diligence (a matter within claimant's control) is the reason claimant did not fully cooperate with the investigation of his claim.

We conclude that claimant cannot establish that he failed to cooperate for reasons beyond his control when he knew that he had made a claim for a work related injury but failed to monitor his mail for correspondence concerning that claim. The duty imposed on claimants by ORS 656.262(14) to "cooperate and assist" carriers in the investigation of claims includes the duty to check whether any mail concerning the claim has been received. Claimant did not do so. We therefore affirm the ALJ's decision to uphold SAIF's denial pursuant to ORS 656.262(15).

In his brief, claimant also contends that the denial of his claim pursuant to ORS 656.262(15) violates Article I, Section 10 of the Oregon Constitution and his due process rights under the United States Constitution. The record does not establish that claimant raised these constitutional challenges at hearing, nor are these arguments adequately developed on review. For these reasons, we decline to consider them. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991) (Board can refuse to address issue raised for the first time on review); Ronald B. Olson, 44 Van Natta 100, 101 (1992) (Board declined to address constitutional argument not adequately developed for review). Moreover, even if we had entertained these arguments, we would not find them persuasive. As set forth above, claimant was denied a hearing on the merits of his claim due to his own lack of diligence.

## ORDER

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

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[4] We note that, in determining whether a claimant has established "good cause" for the untimely filing of a request for hearing, we have held that a claimant has "constructive knowledge" of correspondence concerning the claim if, unbeknownst to the claimant but on the claimant's behalf, a relative receives and signs for a certified, correctly addressed letter. See, e.g., John W. Hamilton, 46 Van Natta 274 (1994) (the claimant had constructive receipt of a denial where his brother received and signed for a correctly addressed letter notifying the claimant of the denial); Anastacio L. Duran, 45 Van Natta 71 (1993) (the claimant had constructive notice of the employer's denial where the claimant's daughter, who was visiting, signed for the letter and placed it, along with the other mail, on a table but did not personally advise the claimant of the letter). Here, claimant's parents admitted to receiving and signing for the certified letters from DCBS. They placed the certified letters on the refrigerator with the rest of claimant's mail. Therefore, claimant had at least constructive knowledge that SAIF wanted additional information and that he was obligated to cooperate with the investigation. For reasons within his control (his lack of diligence in monitoring his mail), he did not receive actual notice of the correspondence from SAIF and DCBS until several weeks after SAIF's February 5, 1997 denial.

In the Matter of the Compensation of
**DENISE J. TURPIN, Claimant**
Own Motion No. 97-0593M
OWN MOTION ORDER
Rasmussen, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted claimant's request for temporary disability compensation for claimant's compensable torn medial meniscus right knee injury. Claimant's aggravation rights expired on October 23, 1990. SAIF opposed authorization of temporary disability compensation, contending that claimant has withdrawn from the work force.

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

It is undisputed that claimant's compensable condition requires surgery. Specifically, on December 1, 1997, Dr. Mohler, claimant's treating physician, opined that claimant's current condition, progressive osteoarthritis of the right knee involving the lateral compartment, required a total joint arthroplasty. Dr. Mohler further related claimant's need for treatment and surgery to claimant's March 21, 1985 compensable injury.

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

SAIF contends that claimant was not in the work force at the time of the current disability. Claimant responds that she was and remains employed at Cottage Grove Hospital and submits supporting documentation. This documentation includes, among other things: copies of a W-2 for 1996 and a December 19, 1997 Earnings Statement stub which evidences claimant's continuing employment at Cottage Grove Hospital. Based on this, we are persuaded by this evidence that claimant is engaged in regular gainful employment and remains in the work force.

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

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
**CRESENCIA GREEN, Claimant**
WCB Case No. 97-00666
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Podnar's order that set aside its denial of claimant's current left shoulder condition. On review, the issue is compensability. We reverse.

## FINDINGS OF FACT

Claimant, a footwear component operator, gradually developed left shoulder pain in August 1996 as a result of pushing heavy containers for two or three hours at a time over three consecutive days. (Ex. 15). On September 9, 1996, Dr. Gavlik diagnosed mild impingement of the left shoulder. (Ex. 17).

On October 15, 1996, Dr. Cook, who had previously treated claimant for a similar problem in the right shoulder, became claimant's attending physician. (Exs. 22, 23). The insurer accepted the claim on November 26, 1996 as a disabling left shoulder strain. (Ex. 32).

The insurer later denied claimant's current left shoulder condition on January 15, 1997, after Dr. Cook agreed that claimant had an anatomic predisposition for shoulder impingement syndrome, and that her work activity, although causing symptoms, was not the major contributing cause of the impingement syndrome condition or treatment necessary to correct it. (Exs. 35, 36). Claimant requested a hearing.

## CONCLUSIONS OF LAW AND OPINION

Citing SAIF v. Nehl, 148 Or App 101 (1997), the ALJ set aside the insurer's denial. The ALJ concluded that the medical evidence, particularly that which Dr. Cook provided, established that claimant's work activity was the "immediate" cause of her need for medical treatment and, thus, that her current left shoulder condition was compensable.

On review, the insurer contends that claimant's current left shoulder condition is the result of an anatomic predisposition and that, while claimant's work activities made her shoulder condition symptomatic, the preexisting, underlying anatomical predisposition is the major contributing cause of her need for medical treatment for her current left shoulder condition. For the following reasons, we agree with the insurer's contentions.

Dr. Cook opined that claimant has an anatomical predisposition for shoulder impingement. (Ex. 35). Based on this opinion, we agree with the ALJ that such a predisposition qualifies as a "preexisting condition" pursuant to ORS 656.005(7)(a)(B).[1] See ORS 656.005(24) (preexisting conditions include predispositions); Darlene J. Reed, 47 Van Natta 1720 (1995) (Board applied amended ORS 656.005(7)(a)(B) to case involving preexisting or predisposing condition that combined with work incidents). Accordingly, we concur with the ALJ that compensability is determined pursuant to ORS 656.005(7)(a)(B).

In Nehl, the court determined that the "immediate" cause of the claimant's need for treatment was the work injury and, consequently, that the treatment was compensable. Id. at 106. We later discussed whether the holding in Nehl overruled Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev den 321 Or 416 (1995), in which the court held that the fact that a work injury precipitates a claimant's

[1] We note that an examining physician, Dr. Peterson, opined that claimant had no "preexisting or predisposing condition." (Ex. 33-5). However, we find Dr. Cook's thoroughly explained opinion that claimant has an underlying anatomical predisposition to developing shoulder impingement, to be more persuasive than Dr. Peterson's unexplained contrary conclusion. See Moe v. Ceiling Systems, 44 Or App 429 (1980) (rejecting conclusory medical opinion).

condition does not necessarily mean that the injury is the major contributing cause of the condition, and that determining major contributing cause involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause. See Gregory C. Noble, 49 Van Natta 764 (1997).

In Noble, we concluded that, under Nehl, a claimant is not required to prove that a work injury is the major contributing cause of the entire combined condition; rather, he or she must prove that the work injury is the major contributing cause of the need for treatment of the combined condition. We further found that the standard for proving major contributing cause, as articulated by Dietz, remained unchanged. Noble, 48 Van Natta at 767.

Subsequent to our decision in Noble, the court in Nehl, on reconsideration, agreed that the concluding sentence in its initial decision regarding the "immediate cause" of the need for treatment misstated the test contemplated by ORS 656.005(7)(a)(B)[2] and replaced that sentence with the following: "We conclude that, regardless of the extent of claimant's underlying condition, if claimant's work injury, when weighed against his preexisting condition, was the major cause of claimant's need for treatment, the combined condition is compensable." SAIF v. Nehl, on recon, 149 Or App 309, 315 (1997).

Applying the Nehl court's articulation of the proper legal standard under ORS 656.005(7)(a)(B), we now proceed to determine whether claimant's current left shoulder condition is compensable. Due to the presence of an alleged anatomical predisposition, we find that the causation issue in this case is a complex medical question which requires expert medical evidence. Uris v. Compensation Department, 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Dr. Cook opined that, while claimant's work activity caused symptoms of this underlying predisposition, it was not the major contributing cause of the impingement syndrome or the treatment necessary to correct it. (Ex. 35). Dr. Pierson, a physician who had previously treated claimant, concurred with Dr. Cook. (Ex. 37-2).

In his deposition, Dr. Cook explained his opinion that claimant has an anatomical predisposition to develop shoulder impingement. (Ex. 38-6, 7, 12, 14). After being given a description of claimant's work activity, Dr. Cook testified that such activity could "precipitate" symptoms in someone with a predisposition to shoulder impingement. (Ex. 38-11). At several other points in the deposition, Dr. Cook referred to claimant's work activity as having precipitated the symptoms that caused claimant to seek medical treatment. (Ex. 38-13, 15, 18). However, Dr. Cook emphasized that the underlying anatomical defect predisposed claimant to having symptoms. Id. Dr. Cook testified that the major factor in claimant's condition was the underlying anatomical predisposition, which restricted clearance of a tendon in the left shoulder. (Ex. 38-21, 29). Dr. Cook further testified that the treatment necessary to correct the impingement syndrome involved removal of a significant portion of the bone on the underside of the acromion to create more clearance for the rotator cuff tendons. (Ex. 38-21).

Based on our review of the medical evidence as a whole, particularly that from Dr. Cook, we conclude that the compensable left shoulder injury is no more than the precipitating cause of claimant's current need for treatment. Because we find that the major contributing cause of the need for treatment of the current combined condition (claimant's impingement syndrome and underlying, preexisting anatomical predisposition) is the preexisting anatomical predisposition, we also conclude that claimant's current left shoulder condition is not compensable under ORS 656.005(7)(a)(B). Given this conclusion, we reverse the ALJ's decision to set aside the insurer's denial.[3]

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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] In light of our disposition of the case, we need not address the insurer's argument in its reply brief that Nehl is inapplicable.

ORDER

The ALJ's order dated July 28, 1997 is reversed. The insurer's January 15, 1997 denial is reinstated and upheld. The ALJ's attorney fee is also reversed.

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In the Matter of the Compensation of
**GEORGE G. McCOY, Claimant**
WCB Case Nos. 96-03335, 95-08721 & 95-08722
ORDER ON REVIEW
Peter O. Hansen, 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) Peterson's order that: (1) upheld the SAIF Corporation's denials of his injury/occupational disease claims for a current back condition; and (2) upheld SAIF's denials of his occupational disease claim for hand conditions. On review, the issue is compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. We change the last paragraph beginning on page 2 to read:

> "On July 3, 1995, SAIF wrote to claimant regarding the 'claim for an injury to your back which you believe occurred on or about March 11, 1995, while you were employed at [the employer].' (Ex. 38). SAIF denied the claim on the grounds that claimant's current back condition remained the responsibility of the accepted 1989 injury claim and his work since the 1989 injury was not the major contributing cause of the overall combined back condition. (Id.)"

We change the first full paragraph on page 3 to read:

> "On April 2, 1996, SAIF wrote to claimant concerning the 'claim for an injury and/or occupational disease to your back which you believe occurred on or about January 2, 1996, while you were employed at [the employer].' (Ex. 49). SAIF denied the claim on the grounds that the current back condition remained the responsibility of the accepted 1989 injury claim and claimant's work since 1989 was not the major contributing cause of the overall combined back condition. (Id.)"

CONCLUSIONS OF LAW AND OPINION

Hand Conditions

We adopt and affirm the ALJ's reasoning and conclusion that claimant failed to establish that his work activities were the major contributing cause of his hand conditions.

Back Condition

Claimant has worked for the employer for approximately 27 years and has three accepted back injury claims with SAIF. In February 1983, claimant injured his back when lifting a sack of cement. (Exs. 1, 2). SAIF accepted the claim. (Ex. 3). On March 11, 1985, claimant injured his back when he was inspecting the city's watershed and the snowmobile he was operating became stuck. (Exs. 4-8). SAIF accepted a low back strain. (Ex. 9). On October 5, 1989, claimant injured his back when he was flushing out a fire hydrant. (Exs. 12A-14). SAIF accepted a lumbosacral strain. (Ex. 17).

In April 1995, claimant sought treatment for low back pain. (Exs. 24, 26). Claimant signed an "801" form on April 6, 1995 for a back strain and he indicated that the date of injury was "March 11, 1985." (Ex. 25). On July 3, 1995, SAIF wrote to claimant regarding the "claim for an injury to your back

which you believe occurred on or about March 11, 1995, while you were employed at [the employer]." (Ex. 38). SAIF denied the claim on the grounds that claimant's current back condition remained the responsibility of the accepted 1989 injury claim and his work since the 1989 injury was not the major contributing cause of the overall combined back condition. (Id.) Claimant requested a hearing on the July 3, 1995 denial.

On January 2, 1996, claimant's attorney asked SAIF to modify its acceptance to include chronic lumbosacral sprain, herniated right disc at L4-5, herniated disc at "L4-S1," bilateral CTS, and diffuse tenosynovitis of the thumbs and fingers. (Ex. 46). On January 5, 1996, claimant's attorney also asked SAIF to accept conditions of L4-5 disc herniation, L5-S1 disc herniation and L3-4 disc herniation. (Ex. 47).

On April 2, 1996, SAIF wrote to claimant concerning the "claim for an injury and/or occupational disease to your back which you believe occurred on or about January 2, 1996, while you were employed at [the employer]." (Ex. 49). SAIF denied the claim on the grounds that the current back condition remained the responsibility of the accepted 1989 injury claim and claimant's work since 1989 was not the major contributing cause of the overall combined back condition. (Id.)

At hearing, the parties agreed to reserve all issues involving the L3-4, L4-5 and L5-S1 disc conditions for future hearing. The parties also agreed to reserve the issue concerning claimant's aggravation rights under the 1989 accepted injury claim for future hearing.

July 3, 1995 Denial

The ALJ concluded that SAIF made a typographical error in its July 3, 1995 denial and the denial should have referred to claimant's March 11, 1985 injury, rather than a March 11, 1995 injury. The ALJ reasoned that claimant had an accepted March 11, 1985 injury and his April 6, 1995 "801" form for a back strain indicated the date of injury was March 11, 1985. (Ex. 25). The ALJ interpreted SAIF's July 3, 1995 denial to mean that it was denying that any treatment or disability related to claimant's prior March 11, 1985 injury. Because the ALJ found no evidence that claimant's need for treatment or disability for his current low back condition was due to the March 11, 1985 injury, SAIF's July 3, 1995 denial was upheld.

Claimant argues that the July 3, 1995 denial should be set aside as a meaningless nullity or as an impermissible back-up denial. He contends that SAIF's denial was a nullity because no new claim was made pursuant to ORS 656.262(7)(a).

A carrier is bound by the express language of its denial. Tattoo v. Barrett Business Service, 118 Or App 348, 351-52 (1993). SAIF's July 3, 1995 denial stated that claimant had filed a "claim for an injury to your back which you believe occurred on or about March 11, 1995, while you were employed at [the employer]." (Ex. 38). There is no evidence in the record that claimant filed a claim for a March 11, 1995 injury. Furthermore, extrinsic evidence may not be used to interpret the express language of a denial. Gregg Muldrow, 49 Van Natta 1866, 1867-68 (1997).

However, a carrier is not precluded from amending its denial at hearing. SAIF v. Ledin, 149 Or App 94 (1997); Muldrow, 49 Van Natta at 1867. Here, we find no evidence that SAIF sought to amend the July 3, 1995 denial at hearing to refer to a March 11, 1985 injury, rather than a March 11, 1995 injury.

There is no evidence that claimant filed a new claim under ORS 656.262(7)(a) for a March 11, 1995 back injury. Therefore, because SAIF's July 3, 1995 denial referring to a March 11, 1995 injury was issued in the absence of a claim, the denial is a nullity and has 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 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).

Because we have determined that SAIF's July 3, 1995 denial referring to a March 11, 1995 injury was a nullity, we need not address claimant's alternative argument that the July 3, 1995 denial was an impermissible back-up denial. Moreover, because we have determined that claimant has made no "claim," he will receive no benefits as a result of our holding that SAIF's denial was a nullity. Thus, we conclude that claimant has not "prevailed" over a denied claim and is not entitled to an assessed attorney fee under ORS 656.386(1). See Stephenson v. Meyer, 150 Or App at 304; Vicky L. Davis, 49 Van Natta at 606.

April 2, 1996 Denial

Regarding the April 2, 1996 denial, the ALJ found no medical opinions that established that claimant's post-1989 work activities were the major contributing cause of his current low back condition. The ALJ concluded that claimant failed to prove that his low back condition worsened due to his post-1989 work activities and, therefore, SAIF's April 2, 1996 denial was upheld.

Claimant contends that SAIF's denial was an invalid back-up denial because it was not based on later obtained evidence that the low back strain was not compensable.

We first clarify the scope of SAIF's April 2, 1996 denial.

On January 2, 1996, claimant's attorney asked SAIF to modify its acceptance to include chronic lumbosacral sprain, herniated right disc at L4-5, herniated disc at "L4-S1," bilateral CTS, and diffuse tenosynovitis of the thumbs and fingers. (Ex. 46). On January 5, 1996, claimant's attorney also asked SAIF to accept conditions of L4-5 disc herniation, L5-S1 disc herniation and L3-4 disc herniation. (Ex. 47).

On April 2, 1996, SAIF wrote to claimant concerning the "claim for an injury and/or occupational disease to your back which you believe occurred on or about January 2, 1996, while you were employed at [the employer]." (Ex. 49). SAIF denied the claim on the grounds that the current back condition remained the responsibility of the accepted 1989 injury claim and claimant's work after 1989 was not the major contributing cause of the overall combined back condition. (Id.)

As we discussed earlier, the parties agreed to reserve the following issues for a future hearing: the L3-4, L4-5 and L5-S1 disc conditions and the aggravation rights under the 1989 accepted injury claim. Therefore, based on claimant's January 1996 letters to SAIF, the only remaining back claim at issue was for a chronic lumbosacral sprain.

Under ORS 656.262(6)(a), if a carrier accepts a claim in good faith, in a case not involving fraud, misrepresentation or other illegal activity by the worker, and "later obtains evidence that the claim is not compensable," the carrier may revoke the claim acceptance and issue a formal denial of the claim, as long as the denial is issued within two years of the date of the initial acceptance.

Here, we find no evidence that SAIF has attempted to revoke a previous acceptance of a "chronic" lumbosacral sprain. Claimant has three low back injuries accepted by SAIF. In February 1983, claimant injured his back when lifting sacks of cement; he was diagnosed with probable mild muscle spasm. (Exs. 1, 2). His March 11, 1985 injury was accepted as a low back strain. (Ex. 9). Claimant's October 5, 1989 injury was accepted as a lumbosacral strain. (Ex. 17). There is no evidence that SAIF has accepted a "chronic" lumbosacral sprain. Therefore, to the extent that SAIF's April 2, 1996 denial included a chronic lumbosacral sprain, it was not a back-up denial.

We agree with the ALJ that claimant's chronic lumbosacral sprain is properly analyzed as an occupational disease claim. Claimant's October 5, 1989 lumbosacral strain remains an accepted claim. Because this occupational disease claim is based on a worsening of claimant's preexisting lumbosacral strain, claimant must prove that his employment conditions were the major contributing cause of the combined condition and pathological worsening of the lumbosacral strain. ORS 656.802(2)(b); Dan D. Cone, 47 Van Natta 1010, on recon 47 Van Natta 2220, on recon 47 Van Natta 2343 (1995).

In his reply brief, claimant asserts that *"[t]here is no medical evidence in the record that claimant's condition of a low back strain has ever changed from the accepted 1989 back strain other than the 'reserved discs.'"* (Claimant's reply br. at 7; emphasis in original). After reviewing the record, we agree with the ALJ that there is no medical evidence that claimant's post-1989 work activities were the major contributing cause of his current low back condition. Consequently, we agree that SAIF's April 2, 1996 denial should be upheld.

ORDER

The ALJ's order dated June 12, 1997 is reversed in part and affirmed in part. That portion of the ALJ's order that upheld SAIF's July 3, 1995 denial of claimant's back injury on March 11, 1995 is reversed. SAIF's denial of that condition is set aside as a nullity. The remainder of the ALJ's order is affirmed.

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In the Matter of the Compensation of
**WILLIAM K. ROSSITER, Claimant**
WCB Case No. 96-08309
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Galton's order that upheld the self-insured employer's partial denial of claimant's injury claim for low back and right sided sciatic pain. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We begin with a summary of relevant facts.

Claimant has had degenerative low back disc disease since at least 1984. In 1989, he fell and injured his low back at work and Dr. Markham performed surgery to repair claimant's L5-S1 disc. A December 3, 1990 Determination Order closed claimant's accepted injury claim and awarded 10 percent unscheduled permanent disability for the low back and 5 percent scheduled permanent disability for the right leg. (Ex. 21)

On December 17, 1995, claimant fell again at work and injured his neck and low back. The employer accepted claimant's claim for a thoracic and lumbar strain. Claimant's low back problems did not resolve thereafter.

On August 15, 1996, the employer issued a partial denial of claimant's "low back and right sided sciatic pain secondary to preexisting degenerative and post traumatic arthritic changes, preexisting degenerative disc disease and preexisting postoperative scarring post 1989 right L5-S1 hemilaminectomy and discectomy." (Ex. 55).

The ALJ found that claimant failed to establish that his current low back condition is compensable. In reaching this conclusion, the ALJ reasoned that claimant does not have a combined condition and his current condition is not related to the 1995 injury, based on the opinions of Drs. Scheinberg and Kirschner (which the ALJ found to be well reasoned and therefore persuasive). The ALJ also discounted the opinions of Drs. Craven and Markham, finding Dr. Markham's opinion conclusory and that Dr. Craven changed his opinion without explanation. We disagree.

The medical record establishes that claimant's current low back pain and right-sided sciatica is caused, in part, by scar tissue (from the prior back surgery), which presses on his right S1 nerve root and preexisting degenerative disease. (See Exs. 40, 42, 70). However, we conclude that the claim is compensable because we find that Dr. Markham's opinion persuasively establishes that the accepted December 17, 1995 strain injury combined with the preexisting condition, worsened it, and constituted the major contributing cause of claimant's resultant need for medical treatment, as explained below.

Dr. Markham performed claimant's 1989 L5-S1 laminectomy and noted that claimant had returned to work after that surgery and done well "with no significant problems" until December 1995, when he slipped and fell at work, injuring his neck and back. (Exs. 73A). Dr. Markham also reported that claimant had an additional work injury, a fall from a ladder in October 1996, which only aggravated his symptoms. (Id.) In addition, Dr. Markham later agreed with claimant's attorney's summary of his opinion:

> "Although the preexisting degenerative disc disease and preexisting post operative scarring following the 1989 surgery materially contribute to [claimant's] current condition, his back was reasonably stable and relatively symptom free for approximately 5 years prior to the December 17, 1995 injury. This fact is particularly significant to your determination of the major contributing cause of [claimant's] current low back and right leg complaints." (Ex. 76-2).

We find Dr. Markham's opinion to be well-reasoned and based on an accurate history.[1] Further, in light of Dr. Markham's advantageous position as the surgeon who treated claimant's back in the 1980's and performed the 1989 L5-S1 surgery, we give Dr. Markham's well-reasoned conclusions considerable weight. See Argonaut Ins. Co. v. Mageske, 93 Or App 698 (1988); Givens v. SAIF, 61 Or App 490, 494 (1983) (The opinion of the treating doctor is entitled to greater weight because he has more firsthand exposure to and knowledge of claimant's condition). In addition, we find that Dr. Markham considered and weighed claimant's preexisting conditions in reaching his opinion on causation. Moreover, his conclusion is consistent with claimant's work history (5 years of working without back problems after his 1989 surgery). For these reasons, we find Dr. Markham's opinion persuasive.

The contrary medical evidence is provided by Drs. Scheinberg and Kirschner, who opined claimant's December 1996 strain injury "resolved." (See Exs. 49, 75). We do not find the examiners' opinions persuasive in this regard, because they are inconsistent with claimant's ongoing symptoms and Dr. Scheinberg's reasoning is internally inconsistent.

Dr. Scheinberg opined that claimant's 1995 work injury probably "impacted on the pre-existing condition to cause a slight pathological worsening." (Ex. 75). However, he also characterized the work injury as a "resolved" strain, and commented that "[a]ny continued discomfort experience by [claimant] . . .in my view relates entirely to his pre-existing condition." (Id., emphasis added). We do not see how the injury could have both resolved and caused a pathological worsening. Assuming it could, we would nonetheless find the examiners' conclusion that claimant's current discomfort is entirely related to the preexisting condition to be inadequately explained. See Blakely v. SAIF, 89 Or App 653, 656, rev den 305 Or 972 (1988) (Physician's opinion lacked persuasive force because it was unexplained).

Under these circumstances, we find no reason to discount Dr. Markham's persuasive opinion. Accordingly, we find that claimant has established that his 1995 accepted injury is the major contributing cause of his current need for treatment for low back and right leg pain. See SAIF v. Nehl, 148 Or App 101, on recon, 149 Or App 309 (1997); Peter G. Wylie, 49 Van Natta 1310 (1997); compare Robert H. Younger, 49 Van Natta 887 (1997).

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $4,500 payable by the 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 May 16, 1997 is reversed. The self-insured employer's denial is set aside and the claim is remanded to the employer for processing according to law. For services at hearing and on review, claimant is awarded a $4,500 attorney fee, payable by the employer.

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[1] We also note that Dr. Craven specifically concurred with Dr. Markham's opinion. (Ex. 77; see Exs. 73A, 76).

In the Matter of the Compensation of
**MIKE R. ARMSTRONG, Claimant**
WCB Case No. 96-07962
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Reinisch, McKenzie, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Lipton's order that set aside its denial of claimant's left knee injury claim. On review, the issue is compensability.

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

Claimant worked for the employer, Windell's Snowboard Camp, as a "digger" when he injured his left knee on June 25, 1996. His work duties included maintaining the snowfield and the "pipe" (used for practicing snowboarding), picking up trash, checking the snowboard jumps, watching out for "poachers," and performing assorted maintenance and errand-running. Claimant used his own snowboard in the course of his work for transportation, to shape the snowboarding area, and to check the quality of pipe maintenance.

On June 25, 1996, during his regular work shift, claimant fell from his snowboard and injured his left knee while riding the pipe.

The ALJ concluded that claimant's injury arose out of and in the course of his employment in part based on a finding that the close "work nexus" between claimant's snowboarding activities and his employment defeated the statutory exclusion (for recreational activities performed primarily for personal pleasure) set out in ORS 656.005(7)(b)(B).[1]

The insurer argues that the ALJ erred because he did not first consider whether claimant's activity was excluded from the definition of a compensable injury under ORS 656.005(7)(b)(B), before determining whether the injury arose out of and in the course and scope of claimant's employment. We agree with the insurer that the proper inquiry under the statute does not provide for a close "work nexus" to defeat the exclusion of ORS 656.005(7)(b)(B). We nevertheless affirm the ALJ's conclusion that claimant's injury claim is compensable.

We insert the following, after the second full paragraph of the "Opinion and Conclusion," to clarify our reasoning.

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. See Julie A. Garcia, 48 Van Natta 776 (1996); Michael W. Hardenbrook, 44 Van Natta 529, aff'd mem Hardenbrook v. Liberty Northwest Insurance Corporation, 117 Or App 543 (1992). However, 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. Garcia, 48 Van Natta at 776.

We have previously held that a statutory exclusion analysis must precede any unitary work connection analysis, when ORS 656.005(7)(b)(B) applies. Hardenbrook, 44 Van Natta at 530; see Andrews v. Tektronix, Inc., 323 Or 154, 161 n. 1 (1996) (Regarding ORS 656.005: "Paragraph (7)(a) is the primary definition of compensability. Paragraph (7)(b) states grounds for exclusion that are additional to those that are inherent in the primary definition found in paragraph (7)(a)."); see also 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).

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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[."]

"The 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 (1994).

Here, we find the evidence insufficient to establish that claimant's primary purpose for "riding the snowboard pipe" was personal pleasure. We reach this conclusion based on the following facts and circumstances.

On June 25, 1996, after raking, salting and side-slipping the snowboard pipe during his regular work shift, claimant rode the pipe. He injured his left knee on that ride, when his board caught and he fell.

Claimant's work duties included building and maintaining snowboard ramps. There is some evidence that claimant was not paid for "light snowboarding in the pipe." (Tr. 44). On the other hand, there is also evidence that claimant's work duties included the exercise of discretion to determine whether a pipe he worked on was in satisfactory condition after he had salted, raked, and sideslipped it. This determination regularly included riding the just-maintained pipe himself. (See Tr. 24-30, 53-54). In this regard, claimant's supervisor testified that diggers such as claimant "definitely have to go over the jumps, and ride the pipe" in order to check them. (Tr. 89). Accordingly, because claimant was riding a pipe he had just repaired at the time of his injury, and that activity was among his regular work duties, we conclude that claimant was not engaged in an activity primarily for his personal pleasure. See Kaiel, 129 Or App at 478 ("The fact that a worker derives pleasure *from* a work activity does not necessarily mean that the worker engages in the activity primarily *for* personal pleasure. It would be absurd to make the compensability of an injury turn on whether a worker has fun doing his or her job."). Under these circumstances, we conclude that claimant's left knee injury is not excluded from the definition of compensable injuries under ORS 656.005(7)(b)(B).

Finally, because we agree with the ALJ that claimant has established legal and medical causation, we further agree that the claim is compensable. See Anita M. Barron, 48 Van Natta 1656, 1657 (1996) (Where the claimant was engaged in an activity within the boundaries of her ultimate work, her injury was compensable); Ester E. Edwards, 44 Van Natta 1065 (1992), aff'd mem Liberty Northwest Insurance Corporation v. Edwards, 118 Or App 748 (1993) (Knee injury incurred during an employer-sponsered volleyball game found compensable, where primary purpose of recreational activity was to enhance interoffice working relationships).

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 June 9, 1997 is affirmed. For services on review, claimant is awarded a $1,500 attorney fee, payable by the insurer.

In the Matter of the Compensation of
**ROBERT C. GRAY, Claimant**
WCB Case No. 96-08812
ORDER ON RECONSIDERATION
Starr & Vinson, Claimant Attorneys
Zimmerman & Nielsen, Defense Attorneys

Claimant has requested reconsideration of our November 12, 1997 Order on Review in which we reinstated claimant's hearing request regarding the insurer's partial denial of his right knee surgery claim and upheld the insurer's denial. Specifically, claimant seeks remand or, alternatively, further analysis of the case in light of ORS 656.005(7)(a)(B) and SAIF v. Nehl, 148 Or App 101, on recon 149 Or App 309 (1997). In order to fully consider claimant's motion, we abated our order on December 12, 1997 and allowed the insurer an opportunity to respond. Having received the insurer's response, we proceed with our reconsideration.

In our prior order, we found no compelling reason to remand this matter to the ALJ for a decision on the merits. On reconsideration, claimant offers no persuasive reasons for us to change that conclusion. As we noted previously, the parties agreed that compensability was at issue and prepared their respective cases accordingly. Consequently, we cannot conclude that the record in this case was "improperly, incompletely, or otherwise insufficiently developed."

We likewise do not find that the court's decision in SAIF v. Nehl, 148 Or App 101, on recon, 149 Or App 309 (1997) provides a compelling reason to remand this matter. Contrary to claimant's assertion, the parties were given ample opportunity to address the Nehl decision during the course of the briefing schedule. In this regard, we note that claimant's September 24, 1997 appellant's brief specifically cites to the court's decision in Nehl. (Claimant's Appellant Brief at p. 4).[1] Under these circumstances, we continue to find no compelling reason to remand this matter to the ALJ. Consequently, claimant's motion for remand is denied.

Finally, claimant argues that we did not address whether his compensable injury was the major contributing cause of the disability, as opposed to need for medical treatment, for his combined condition. We disagree. In upholding the insurer's denial, we specifically concluded that claimant had not established "that the 1995 work injury was the major contributing cause **of his disability or need for medical treatment** for his combined condition." (Order on Review at p. 4)(Emphasis supplied). Moreover, although claimant asserts that the compensable injury is the major contributing cause of his disability from the combined condition, Dr. Jones, his attending physician, does not support this assertion. In fact, Dr. Jones agreed with Dr. Weintraub that the major contributing cause of claimant's combined condition was the preexisting condition(s). (Exs. 59, 62). There is no other medical evidence which supports claimant's contention that the compensable injury was the major contributing cause of his disability for his combined condition. Based on this, we continue to conclude that claimant has not established that his 1995 work injury is the major contributing cause of his disability or need for medical treatment for his combined condition.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our November 12, 1997 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.

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[1] In any event, claimant has now had an additional opportunity to present his argument in light of the Nehl holding.

In the Matter of the Compensation of
**LAMON HAYES, Claimant**
WCB Case No. 96-09700
ORDER ON REVIEW
McGill & Kapranos, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Lipton's order that set aside its denial of claimant's occupational disease claim for bilateral upper extremity conditions. On review, the issue is compensability. We reverse in part, modify in part and affirm in part.

## FINDINGS OF FACT

We adopt the ALJ's "findings of fact" with the exception of his finding that claimant's work activities are the major contributing cause of his rhabdomyolysis (muscle deterioration) condition. In addition, we modify the ALJ's description of claimant's job duties as follows. While we agree with the ALJ that the bulk of claimant's job consisted of stripping quarter cubes of margarine, claimant also stripped tubs of margarine and packed two-pound pints of butter into a box. (Trs. 8, 9).

## CONCLUSIONS OF LAW AND OPINION

Determining that the medical opinion of a consulting physician (Dr. Browning) was more persuasive than that of the attending physician (Dr. Potts) and an examining physician (Dr. Podemski), the ALJ set aside the employer's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome and rhabdomyolysis. In addition to asserting that the medical evidence does not establish the compensability of claimant's bilateral carpal tunnel syndrome, the employer contends on review that Dr. Browning's opinion cannot establish the compensability of the rhabdomyolysis condition because she never addressed the causation of that condition.

We agree for the reasons cited by the ALJ that Dr. Browning provided the most persuasive medical opinion on this record. We also agree with the ALJ's reasoning in finding claimant's bilateral carpal tunnel to be compensable. However, the employer correctly notes that Dr. Browning never addressed the causation issue with respect to the rhabdomyolysis. (Ex. 18). Thus, we agree with the employer that Dr. Browning's opinion cannot establish the compensability of that condition.[1] It follows that the ALJ's order must be reversed to the extent that it set aside the portion of the employer's denial concerning the rhabdomyolysis condition.

The ALJ awarded claimant a $3,500 attorney fee pursuant to ORS 656.386(1) for prevailing over the employer's denial of the bilateral carpal tunnel and rhabdomyolysis. Because we have reversed part of the ALJ's order and upheld the denial of compensability of the latter condition, we reduce the ALJ's attorney fee award to $3,000 for claimant's counsel's services at hearing. In reaching this conclusion, we have considered the factors set forth in OAR 438-015-0010(4), particularly the time devoted to the 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.

In addition, claimant's counsel is entitled to an assessed fee for services on review with regard to the compensability of the bilateral carpal tunnel condition. ORS 656.382(2); Laura Maderos, 48 Van Natta 538, on recon 48 Van Natta 838 (1996) (even though overall compensation reduced on review, attorney fee awarded pursuant to ORS 656.382(2) because compensation was not reduced with respect to right shoulder capsulitis condition). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review with regard to the compensable condition is $750, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to this compensability issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

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[1] We note that Dr. Potts opined that the rhabdomyolysis condition was related to claimant's employment. (Ex. 27-15). However, we agree with the ALJ's reasoning that Dr. Potts' opinion was insufficient to establish the compensability of that condition. Dr. Podemski opined that claimant's work was not likely to have caused the rhabdomyolysis condition. (Ex. 21-3).

ORDER

The ALJ's order dated August 20, 1997 is reversed in part, modified in part and affirmed in part. The portion of the ALJ's order which set aside the employer's denial of the rhabdomyolysis condition is reversed. The portion of the employer's denial concerning rhabdomyolysis is reinstated and upheld. The ALJ's attorney fee award is modified. In lieu of the ALJ's award, claimant is awarded an attorney fee of $3,000, payable by the employer. For services on review, claimant's attorney is awarded an assessed fee of $750, to be paid by the employer. The remainder of ALJ's order is affirmed.

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In the Matter of the Compensation of
**PAULA J. SHEPHERD, Claimant**
WCB Case No. 96-10526
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Thomas A. Andersen, Defense Attorney

Reviewed by Board Members Moller and Bock.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Livesley's order that: (1) affirmed an Order on Reconsideration that awarded no scheduled permanent disability; and (2) increased claimant's unscheduled permanent disability for a neck condition from 2 percent (6.4 degrees), as awarded by an Order on Reconsideration, to 6 percent ( 19.2 degrees). The insurer cross-requests review of that portion of the ALJ's order concerning unscheduled permanent disability. On review, the issues are extent of scheduled and unscheduled permanent disability.

We adopt and affirm the ALJ's order with the following supplementation regarding claimant's contention that she is entitled to a "social vocational" value of 1, resulting in increased unscheduled permanent disability. Notwithstanding claimant's contention, the record establishes that she sought at Hearing an increase in her unscheduled permanent disability award from 2 percent to 6 percent. In light of such circumstances, we decline to consider claimant's request for an award greater than the 6 percent award she requested at the hearing. See Ronald L. Jordan, 48 Van Natta 2356 (1996).

Claimant's attorney is entitled to an assessed fee for services on review because the insurer requested review of that portion of the ALJ's order concerning extent of unscheduled permanent disability and our order did not result in any decreased compensation. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $800, payable by the insurer. 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 May 12, 1997 is affirmed. For services on review regarding claimant's reply to the insurer's cross-request, claimant's attorney is awarded an assessed attorney fee of $800, to be paid by the insurer.

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In the Matter of the Compensation of
**STEVEN J. MYERS, Claimant**
WCB Case No. 96-06917
ORDER ON REVIEW
Quintin Estell, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Myzak's order that upheld the insurer's partial denial of his claim for a cervical condition. On review, the issue is compensability. We reverse.

## FINDINGS OF FACT

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

Claimant, 44 years old at the time of hearing, has preexisting degenerative changes in his cervical spine. During the course and scope of his employment on February 8, 1996, claimant slipped on a ladder rung. Claimant pushed away from the ladder and fell backwards, striking his back across the shoulder blades on the top of an "air handler" unit[1] and the base of his head at the top of his spine on some duct work. Claimant then dropped down to the floor onto his knees and fell over to the right.

Prior to his injury accident, claimant's upper back, neck, and right arm were asymptomatic. Since this injury accident, claimant has experienced neck pain and intermittent numbness in the right arm, thumb index (fore), and middle fingers. The claim was accepted for cervicothoracic sprain/strain and right-sided nerve root irritation.

Treatment has been conservative. A MRI of March 28, 1996 revealed: spinal stenosis at C4-5, C5-6, and C6-7; effacement of the CSF space with deformity of the cord at C5-6 and C6-7; neural foraminal narrowing at C5-6 and C6-7; disc bulging and herniation at C3-4; and, disc material extending posteriorly at C5-6 and C6-7.

Claimant and the employer's witnesses are credible.

## CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant had not established that his work injury was the major contributing cause of his cervical condition. We disagree.

The medical evidence is in agreement that claimant's industrial injury combined with his preexisting cervical condition. (Exs. 20, 31-13, 34-44). Therefore, in order to establish compensability, claimant must prove that the industrial injury is the major contributing cause of his disability or need for medical treatment of the combined condition. ORS 656.005(7)(a)(B); SAIF v. Nehl, 148 Or App 101, on recon 149 Or App 309 (1997).

Dr. Camacho, claimant's treating physician, opined that the industrial injury was the major contributing cause of claimant's condition and need for treatment. (Ex 31-18). Dr. Camacho explained that as a result of the fall, additional stress was placed on claimant's C5-6 disc causing it to rupture or bulge. (Ex. 31-14). Dr. Camacho further explained that the fall was also the major cause of the disc extrusion at C6-7, cervical spinal fluid effacement, and the resulting nerve compression at C5-6 and C6-7. (Ex. 31-18).

In contrast, Dr. Seres, a neurosurgeon who examined claimant once at the request of the insurer, opined that while claimant may have sustained nerve root irritation as a result of the work incident, he did not sustain any damage to his spinal cord. (Ex. 32). Dr. Seres explained that because

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[1] Claimant is 5'9". The top of the "air handler" unit is about six feet. The rung claimant slipped on is about three feet from the floor.

claimant had a narrow spinal canal, he suffered small disc bulges prior to the injury which left little room for the cervical discs. (Ex. 34-41). Dr. Seres concluded that claimant's preexisting condition was the major cause of claimant's cervical condition. (Ex. 34-44).

When medical evidence is divided, the opinion of the treating physician is generally deferred to, absent persuasive reasons not to do so. See Weiland v. SAIF, 64 Or App 810 (1983). Here, we find no persuasive reasons not to defer to the opinion of Dr. Camacho. Dr. Camacho's opinion demonstrates that he has considered the only two causal factors (the preexisting cervical condition and the industrial injury) and persuasively explains why the industrial injury was the major cause of claimant's disability and need for treatment for his combined cervical condition. Based on Dr. Camacho's opinion, claimant has carried his burden of proving that his combined cervical condition is compensable under ORS 656.005(7)(a)(B).

In reaching this conclusion, we note that the ALJ believed the resolution of this case was controlled by our decision in Guadalupe L. Sarmiento, 48 Van Natta 2495 (1996). We disagree.

Our decision in Sarmiento was based on the particular facts of that case. We did not find the opinion of a consulting neurosurgeon sufficient to carry the claimant's burden of proof as it was inconsistent and only addressed the causal aspect of one portion (low back strain) of the claimant's combined condition. In any event, the fact that a physician's opinion is not persuasive in one case has no bearing on the persuasiveness of a different physician in a different case. Rather, our decision is based solely on the record before us in this case. ORS 656.295(5).

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

ORDER

The ALJ's order dated April 25, 1997 is reversed. The insurer's denial, dated June 25, 1996, 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 $4,000, as a reasonable assessed attorney fee, payable by the insurer.

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January 14, 1998 Cite as 50 Van Natta 60 (1998)

In the Matter of the Compensation of
**ROY HAKANSON, Claimant**
Own Motion No. 97-0069M
OWN MOTION ORDER OF ABATEMENT
Cole, Cary & Wing, Claimant Attorneys

Claimant requests reconsideration of our December 22, 1997 Own Motion Order Reviewing Carrier Closure, in which we affirmed the employer's August 29, 1997 Notice of Closure in its entirety.

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

IT IS SO ORDERED.

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In the Matter of the Compensation of
**ALYCE J. LANGLEY, Claimant**
WCB Case No. 96-09992
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Cowling, Hornecker, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Michael Johnson'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.

Claimant argues that because of its failure to contest a prior ALJ's permanent disability award, the employer is barred under Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996) from denying claimant's lumbar degenerative disease condition. However, we have held that amended ORS 656.262(10) has overruled the holding of Messmer. Keith Topits, 49 Van Natta 1538 (1997). Under amended ORS 656.262(10), the failure to appeal or seek review of a litigation order does 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. Thus, whether or not the prior ALJ's order awarded benefits for the degenerative condition, the employer is not precluded from denying that condition unless it has been formally accepted.

Claimant next argues that the degenerative condition was accepted in 1987 when the employer's denials were rescinded. Claimant notes that no formal acceptance notice issued and that the only evidence of what was accepted was the express language of the denials and the medical reports that were received at the time of the denials. Claimant argues that by rescinding its denials, the employer accepted ankle and back "problems" and that under Georgia Pacific v. Piwowar, 305 Or 494 (1988), the employer's acceptance of "problems" included the underlying conditions causing such problems.

Where there is no specific acceptance, we look to the contemporaneous evidence to determine the scope of the carrier's acceptance. Cecilia A. Wahl, 44 Van Natta 2505 (1992).

Here, the "801" claim form filed in 1985 indicated that the condition claimed was a back "strain." (Ex. 3). The condition was diagnosed by Dr. Peterson as a lumbar muscle strain. (Exs. 4; 5,7). Dr. Jansch diagnosed claimant's condition on January 17, 1986 as "L.S. spasm with sciatic pain, pain (L) foot (digits III IV V)." (Ex. 6). X-rays at that time revealed "mild degenerative arthritis." Id. Dr. Jansch later identified claimant's condition as "chronic lower abdominal pain and lumbosacral back pain with pain radiating down left leg to digits III, IV, and V of the left foot since July 02, 1985." (Ex. 29). Dr. Womack's assessment was "chronic back pain with a possible radicular component"; however, an electrodiagnostic study by Dr. Womack later revealed no evidence of radiculopathy, myopathy or peripheral neuropathy. (Exs. 8-2;. 9).

On October 27, 1986, the employer denied claimant's claim "alleging ankle and back problems." (Ex. 22). The employer issued a corrected denial on November 26, 1986 again indicating that claimant's claim for ankle and back problems was denied. (Ex. 27). In 1987, the parties entered into a stipulation providing, in relevant part, that the employer "rescinds denials of claim dated October 27, 1986 and November 26, 1986 * * *." (Ex. 35).

Although there is evidence from Dr. Kitchel that claimant's current low back and lower extremity symptoms are now caused by lumbar degenerative disease, the medical evidence does not attribute claimant's 1987 symptoms to the degenerative condition. Dr. Smith speculates in a 1988 deposition that claimant's 1985 compensable injury was a strain or sprain superimposed on mild degenerative changes. (Ex. 82-25). However, to the extent that Dr. Smith's opinion suggests that some of claimant's symptoms in 1987 may have been attributable to degenerative disease, we are not persuaded by that opinion. Dr. Smith did not examine claimant at the time of the initial injury or at the time the denials were rescinded. Moreover, his opinion was given in the context of addressing claimant's permanent disability due to the accepted claim. Thus, to the extent that his opinion relates claimant's 1987 symptoms to degenerative disease, we do not find it persuasive.

Even assuming that the employer accepted low back and left ankle "problems" as claimant argues, there is no persuasive evidence that the "problems" at that time were caused by the mild degenerative disease.[1] Under such circumstances, we are unable to find, based on this record, that the scope of the employer's 1987 acceptance included degenerative disease.

ORDER

The ALJ's order dated May 5, 1997 is affirmed.

[1] Because there is no evidence that claimant's low back and ankle symptoms in 1987 were caused by degenerative disease, we find the Piwowar case cited by claimant distinguishable on its facts. In Piwowar, the employer accepted a claim for a sore back, which was merely a symptom of an underlying condition of ankylosing spondylitis. Here, in contrast, there is no persuasive medical evidence that claimant's low back and ankle problems in 1987 were symptoms of degenerative disease.



In the Matter of the Compensation of
**JOE M. MANN, Claimant**
WCB Case No. 96-01194
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Mitchell, Lang & Smith, Defense Attorneys

Reviewed by the Board en banc.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that: (1) declined to award interim compensation for the period beginning August 8, 1996; and (2) declined to assess a penalty for the self-insured employer's allegedly unreasonable refusal to pay interim compensation. On review, the issues are interim compensation and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of his finding of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Interim Compensation

We summarize the relevant facts. Claimant suffered multiple injuries when he fell 26 to 40 feet from a roof while working on January 13, 1995. His claim was accepted for rib fractures, finger dislocation and closed head injury. His condition was declared medically stationary in July 1995, and the claim was closed by Determination Order on September 8, 1995, with an award of temporary total disability benefits. (Ex. 29). The determination was affirmed by Order on Reconsideration dated November 22, 1995. (Ex. 37).

Meanwhile, in September 1995, claimant was hospitalized for a seizure. He recovered and did not seek follow-up care. (Ex. 41-1). On December 20, 1995, the employer denied the claim for the seizure. (Ex. 39). In April 1996, claimant felt light-headed and nearly passed out while at home. (Ex. 41-4). Subsequently, following a neurological consultation, he was diagnosed with post-traumatic headaches and post-traumatic vestibular dysfunction. (Ex. 44-3).

On August 8, 1996, Dr. So, claimant's attending physician, had a telephone conference with the employer's attorney and advised that the post-traumatic headaches and post-traumatic vestibular dysfunction were related to the accepted closed head injury and that claimant would be unable to resume work pending therapy over the next 12 months. (Ex. 51).

By letter dated September 26, 1996, claimant's attorney requested that the employer "correct" its acceptance notice to include post-traumatic headaches and post-traumatic vestibular dysfunction. (Ex. 52A). The parties agreed to process the September 26 letter as a "new medical condition" claim pursuant to ORS 656.262(7). A Notice of Claim For Aggravation was eventually filed on claimant's behalf on November 27, 1996. (Ex. 57). The employer did not pay interim compensation while processing the new medical condition claim.

Claimant requested a hearing, seeking payment of interim compensation for the period beginning August 8, 1996, the date of Dr. So's telephone conference with the employer's attorney. The ALJ refused, holding that claimant's request for modification of the acceptance notice to include additional conditions did not trigger the employer's duty to pay interim compensation under ORS 656.262(4)(a). Reasoning that the duty to pay interim compensation is triggered by the filing of either an initial claim or an aggravation claim, the ALJ concluded that, because the initial claim was accepted and closed, the duty to pay interim compensation could only be triggered by the filing of an aggravation claim. On review, claimant argues that the employer's receipt of notice of a disabling "new medical condition" claim on August 8, 1996 triggered its duty to pay interim compensation. We agree and reverse on this issue.

Our statutory analysis begins with the text and context of the relevant statutes. ORS 174.20; PGE v. Bureau of Labor and Industries, 317 Or 606, 610 (1993). ORS 656.262(4)(a) provides that "[t]he first installment of temporary disability compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim, if the attending physician authorizes the payment of temporary disability compensation." (Emphasis supplied.) The term "claim" is defined by statute as "a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge." ORS 656.005(6). We recently held that this statutory definition is broad enough to include a "post-closure" new medical condition claim under ORS 656.262(7). Mario R. Castaneda, 49 Van Natta 2135 (1997); accord SAIF v. Allen, 320 Or 192, 203 (1994) (definition of claim under ORS 656.005(6) is not limited to initial claims). We also concluded in Castaneda that this statutory construction did not conflict with the structure or purpose of the workers' compensation scheme as a whole. In particular, we found no statutory provision that expressly or impliedly excluded new medical condition claims from the provisions of ORS 656.262(4). Accordingly, we construe the term "claim" in ORS 656.262(4)(a) to include a new medical condition that is filed after claim closure.

Our construction is consistent with the statutory scheme as amended by the 1997 Legislature. Subsequent to the ALJ's order, the legislature enacted ORS 656.262(7)(c). HB 2971, 69th Leg., Reg. Sess. (July 25, 1997). Pursuant to this statutory provision, "[i]f a condition is found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition." (Emphasis added). ORS 656.262(7)(c) is retroactively applicable to this case.[1] Bay Area Hospital v. Landers, 150 Or App 154 (1997); Ronald D. Smith, 49 Van Natta 1807 (1997).

In Castaneda, we held that, under ORS 656.262(7)(c), if a new medical condition is found compensable after claim closure, the insurer must "reopen the claim for processing" regarding that condition. We further held that the insurer's duty to "reopen the claim for processing" included the payment of any "procedural" temporary disability benefits that may be due under ORS 656.262(4)(a) for the new medical condition.

Interim compensation is paid upon receipt of notice of a claim until the claim is accepted or denied, while temporary disability is paid after acceptance of the claim. See Jones v. Emanuel Hospital, 280 Or 147 (1977). Yet, there is a close identity between interim compensation and temporary disability; they are paid only if the claimant is at least partially disabled, and the amount of interim compensation is computed in the same manner as temporary disability benefits. See Bono v. SAIF, 298 Or 405, 408-409 (1984).

Based on the close identity between interim compensation and temporary disability, and our ruling in Castaneda that the post-closure processing of a new medical condition claim includes the payment of temporary disability that may be due for the new condition under ORS 656.262(4)(a), we conclude that the filing of a new medical condition claim after claim closure triggers the payment of interim compensation that may be due under ORS 656.262(4)(a). In this regard, we find no language in ORS 656.262(4), ORS 656.262(7) or the aggravation statute, ORS 656.273, which makes the filing of an aggravation claim a prerequisite for receipt of interim compensation for "post-closure" new medical conditions.

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[1] ORS 656.262(7)(c) applies to all claims or causes of action existing or arising on or after the July 25, 1995 effective date of HB 2971, regardless of the date of injury or the date a claim is presented. HB 2971, Section 2. Because the claim in this case existed on the effective date of HB 2971, and because that Act is intended to be fully retroactive, we apply ORS 656.262(7)(c) to this case.

In summary, based on the statutory text and context and consistent with our holding in Castaneda, we conclude that the employer's duty to begin payment of interim compensation was triggered by its receipt of notice of a new medical condition after the claim was closed, and the attending physician's authorization of temporary disability.[2] Here, the employer received notice of claimant's new medical condition claim on August 8, 1996. (Ex. 51). In addition, the employer simultaneously received Dr. So's authorization for claimant to be released from work pending therapy for his new medical condition. (Id.) Thus, the employer was required to begin payment of interim compensation by August 22, 1996, the 14th day after August 8, 1996. Furthermore, based on our review of the record, we find no basis for terminating payment of interim compensation prior to the date of hearing in this matter. Accordingly, payment of interim compensation shall continue until termination is authorized by law.

Penalty

Claimant also contends that he is entitled to a penalty for the employer's refusal to pay interim compensation. On review, the employer argues that it had a legitimate doubt about its liability for interim compensation under the facts of this case. 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).

Before Castaneda, there was no decision directly holding that interim compensation for new medical conditions filed after claim closure must be paid under ORS 656.262(4). Therefore, we find that the employer had a legitimate doubt regarding its legal liability, and a penalty is not warranted.

ORDER

The ALJ's order dated December 30, 1996 is reversed in part and affirmed in part. The portion of the order that declined to order payment of interim compensation is reversed. The employer is directed to pay claimant interim compensation for the period beginning August 8, 1996 until termination is authorized by law. Claimant's attorney is awarded an attorney fee of 25 percent of the additional compensation created by this order, not to exceed $3,800, payable out of compensation and directly to claimant's attorney. The remainder of the ALJ's order is affirmed.

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[2] The employer cites to Sandra Miles, 48 Van Natta 553 (1996), in which we stated that, after claim closure, a worker may receive additional temporary disability only by proving that the closure was premature or by proving an aggravation claim. However, because Miles was decided before the 1997 amendments to ORS 656.262(7), we find that case to be distinguishable.

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In the Matter of the Compensation of
**EDWARD R. REUTER, Claimant**
Own Motion No. 97-0570M
OWN MOTION ORDER OF DISMISSAL
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for own motion relief for claimant's compensable inflammation or irritation of joints, tendon or muscles, left knee injury. Claimant's aggravation rights expired on May 25, 1990. Although SAIF agrees that claimant's current left knee condition is causally related to the accepted condition and it is responsible for claimant's current condition, SAIF opposes authorization of temporary disability compensation, contending that claimant has withdrawn from the work force. In addition, SAIF notes that its positions regarding whether claimant requires surgery for his current condition and the reasonableness and necessity of that surgery remain undetermined, pending a decision from a Managed Care Organization (MCO) regarding those issues.

By letter dated October 6, 1997, claimant explained that he was not seeking temporary disability benefits because he has retired from the work force. However, he requests medical treatment for his compensable left knee condition. Specifically, he requests the left total knee replacement recommended by Dr. Lantz.

Because claimant's aggravation rights have expired on the 1982 injury claim, the Board has exclusive jurisdiction over reopening this claim for temporary disability benefits under limited circumstances when claimant's condition has worsened requiring inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). Under such circumstances, we may authorize the payment of temporary disability benefits from the time the worker is actually hospitalized or undergoes outpatient surgery, provided that claimant is in the work force at the time of disability. Id; Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989); Weyerhaeuser v. Kepford, 100 Or App 410, 414, rev den 310 Or 71 (1990).

On the other hand, since claimant was compensably injured after December 31, 1965, the Board's own motion jurisdiction does not extend to issues regarding the reasonableness and necessity of medical treatment. ORS 656.278(1)(b); compare Gerald S. Gaage, 42 Van Natta 2722 (1990) (in cases involving certain pre-1966 injury claims, Board may exercise its own motion authority to reopen a claim for payment of medical benefits). Instead, such issues are within the jurisdiction of the Director. ORS 656.245(6); 656.260; 656.327. Therefore, if claimant disputes the pending decision by the MCO regarding the reasonableness and necessity of the proposed left knee surgery, the Director provides the appropriate forum for resolution of that dispute.[1]

Here, claimant is requesting only medical services. Under the circumstances of this case, the Board in its own motion authority does not have jurisdiction over the medical service issue.

Accordingly, we dismiss the request for own motion relief.

IT IS SO ORDERED.

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[1] 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

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In the Matter of the Compensation of
**ROBERT S. GRADT, Claimant**
Own Motion No. 97-0588M
OWN MOTION ORDER

The self-insured employer has submitted claimant's request for temporary disability compensation for claimant's compensable low back strain injury. Claimant's aggravation rights expired on August 25, 1993. The employer agrees that claimant's current condition, lumbar spinal stenosis with radiculopathy, 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, the employer 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).

The employer contends that claimant was not in the work force at the time of the current disability. Claimant responded to the employer's contention by letter dated December 30, 1997. Claimant provided copies of medical reports and claim forms which evidence his current disability and need for treatment. The documentation provided by claimant also evidences his retirement in 1989 and by claimant's own statement, he has been unable to work since his retirement. Although claimant indicates he retired because he was unable to work due to the compensable condition, he does not provide a medical opinion which would support his contention.

Further, Dr. Rosenbaum, in his November 7, 1997 IME report, indicated that claimant was found medically stationary on May 24, 1988 with mild to moderate restrictions. Dr. Rosenbaum reported claimant's statement that he retired in 1989 "hoping that his back would not require further treatment." The evidence in the record supports the contention that claimant voluntarily left the work force when he retired. Claimant has not provided a medical opinion supporting his contention that he is currently unable to work or seek work due to his 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.

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January 16, 1998 Cite as 50 Van Natta 66 (1998)

In the Matter of the Compensation of
**GERALD F. JAENSCH, Claimant**
WCB Case No. 96-11233
ORDER ON REVIEW
Coughlin, et al, Claimant Attorneys
Mitchell, Lang, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) found that claimant was entitled to temporary disability benefits after September 19, 1996; and (2) assessed a penalty for allegedly unreasonable claim processing. Claimant moved to dismiss the matter as moot. On review, the issues are dismissal, temporary disability benefits, and penalty. We deny the motion to dismiss and reverse.

## FINDINGS OF FACT

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

On March 12, 1996, as an alternative to taking claimant completely off work, Dr. Kopp released claimant to sedentary work with restrictions to include no lifting, no standing for long periods of time, no stooping, no crouching, no bending, and minimal walking. (Exs. 2-1, 3). Claimant returned to modified work with the employer and received his regular wage. (Exs. 7, 10; Tr. 15).

On September 18, 1996, the employer terminated claimant's employment for disciplinary reasons. (Tr. 65-66, 74-76). Claimant was not terminated because he was unable to perform his job due to the compensable injury.

In October 1996, Dr. Corson believed that claimant was capable of performing at least sedentary work. (Ex. 13-1).

Claimant requested a hearing, asserting that the employer improperly failed to pay temporary total disability while his claim was in open status. A hearing was held on March 25, 1997 concerning the issue of claimant's entitlement to procedural temporary disability benefits. By an Opinion and Order dated April 25, 1997, the ALJ found that claimant was entitled to temporary disability benefits from September 19, 1996 until the claim was closed or termination of benefits was otherwise authorized. The ALJ also awarded a penalty for the insurer's unreasonable claim processing for its failure to commence paying benefits after September 19, 1996.

On May 21, 1997, a Determination Order[1] issued awarding temporary disability from March 6, 1996 through January 20, 1997, the medically stationary date. The insurer requested reconsideration. However, neither party raised the issue of temporary disability, and the August 29, 1997 Order on Reconsideration[2] affirmed the Determination Order with respect to temporary disability.

We do not adopt the ALJ's ultimate findings of fact.

## CONCLUSIONS OF LAW AND OPINION

### Motion to Dismiss

The issue in this case concerns claimant's procedural entitlement to temporary disability benefits after he was terminated from work on September 18, 1996. Subsequent to the hearing, a Determination Order issued awarding claimant temporary disability benefits from March 5, 1996 through January 20, 1997, the medically stationary date. An Order on Reconsideration affirmed the temporary disability award, and the Order on Reconsideration has become final. Because the closure orders addressed the same temporary disability period that was at issue at the hearing, and because the closure orders have become final, claimant contends that the insurer's request for review should be dismissed as moot.

The insurer objects, arguing that the closure orders did not resolve the question of whether claimant is entitled to temporary total or temporary partial disability for the period at issue. For the following reasons, we conclude that dismissal is not appropriate.

The insurer has timely requested review of the ALJ's order. ORS 656.289(3). Claimant does not contend that his notice of the request for hearing was defective. See ORS 656.295(2). Therefore, as a procedural matter, we are authorized to review the ALJ's decision. See Elvia H. Hillner, 49 Van Natta 567 (1997); Mike D. Sullivan, 45 Van Natta 990 (1993). Furthermore, upon review, we are authorized to affirm, reverse, modify or supplement the ALJ's order, as well as make such disposition of the case as we determine to be appropriate. ORS 656.295(6); Donald L. Lowe, 41 Van Natta 1873, 1874 (1989). Therefore, we conclude that dismissal of the insurer's request for review is not appropriate.

### Temporary Disability

Claimant returned to modified work, at his regular wage, after compensably injuring his left foot. While claimant remained on modified duty, the employer terminated his employment for disciplinary reasons on September 18, 1996.

The ALJ determined that claimant was entitled to procedural temporary disability benefits beginning September 19, 1996, and continuing until the claim was closed or termination of benefits was otherwise authorized by law. The ALJ did not specify whether claimant was entitled to temporary total or temporary partial disability benefits. However, based on the ALJ's discussion and application of Hallmark Fisheries v. Harvey, 100 Or App 657 (1990), and ORS 656.268(3),[3] we conclude that the ALJ intended to award claimant temporary total disability benefits.

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[1] Claimant attached a copy of the May 21, 1997 Determination Order with his Motion to Dismiss, marked as Exhibit A. We take administrative notice of this document. See Kathy L. Paul, 49 Van Natta 1303, 1304 n.2 (1997).

[2] Claimant also attached a copy of the August 29, 1997 Order on Reconsideration with his Motion to Dismiss, marked as Exhibit B. We also take administrative notice of this document.

[3] ORS 656.268(3) provides, in material part, that "[t]emporary **total** disability benefits shall continue until whichever of the following events first occurs: * * *." (Emphasis supplied).

The issue before the ALJ concerned procedural temporary disability benefits because the claim was still open. Subsequent to the hearing, however, the claim was closed and a Determination Order awarded claimant substantive temporary disability benefits from March 6, 1996 through January 20, 1997. The temporary disability award was affirmed by an Order on Reconsideration, and the Order on Reconsideration became final. Thus, there is a final order awarding claimant temporary disability benefits for the same period of time that was in issue before the ALJ.

Because it is a "matter concerning a claim," we have jurisdiction over requests for procedural temporary disability benefits even though the claim has subsequently been closed and a claimant's substantive entitlement to temporary disability benefits have been determined. See Alfredo Martinez, 49 Van Natta 67 (1997). However, we are not authorized to award procedural disability for time periods that have been substantively determined by final closure orders. See Lebanon Plywood v. Seiber, 113 Or App 651 (1992); Martinez, 49 Van Natta at 68.

Here, as noted above, the ALJ awarded procedural temporary total disability benefits beginning September 19, 1996. The Determination Order, as affirmed by the Order on Reconsideration, awarded a period of temporary disability benefits from March 6, 1996 through January 20, 1997.[4] Because claimant's entitlement to temporary disability benefits for the time period granted by the ALJ has been substantively determined by the final Order on Reconsideration, we are without authority to award procedural temporary disability benefits for the same time period. Consequently, the ALJ's order award of temporary total disability benefits must be reversed.

Penalty

The ALJ found that the insurer's failure to pay temporary total disability benefits was unreasonable and assessed a penalty. We disagree.

As a preliminary matter, we note that although closure of the claim deprived us of the authority to grant claimant procedural temporary disability benefits, a penalty may still be assessed for an unreasonable failure to pay procedural disability benefits. See John R. Heath, 45 Van Natta 466, 467 (1993), aff'd Anodizing, Inc. v. Heath, 129 Or App 352 (1994).

Here, we do not find that insurer's failure to pay temporary total disability was unreasonable based on the following reasoning.

Claimant sustained a compensable injury in March 1996. Shortly thereafter, claimant returned to modified work with the employer and received his regular wage. (Exs. 7, 10; Tr. 15). Thus, at that time, claimant was entitled to temporary partial disability benefits, but the rate of such benefits was zero as claimant was receiving his regular wage. On September 18, 1996, claimant was terminated. At that time, claimant remained restricted to modified work. (Exs. 12, 13). There is no evidence which establishes that claimant was entitled to temporary total disability benefits at that time. Based on this, we do not find that the insurer's failure to pay temporary total disability benefits after September 18, 1996 was unreasonable.[5] Consequently, a penalty is not warranted.

ORDER

The ALJ's order dated April 25, 1997 is reversed. The ALJ's awards of procedural temporary disability benefits, penalties, and out-of-compensation attorney fees are reversed.

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[4] Our order only addresses whether the ALJ had the authority to grant procedural temporary disability benefits. We have herein concluded the ALJ lacked such authority. Any potential "enforcement " issue regarding whether the Order on Reconsideration awarded temporary partial disability or temporary total disability benefits is not before us.

[5] Although claimant may have remained entitled to temporary partial disability benefits after September 18, 1997, the rate of such benefits was zero. Consequently, the insurer's failure to pay such benefits would likewise not be the basis for a penalty.

In the Matter of the Compensation of
**RALPH L. MORRIS, Claimant**
WCB Case No. 97-01319
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review[1] of those portions of Administrative Law Judge (ALJ) Marshall's order that: (1) set aside SAIF's partial denial of claimant's left knee chondromalacia and tibial fracture conditions; and (2) awarded a carrier-paid attorney fee for overturning the denial. On review, the issues are compensability and attorney fees. We modify in part and reverse in part.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

Claimant filed a claim for a November 2, 1996 left knee injury. X-rays and tomograms showed a preexisting fracture of the medial tibial plateau and degenerative arthritis of the medial compartment of the left knee. (Exs. 3, 4, 6). Dr. Lantz opined that claimant might have a new chondral injury and a meniscal tear and requested arthroscopic surgery to evaluate the knee. (Ex. 3). In response to a query from SAIF, Dr. Lantz opined that the injury combined with the preexisting condition and was the major cause of the need for treatment of claimant's left knee. (Ex. 6). Subsequent to surgery, Dr. Lantz diagnosed: medial meniscal tear; chondromalacia of the medial femoral condyle and patella; and a loose interarticular tibial plateau fracture. (Ex. 8).

On February 3, 1997, SAIF accepted the medial meniscus tear and partially denied the chondromalacia of the medial femoral condyle and patella and the fracture of the interarticular tibial plateau, on the basis that claimant's November 1996 injury was not the major contributing cause of those conditions. (Exs. 9, 10). On February 13, 1997, claimant filed a request for hearing on the denial.

By letter dated April 22, 1997, SAIF rescinded its denial on the basis that neither claimant nor his attorney had made formal claims in writing for the denied conditions. In its letter, SAIF stated: "If a formal claim is made for these conditions in the future, SAIF reserves the right to review them for compensability at that time." (Ex. 13).

At hearing, SAIF asserted that, since claimant had made no claim in writing for the denied conditions, and SAIF had withdrawn its denial, the Hearings Division lacked authority to resolve the matter.

Relying on Safeway Stores v. Smith, 117 Or App 224 (1992), the ALJ essentially found that the medical record as a whole, including SAIF's inquiries regarding causation, constituted a claim for the chondromalacia and tibial fracture conditions, which SAIF formally denied. Thus, the ALJ reasoned, where the carrier had already issued a formal denial, ORS 656.262(6)(d)[2] was inapplicable, and, as

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[1] Although claimant filed a cross-request for review, he did not raise any additional issues on review.

[2] ORS 656.262(6)(d) was not amended by the 1997 Legislature and provides:

"An injured worker who believes that a condition has been incorrectly omitted from a notice of acceptance, or that the notice is otherwise deficient, first must communicate in writing to the insurer or self-insured employer the worker's objections to the notice. The insurer or self-insured employer has 30 days from receipt of the communication from the worker to revise the notice or to make other written clarification in response. A worker who fails to comply with the communication requirements of this paragraph may not allege at any hearing or other proceeding on the claim a de facto denial of a condition based on information in the notice of acceptance from the insurer or self-insured employer. Notwithstanding any other provision of this chapter, the worker may initiate objection to the notice of acceptance at any time."

claimant's denied conditions arose prior to the acceptance, ORS 656.262(7)(a)[3] was inapplicable as well. Therefore, the ALJ reasoned, because claimant had made a claim for the denied conditions, and SAIF's "rescission" of its denial was based solely on its position that claimant had not made a claim for those conditions, the rescission was invalid and the compensability issue was properly before the Hearings Division.

Alternatively, the ALJ concluded, even if SAIF had effectively withdrawn its denial, it had de facto denied the additional left knee conditions, as more than 90 days had passed since SAIF received Dr. Lantz's reports regarding the chondromalacia and tibial fracture conditions. Finally, on the merits, the ALJ held that claimant's combined condition, including the tibial fracture and chondromalacia, was compensable and awarded claimant's counsel an attorney fee for overturning SAIF's denial.

On review, SAIF contends that its denial was premature and a nullity, as claimant failed to communicate in writing that the chondromalacia and tibial plateau fracture conditions had been incorrectly omitted from the Notice of Acceptance as required under ORS 656.262(6)(d), or to request formal written acceptance of "new medical conditions" as required under ORS 656.262(7)(a). Thus, SAIF reasons, the ALJ had no jurisdiction to address the compensability issue and award an attorney fee. SAIF also contends that, even if it had effectively withdrawn its denial, claimant was barred from alleging a "de facto" denial. We conclude that the ALJ has jurisdiction to consider the dispute;[4] however, for the following reasons, we hold that SAIF's denial was premature.

A physician's report requesting medical services for a specified condition is no longer sufficient to be a request for compensation. ORS 656.262(7)(a); Brian D. Shipley, 48 Van Natta 994, on recon 48 Van Natta 2280, 2281 (1996).

In Shipley, we explained that, prior to the passage of ORS 656.262(7)(a), a physician's report requesting medical services for a specified condition was sufficient to be a request for compensation. Safeway Stores, Inc. v. Smith, 117 Or App 224, 227 (1992). However, based on the text and context of ORS 656.262(7)(a), we held that a claimant must now formally request written acceptance of claims for aggravation or new medical conditions in order to trigger the running of the 90-day period in which a carrier has to accept or deny a claim. Shipley, 48 Van Natta at 2281. Consequently, absent a formal request for written acceptance of a claim for aggravation or a new medical condition, a claimant is barred from asserting a "de facto" denial based on failure to accept or deny a "new condition" after 90 days.

Here, claimant's reliance on the medical record and Dr. Lantz's reports and request for surgery to establish that he has made a claim for his unaccepted chondromalacia and tibial fracture conditions is misplaced. Moreover, Dr. Lantz's reports did not comply with the statute in making a "new medical condition" claim for the chondromalacia and tibial plateau fracture conditions. Even though Dr. Lantz's December 4, 1996, response to SAIF's query supports a causal relationship between the compensable injury and the preexisting chondromalacia and tibial plateau fracture conditions, the report does not "clearly request formal written acceptance" of those conditions. Furthermore, claimant's request for

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[3] ORS 656.262(7)(a) was not amended by the 1997 Legislature and provides:

"After claim acceptance, written notice of acceptance or denial of claims for aggravation or new medical conditions shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the insurer or self-insured employer receives written notice of such claims. New medical condition claims must clearly request formal written acceptance of the condition and are not made by the receipt of a medical claim billing for the provision of, or requesting permission to provide, medical treatment for the new condition. The worker must clearly request formal written acceptance of any new medical condition from the insurer or self-insured employer. The insurer or self-insured employer is not required to accept each and every diagnosis or medical condition with particularity, so long as the acceptance tendered reasonably apprises the claimant and medical providers of the nature of the compensable conditions. Notwithstanding any other provision of this chapter, the worker may initiate a new medical condition claim at any time."

[4] The ALJ had the authority under ORS 656.704(3) and ORS 656.708 to decide the issue in dispute. SAIF v. Roles, 111 Or App 597 (1992) (subject matter jurisdiction depends solely upon whether a decision-making body has the authority to make an inquiry and exists when a statute authorizes that body to do something about the dispute; an ALJ's erroneous exercise of that authority did not deprive him of subject matter jurisdiction).

hearing does not meet this requirement under ORS 656.262(7)(a). Diane S. Hill, 48 Van Natta 2351, 2352-53 (1996), aff'd mem Hill v. Stuart Andersons, 149 Or App 496 (1997) (in a new medical condition claim that arises after acceptance, a hearing request concerning an unaccepted condition is premature where a "new medical condition" claim has not been filed with the carrier prior to the filing of the hearing request and the carrier has challenged the propriety of the compensability proceeding). Nor does it satisfy the "communication in writing" prerequisite in ORS 656.262(6)(d), because the communication must precede the hearing request. Shannon E. Jenkins, 48 Van Natta 1482 (1996), aff'd mem Jenkins v. Continental Baking Co., 135 Or App 436 (1997). Thus, because there was no "communication in writing" by claimant regarding objections to SAIF's acceptance that preceded claimant's request for hearing, claimant is precluded from proceeding to hearing on the issue of "de facto" denial. Id. at 1484, 1486.

Based on the aforementioned reasoning, we conclude that claimant did not make a claim for his chondromalacia and tibial plateau fracture conditions. Consequently, because claimant has not filed a "new medical condition" claim for those conditions, and SAIF contested the propriety of proceeding with litigation of the compensability issue,[5] we conclude that SAIF's partial denial of those conditions was premature. Vicki L. Davis, 49 Van Natta 603 (1997).

In Davis, the claimant was injured at work on March 15, 1995, and the carrier accepted the claim for lumbar strain and rib contusion. An x-ray taken the day after the injury indicated mild degenerative disc disease throughout claimant's lumbosacral spine, which was confirmed by several physicians. Contending that the degenerative conditions were unrelated to the accepted lumbar strain injury, the carrier issued a "pre-closure" precautionary partial denial.

We held that the carrier's denial was premature because the claimant had not made a claim for her degenerative conditions. Relying on Ramona E. Hamilton, 48 Van Natta 2438 (1996), we reasoned that, because neither the claimant nor her physician made a "clear request" for a "formal written acceptance" of any degenerative conditions, there had not been a "new medical condition" claim under ORS 656.262(7)(a). Inasmuch as a denial issued in the absence of a claim is a nullity, we found that the carrier's denial had no legal effect.

We reach the same conclusion in this case. Here, SAIF accepted a "medial meniscus tear." (Ex. 9). Thereafter, as discussed above, neither claimant nor his physician made a "clear request" for "formal written acceptance" of chondromalacia of the medial femoral condyle and patella and fracture of the interarticular tibial plateau. Therefore, we find no "new medical condition" claim was made pursuant to ORS 656.262(7)(a). Thus, since a denial issued in the absence of a claim is a nullity, we find that SAIF's denial of the chondromalacia and fracture conditions has no legal effect. Altamirano v. Woodburn Nursery, Inc., 133 Or App 16, 19-20 (1995); Vicki L. Davis, 49 Van Natta at 604. Therefore, we vacate the ALJ's decision to set aside SAIF's denial.

Inasmuch as we have determined that claimant has made no "claim," he will receive no benefits as a result of our holding that the insurer's denial was premature and a nullity. Consequently, whether the denial was "rescinded" by SAIF or "set aside" as premature, claimant has not "prevailed" over a denied claim and is, therefore, not entitled to an assessed attorney fee under ORS 656.386(1)[6]. Stephenson v. Meyer, 150 Or App 300 (1997).

## ORDER

The ALJ's order dated May 20, 1997 is modified in part, reversed in part and affirmed in part. That portion of the order that set aside the insurer's denial is modified to set aside the denial as premature. The ALJ's attorney fee award is reversed. The remainder of the order is affirmed.

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[5] This decision should not be construed as prohibiting parties in a workers' compensation proceeding from agreeing to litigate issues not properly raised. See Diane S. Hill, 48 Van Natta at 2356 n.2, citing EBI Companies v. Thomas, 66 Or App 105 (1983).

[6] We note that the 1997 Legislature revised ORS 656.386(1). However, the revisions that went into effect on July 25, 1997, were not made retroactive and are therefore not applicable to this case. Stephenson, 150 Or App at 301 n.3.

In the Matter of the Compensation of
**DEWAYNE A. MERIDITH, Claimant**
WCB Case No. 96-07387
ORDER ON REVIEW
Rasmussen, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) McWilliams' order that upheld the SAIF Corporation's denial of claimant's injury claim for the right knee and right shoulder. On review, the issue is compensability. We affirm.

## FINDINGS OF FACT AND ULTIMATE FACT

We adopt the ALJ's findings as corrected and supplemented below.

Claimant's February 1990 right shoulder injury was aggravated in an incident with police officers in July 1991, when claimant was pulled from his vehicle.

Claimant received treatment for his prior right shoulder symptoms through July 1995, rather than April 1995.

Dr. McHan's June 11, 1996 chart notes reference an "old injury" to the left knee. The chart notes do not expressly identify claimant's current symptoms.

## CONCLUSIONS OF LAW AND OPINION

We adopt the ALJ's "Conclusions of Law and Reasoning" subject to the following comment.

The ALJ analyzed claimant's current right shoulder condition as a combined condition under ORS 656.005(7)(a)(B). On review, claimant contends that the record does not establish that the June 5, 1996 injury combined with a preexisting right shoulder condition. We need not address this issue, as we are not persuaded that claimant has established compensability of his right shoulder condition under either a material or the major contributing cause standard. In this regard, we adopt the ALJ's determination that the opinions of Drs. Weller and LeGat are not persuasive because they are based on claimant's inaccurate and unreliable account of his injury and subsequent symptoms.

## ORDER

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

In the Matter of the Compensation of
**NANCY B. ALEXANDER, Claimant**
WCB Case Nos. 95-02601 & 95-01908
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Mills' order that: (1) excluded "post-reconsideration order" evidence; (2) affirmed an Order on Reconsideration that awarded claimant 25 percent (80 degrees) unscheduled permanent disability for her low back condition; and (3) found claimant to be medically stationary on July 27, 1994. On review, the issues are evidence, premature closure, and extent of permanent disability. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the following corrections:

In the first sentence of the first paragraph of the ALJ's findings of fact, we change the date of injury from March 3, 1996, to March 6, 1992.

In the last sentence of the seventh paragraph of the ALJ's findings of fact, we change "Dr. Mawk" to "Dr. Long."

## CONCLUSIONS OF LAW AND OPINION

### Premature Closure

Claimant sustained a low back injury at work on March 6, 1992. In August 1993, claimant underwent L4-5 and L5-S1 surgery by Dr. Mawk. Because claimant did not improve, Dr. Mawk re-explored the L4-5 level in May 1994. Thereafter, claimant received physical therapy on referral from Dr. Long.

On November 22, 1994, a Notice of Closure issued, closing the claim and finding that claimant was medically stationary on July 27, 1994. Claimant requested reconsideration. Dr. Vessely performed a medical arbiter examination. An Order on Reconsideration issued February 1, 1995, affirming the Notice of Closure with respect to the medically stationary date.

The ALJ affirmed the Order on Reconsideration. Claimant contends, relying on Dr. Long's reports, that her claim was prematurely closed because she was not medically stationary on July 27, 1994. We agree.

"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 the claimant's burden to prove, by a preponderance of the evidence, that his or her condition was not medically stationary at the time the claim was closed. Berliner v. Weyerhaeuser Co., 54 Or App 624, 628 (1981). Whether a claimant is medically stationary at the time of claim closure is determined by the medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981). Whether a claimant's condition is medically stationary is determined by the attending physician, or by a preponderance of medical opinion. Former OAR 436-30-035(1) (WCD Admin. Order 5-1992). When there is a conflict in the medical opinions, greater weight shall be given to those medical opinions that are based on the most accurate history and most objective findings, on sound medical principles, and on clear and concise reasoning. Former OAR 436-30-035(2).

Here, Drs. Mawk, Long and Vessely offered opinions regarding whether claimant was medically stationary at the time of claim closure.

Dr. Mawk, a neurosurgeon who performed claimant's low back surgeries, indicated that claimant was "discharged from neurosurgical follow up" on July 27, 1994. (Ex. 97). He subsequently confirmed that claimant was medically stationary on that date. (Ex. 104). Dr. Vessely, an orthopedist who performed a medical arbiter examination on January 21, 1995, also believed that claimant was medically stationary "from an objective point of view." (Ex. 114-5).

By contrast, Dr. Long, a physical medicine and rehabilitation physician, prescribed physical therapy for claimant on September 2, 1994. (Ex. 101). Claimant had been receiving physical therapy treatment once per week subsequent to Dr. Mawk's examination on July 27, 1994. (See Exs. 98, 100). Dr. Long did not believe that claimant was medically stationary at the time her claim was closed. (See Exs. 102, 107). Rather, he opined that claimant still needed curative physical therapy treatment to address the myofascial residuals of her low back condition. (Exs. 102, 113).

We find Dr. Long's opinion to be based on accurate and complete information and supported by a full, well-reasoned explanation of the need for treatment. Dr. Long explained the basis for his recommendation for continued physical therapy, the goals of such treatment, and the duration of the treatment. In addition, Dr. Long saw claimant several times for this back condition, beginning in August 1993. Thus, he had the opportunity to observe her condition and progress over a period of time.

By contrast, Dr. Vessely saw claimant only once for a medical arbiter examination in January 1995. Thus, he was at a disadvantage to determine whether claimant was medically stationary at the time her claim was closed. We give his opinion little weight on the medically stationary issue. We also give little weight to Dr. Mawk's opinion. Initially, Dr. Mawk opined that claimant was released from **neurosurgical** follow up on July 27, 1994, while she was continuing to receive physical therapy treatment at that time. (Ex. 97). Later, he simply stated that claimant was medically stationary on July 27, 1994, without providing any explanation or discussion of the fact that she was continuing to receive physical therapy treatment at that time under Dr. Long's care. (See Ex. 104).

Under such circumstances, we find that Dr. Long's opinion is more persuasive and constitutes the preponderance of medical opinion regarding the medically stationary issue. Therefore, we conclude that claimant was not medically stationary at the time of claim closure in November 1994.

Extent of Permanent Disability

Because we have found that claimant's claim was prematurely closed, it is unnecessary to address the issue of the extent of permanent disability.

Evidence

The ALJ admitted only those documents that were generated prior to the issuance of the Order on Reconsideration. (Exs. 116, 117). Claimant contends that the "post-reconsideration order" documents should have been admitted. We need not resolve this issue because we would reach the same conclusion in this case whether or not we considered the "post-reconsideration order" evidence.

Attorney Fees

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 the 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 November 21, 1996, is reversed. The February 1, 1995 Order on Reconsideration and November 22, 1994 Notice of Closure are set aside 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.

In the Matter of the Compensation of
**MARILYN A. CRISP, Claimant**
WCB Case No. 96-01221
ORDER ON REMAND
Malagon, Moore, et al, Claimant Attorneys
John M. Pitcher, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Weyerhaeuser Company v. Crisp, 150 Or App 361 (1997). The court has reversed our prior order, Marilyn A. Crisp, 48 Van Natta 2552 (1996), which set aside the self-insured employer's denial of claimant's claim for a low back degenerative condition. Citing the 1997 amendments to ORS 656.262(10), the court has remanded for reconsideration of our determination that the employer was precluded from contesting the compensability of claimant's low back degenerative condition by virtue of its failure to contest a prior Administrative Law Judge's (ALJ's) award of permanent disability for claimant's low back.

## FINDINGS OF FACT

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

## CONCLUSIONS OF LAW AND OPINION

Claimant suffered a compensable lower back strain/sprain in October 1981, for which an October 1983 Determination Order awarded unscheduled permanent disability. An October 1984 Opinion and Order affirmed the Determination Order's award.

Claimant sought treatment for low back pain in 1986, 1989, 1990, 1993, and 1995. On January 5, 1996, the employer denied claimant's current low back condition. Claimant requested a hearing.

The ALJ found that the 1984 Opinion and Order awarded permanent disability for claimant's degenerative condition. Consequently, pursuant to Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), rev den 320 Or 507 (1995) (Messmer I) and Deluxe Cabinet Works v. Messmer, 140 Or App 548, rev den 324 Or 305 (1996) (Messmer II), the ALJ concluded that the employer was effectively forced to accept claimant's degenerative condition and its denial was therefore precluded.

On review, we affirmed the ALJ's order, citing Messmer II. Crisp, 48 Van Natta 2552 (Member Haynes, dissenting). The employer petitioned the court for judicial review of our decision. The court reversed our order and remanded the case to us for reconsideration in light of the 1997 amendments to ORS 656.262(10) (which apply to this case).

Subsequent to 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).

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 degenerative condition under the amended statute (even if claimant's prior low back permanent disability award was based in part on her degenerative condition and the employer failed to appeal the litigation order which upheld that award). Accordingly, we proceed to the merits.

It is undisputed that claimant's degenerative condition preexisted her compensable 1981 strain injury. In addition, to the extent that the work injury still contributes to claimant's current low back condition, it does so in combination with the preexisting condition. (See Exs. 16, 17). Under these circumstances, claimant is subject to the "major contributing cause" standard of proof. See ORS 656.005(7)(a)(B).

The medical evidence concerning the nature and cause of claimant's low back problems is provided by Drs. Schachner, Matteri, Duff, and Nagel. (Exs. 8A, 8B, 13, 16, 17). Dr. Schachner opined that "a fair amount of [claimant's] symptoms are still referable to the degenerative disc disease." (Ex. 8A). He also noted that claimant's ongoing disease-related symptoms "waxed and waned, according to activities and have been slowly progressive which follows the natural course of events seen in individuals with this symptomatic disorder." (Ex. 8B).

Dr. Matteri saw "no industrial component to [claimant's] condition." (Ex. 13).

Dr. Duff opined that claimant's ongoing back complaints are related more to her underlying degenerative process than to her work for the employer or to back strain injuries. (Ex. 16-4).

Dr. Nagel acknowledged claimant's "significant lumbar arthritic and degenerative disease" and opined that claimant's 1981 work injury "is playing a material role in her current need for treatment." (Ex. 17-1).

After reconsidering the record and finding no evidence sufficient to establish that claimant's compensable injury was the "major contributing cause" of her current low back condition, we conclude that the condition is not compensable. See Cindy L. Keen, 49 Van Natta 1460 (1997)) (Where the claimant failed to establish that her work injury was the major contributing cause of her current condition or her need for treatment for that condition, the claim was not compensable).

Accordingly, on reconsideration, the ALJ's order dated July 22, 1996 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**RODNEY W. CAROTHERS, Claimant**
WCB Case No. 96-00472
ORDER ON REMAND
Dobbins, McCurdy & Yu, Claimant Attorneys
Michael O. Whitty (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Carothers v. Robert Westlund Construction, 149 Or App 457 (1997). The court has reversed our prior order, Rodney W. Carothers, 48 Van Natta 2372 (1996), which had 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" under ORS 656.126(5) and (7) when injured in Washington and, as such, was not an Oregon subject worker. The court has remanded for reconsideration, with instructions to apply the "permanent employment test" to determine whether claimant was an Oregon subject worker.

The parties have submitted a proposed "Stipulation and Disputed Claim Settlement Agreement," 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 settlement further provides that "the Request for Hearing thereon shall be dismissed with prejudice . . . in full settlement of all issues raised or raisable."

We have approved the parties' settlement, thereby fully and finally resolving this dispute, in lieu of all prior orders. Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**GINNY K. EVANS, Claimant**
Own Motion No. 96-0603M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Welch, et al, Claimant Attorneys

Claimant requests review of the self-insured employer's October 21, 1997 Notice of Closure which closed her claim with an award of temporary disability compensation from June 17, 1996 through August 31, 1996. The employer declared claimant medically stationary as of October 7, 1997. Claimant contends that she is entitled to temporary disability compensation beyond August 31, 1996.

By Own Motion Order dated February 26, 1997, we authorized the reopening of claimant's claim to provide temporary total disability compensation beginning June 16, 1996, the date she was hospitalized for compensable low back surgery. ORS 656.278(1)(a).

A claim may not be closed unless the claimant's condition is medically stationary. See OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12, (1980).

Claimant does not contend that her medically stationary date is incorrect or that she was not medically stationary when the employer closed her claim. In any event, the record would not support such a contention.[1] Rather, claimant contends that she 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 her 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). Although medical verification of an inability to work is not necessary to be entitled to substantive temporary disability, such evidence may provide proof of disability. SAIF v. Taylor, 126 Or App 658 (1994).

Claimant "protests the failure to award time loss benefits beyond August 31, 1996." (December 2, 1997 letter from claimant's attorney to the Board). In support of her contention, claimant submitted a copy of Dr. Breen's "Supplemental Medical Report," which indicated that claimant was released for regular work as of October 7, 1997, the date she was medically stationary, with permanent limitations on lifting or carrying over 35 pounds.

In response, the employer stated that claimant "was released to regular work duties on 8/31/96. She advised us that after that date, she received unemployment benefits from 8/31/96 to 11/22/96 in the total amount of $1800.96." (December 12, 1997 letter from the employer's claims processing agent to the Board). The employer submitted a copy of claimant's medical file relating to this own motion claim. Although the material submitted by the employer was voluminous, it contained very little material relevant to the issue at hand, i.e., claimant's entitlement to substantive temporary disability benefits. In addition, it contained no evidence to support the employer's contention that claimant was released to regular work on August 31, 1996.

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[1] In this regard, Dr. Breen, one of claimant's treating physician at Kaiser, provided the only medical evidence regarding claimant's medical stationary status. Following a closing exam on October 7, 1997, Dr. Breen indicated that claimant was medically stationary as of that date. (October 7, 1997 Closing Exam from Dr. Breen; October 7, 1997 "Supplemental Medical Report" from Dr. Breen). Dr. Breen's opinion is unrebutted. Furthermore, there is no evidence that claimant was not medically stationary at the time her claim was closed on October 21, 1997.

Following is a summary of the information submitted by the employer that may be relevant to claimant's disability status prior to becoming medically stationary on October 7, 1997. On June 7, 1996, claimant was examined by Mr. Hollenback, a physician's assistant with Kaiser, who released her from work from June 7, 1996 to July 1, 1996, the date of her next appointment with Mr. Hollenback. [We note that, prior to her next appointment with Mr. Hollenback, claimant underwent compensable low back surgery and was disabled as a result of that surgery]. In July 1997, claimant underwent an epidural injection to treat low back and lower extremity pain. (July 8, 1997 Chart note from Dr. Rodney, treating physician with Kaiser). On August 11, 1997, claimant was examined by Dr. Kreps, consulting physician, who recommended a series of caudal epidural steroid blocks to treat her ongoing low back and bilateral lower extremity pain. (August 11, 1997 Pain Management Consultation from Dr. Kreps). In the history section of his consultation report, Dr. Kreps noted that claimant "works full-time as a house manager." Id. The employer also submitted a copy of Dr. Breen's "Supplemental Medical Report," which is summarized above.

There is no evidence in the file supporting the employer's contention that claimant was released to regular work on August 31, 1996, or that her temporary disability due to the compensable injury ended on that date. Furthermore, although Dr. Kreps reported that claimant was working full-time as a house manager, he gave no opinion as to what that work entailed or claimant's disability status. On this record, we find Dr. Breen's release to regular work on October 7, 1997 establishes the date through which claimant was disabled due to the compensable injury.

Thus, we find the preponderance of the evidence establishes that claimant is entitled to substantive temporary total disability compensation from June 16, 1996 to October 7, 1997. The employer may offset any wages claimant earned or unemployment benefits she received during that period. See Wells v. Pete Walker's Auto Body, 86 Or App 739, rev den 304 Or 406 (1987) (court held that unemployment benefits could be treated as post-injury wage earnings and could be offset against temporary disability benefits). The employer's October 21, 1997 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 the insurer directly to claimant's attorney. See OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**BRIAN P. HANSBERRY, Claimant**
WCB Case No. 96-08392
ORDER OF ABATEMENT
Vick & Conroyd, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

On December 19, 1997, we affirmed an Administrative Law Judge's (ALJ's) order that had set aside the insurer's denial of his occupational disease/injury claim for an L5-S1 disc herniation, S1 radiculopathy and lumbosacral neuritis. Announcing that the parties have resolved their dispute, the insurer seeks abatement of our decision to await consideration of their proposed settlement.

In light of the insurer's representation, we withdraw our December 19, 1997 order. On receipt of the parties' executed agreement, we will proceed with our reconsideration. In the meantime, the parties are requested to keep us fully apprised of any future developments regarding this case.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**ALICE L. KNOX, Claimant**
WCB Case No. 96-06382
ORDER ON REVIEW
Lavis & DiBartolomeao, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Galton's order that: (1) excluded certain evidence offered by the insurer; (2) set aside its denials of claimant's claim for bilateral carpal tunnel syndrome (CTS) and overuse syndrome (OS); and (3) awarded a $4,500 attorney fee for claimant's counsel's efforts in setting aside the denials. On review, the issues are evidence, compensability, aggravation, and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the following modifications:

In the first sentence of the first complete paragraph on page 3 of the ALJ's Opinion and Order, we change "Dr. Swanson" to "Dr. Little."

In the second paragraph on page 4 of the Opinion and Order, we delete the phrase "at which time he became her attending physician" from the first sentence, as well as the subsequent reference to "Ex. 7."

In the following paragraph, we replace the second sentence with the following: "On the same date, Dr. Swanson completed an aggravation form. (Ex. 11)."

In the third sentence of the fifth paragraph on page 4 of the Opinion and Order, we delete "MTC" from that sentence.

We do not adopt the ALJ's ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant was employed by MTC from June 1993 until December 1995, first as a buyer, then as a caseload coordinator. In the latter position, claimant's work entailed, among other duties, computer data entry and keyboarding, typing, and filling out NCR forms by hand. In June 1994, claimant sought treatment for bilateral symptoms of pain, tingling and numbness in her arms and hands. Claimant's family physician, Dr. Little, indicated that claimant's symptoms were consistent with an overuse-type phenomenon or a carpal tunnel impingement syndrome. In August 1994, the insurer accepted claimant's condition as a "hand strain."

Claimant again sought treatment from Dr. Little in October 1995 for worsening symptoms in her hands.

In December 1995, claimant left MTC and immediately began employment with a realty firm, first as a secretary. In approximately April 1996, claimant was promoted to an administrative assistant. Claimant's work in these positions was less hand-intensive than her work at MTC.

In April 1996, claimant again sought treatment for her hand symptoms. Electrodiagnostic studies revealed bilateral moderate to severe median nerve compromise or injury in the carpal tunnel. Dr. Little referred claimant to orthopedist Dr. Swanson, who recommended surgery. During the summer of 1996, Dr. Swanson performed carpal tunnel release surgery on both arms.

On July 2, 1996, the insurer denied compensability of the treatment for claimant's CTS condition. (Ex. 16). On October 4, 1996, claimant requested, pursuant to ORS 656.262(6)(d), that the insurer amend its original acceptance of her "hand strain" to include bilateral OS and CTS conditions. (Ex. 21A). On October 29, 1997, the insurer denied claimant's conditions, and claimant requested a hearing. (Ex. 22).

The ALJ set aside the insurer's denials, and the insurer requested Board review. The insurer contends that claimant's bilateral CTS and OS conditions are not compensable. We agree.

Evidence

The ALJ excluded two documents offered by the insurer, marked as Exhibits 3A and 3B. On review, the insurer contends that the ALJ erred in excluding the documents.

We need not address the insurer's arguments, because we find that, even if the documents were admitted, the result in this case would not change. This case concerns the compensability of claimant's bilateral CTS and OS conditions, either as an aggravation of an accepted claim, or as a new medical condition. This is primarily a medical issue which must be resolved on the basis of medical evidence. The documents at issue, claimant's application for a new job (Ex. 3A) and her exit survey completed upon leaving employment with MTC (Ex. 3B), are not medical documents that aid in resolution of the compensability issue in this case. Thus, even if the documents were admitted, they would not affect the outcome in this case. Therefore, we find that the dispute over admissibility of Exhibits 3A and 3B is moot. On this basis, the ALJ's ruling will not be disturbed.

Compensability

Claimant contends that her bilateral CTS and OS conditions are compensable. Claimant has an accepted claim for "hand strain." Because the insurer has not accepted the bilateral OS and CTS conditions, it is claimant's burden to prove that the conditions are compensable.[1] See ORS 656.266.

In determining the compensability of the conditions, our first task is to determine which provisions of the Workers' Compensation Law are applicable. Hewlett-Packard Co. v. Renalds, 132 Or App 288, 292 (1995).

To determine the appropriate standard for analyzing compensability, we focus on whether claimant's bilateral CTS and OS conditions constitute an "event," as distinct from an ongoing condition or state of the body, and whether the onset was sudden or gradual. Mathel v. Josephine County, 319 Or 235, 240 (1994); James v. SAIF, 290 Or 343, 348 (1981); Valtinson v. SAIF, 56 Or App 184, 187 (1982). The phrase "sudden in onset" refers to an injury occurring during a short, discrete period, rather than over a long period of time. Donald Drake Co. v. Lundmark, 63 Or App 261, 266 (1983), rev den 296 Or 350 (1984); Valtinson, 56 Or App at 188 ("sudden in onset" does not have to be "instantaneous").

Here, there is no evidence that claimant's hand conditions arose as the result of a discrete "event." Rather, claimant's symptoms developed over a two-year period of time, allegedly due to work activities during that period. Therefore, it is appropriate to analyze the compensability of claimant's bilateral CTS and OS conditions as an occupational disease. See ORS 656.802(1)(a)(C).

In order to prove compensability of an occupational disease, claimant must establish that work conditions were the major contributing cause of the disease. 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), rev dismissed 321 Or 416 (1995). Because claimant's bilateral hand symptoms developed over a long period of time and are potentially due to multiple causes, compensability presents a complex medical question which requires expert medical evidence to resolve. Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Here, the principal medical opinions that address causation are from Dr. Swanson and Dr. Button. Dr. Little, claimant's attending physician, declined to provide an opinion concerning causation, and Dr. Radecki, who performed electrodiagnostic tests, simply agreed with Dr. Button. (Exs. 10, 18). Therefore, we do not find Dr. Little's and Dr. Radecki's opinions helpful in resolving the causation issue.

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[1] Whether acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449 (1992). Here, the only evidence regarding what condition was accepted by the insurer is an August 1, 1994 notice of acceptance. (Ex. 4). Based on this evidence, we conclude that the insurer accepted a "hand strain."

Dr. Swanson, an orthopedist who examined claimant at her attending physician's request and who performed claimant's bilateral carpal tunnel surgeries, initially examined claimant in May 1996 and diagnosed bilateral CTS. (Exs. 8, 19A). Dr. Swanson opined that claimant's work activities were the major contributing cause of her bilateral CTS. (Exs. 11, 19). Although Dr. Swanson acknowledged that the etiology of CTS is unknown, and that numerous factors could contribute to the development of CTS, including a relatively small carpal canal, he nevertheless concluded that work activities were the major contributing cause of claimant's bilateral CTS. (Exs. 15, 19). More specifically, Dr. Swanson opined that claimant's work activities at MTC were the major contributing cause of her bilateral CTS. (Ex. 19).

Dr. Button, a hand surgeon who examined claimant once at the insurer's request, also diagnosed bilateral CTS. He suggested several potentially causal contributing factors, including claimant's age, gender and heredity. Dr. Button thought that hereditary factors could contribute by causing a congenitally narrow carpal tunnel, because Dr. Button thought that claimant's father had undergone carpal tunnel surgery. However, Dr. Button did not believe that claimant's work activities were either a material or the major contributing cause of her CTS condition or its worsening. Reasoning that claimant's hand symptoms continued after she began working in a less hand-intensive job, Dr. Button concluded that it was unlikely that claimant's work activities were the major contributing cause of her bilateral CTS condition. (Ex. 12).

When medical opinions differ, we generally accord greater weight to those opinions that are well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). In order for claimant to carry her burden, a preponderance of the evidence must support compensability. Hutcheson v. Weyerhaeuser, 288 Or 51, 55 (1979).

Although Dr. Swanson opines that claimant's work activities are the major contributing cause of her bilateral CTS, his opinion is entirely conclusory. Dr. Swanson notes that the etiology of CTS is unknown, and that many factors are potentially contributory, but he offers no discussion of the relative contribution of the different factors or why he concludes that work activity is the major cause in claimant's case. Therefore, we do not find Dr. Swanson's opinion persuasive. Although we do not find Dr. Button's opinion persuasive either, we are unable to find that Dr. Swanson's opinion outweighs Dr. Button's opinion. Accordingly, we conclude that claimant has failed to carry her burden of proving the compensability of her bilateral CTS and OS conditions. See ORS 656.266; 656.802(1).

Moreover, even if we were to find Dr. Swanson's opinion more persuasive than Dr. Button's, we would still conclude that Dr. Swanson's opinion fails to carry claimant's burden of establishing that work activities were the major contributing cause of her bilateral CTS condition. Dr. Swanson identifies numerous potentially contributory factors, but he fails to discuss their relative contribution to claimant's CTS condition. Therefore, we would conclude that Dr. Swanson's opinion is insufficient to establish that work activities were the major contributing cause of claimant's condition. See Dietz v. Ramuda, 130 Or App at 401.

Because we have found that claimant's condition is not compensable as an occupational disease, it is unnecessary to address the insurer's arguments that claimant's occupational disease claim was not timely filed under ORS 656.807, and that claimant was precluded from litigating the compensability of an occupational disease claim.

Aggravation

Claimant contends that her bilateral CTS and OS conditions are compensable as an aggravation of her accepted, nondisabling "hand strain." We disagree.

An aggravation claim is a claim for additional compensation for worsened conditions resulting from the original injury. ORS 656.273(1). The statute further 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." Id. We have previously held that the statute requires proof of two elements in order to establish a compensable aggravation: (1) a compensable condition; and (2) an "actual worsening." Peter J. LaFreniere, 48 Van Natta 988 (1996); Gloria T. Olson, 47 Van Natta 2348 (1995). If the allegedly worsened condition is not already a compensable condition, compensability must first be established. Id.; see also Dennis P. Adams, 49 Van Natta 842 (1997).

Here, claimant's only compensable condition is "hand strain." Therefore, in order to prove a compensable aggravation, claimant needs to establish that the bilateral CTS and OS conditions represent a worsening of the accepted hand strain condition.

Because of the considerable length of time between acceptance of claimant's hand strain and her claim for bilateral CTS and OS conditions, we find that the question of whether the bilateral CTS and OS conditions represent a worsening of the accepted hand strain is medically complex. Therefore, we require expert medical evidence to resolve the question. Kassahn, 76 Or App at 109.

Here, however, there is no medical evidence indicating that the bilateral CTS and OS conditions represent a worsening of claimant's accepted hand strain. There is not even medical evidence indicating that the conditions are related. Therefore, we conclude that claimant's current conditions do not represent a worsening of her accepted hand strain.

Attorney Fees

Since claimant has not prevailed over the denial of her claim, she is not entitled to an attorney fee. ORS 656.386(1). Therefore, the attorney fee issue raised by the insurer is moot, and we need not address it.

ORDER

The ALJ's order dated March 31, 1997 is reversed. The insurer's July 2, 1996 and October 29, 1996 denials are reinstated and upheld. The ALJ's attorney fee award is reversed.

**Member Bock specially concurring.**

I agree that claimant has not established that her bilateral wrist and arm conditions are compensable. I write separately to address the evidentiary issue.

The insurer did not disclose Exhibits 3A and 3B to claimant prior to the hearing. When Exhibit 3A was initially offered, counsel for the insurer indicated that it was not withheld for purposes of impeaching claimant. (Tr. 20). When the ALJ sustained claimant's objection on timeliness grounds, counsel for the insurer then indicated that the document was for impeachment purposes. (Id.) On review, the insurer reasserts its argument that the documents were not discoverable because they constitute impeachment evidence.

We have previously held that, under ORS 656.283(7) and OAR 438-007-0017, a party may withhold evidence it reasonably believes to be relevant and material for purposes of impeachment even if that evidence may have some other relevance to the claim being litigated. Marylin L. Hunt, 49 Van Natta 1456, 1457 (1997). However, we have continued to hold, consistent with our earlier decisions in Sandra E. Post, 48 Van Natta 1741 (1996) and Kenneth D. Legore, 48 Van Natta 1577 (1996), that if there is a dispute concerning the withholding of impeachment evidence, the ALJ shall view the evidence in camera to determine if it constitutes impeachment evidence. Id. at n.6. If the ALJ determines that the evidence has no relevancy regarding witness credibility, then the evidence is subject to disclosure under OAR 438-007-0015. Id.

Here, at the time the insurer received the documents, there was no contrary evidence in the record. That is, nothing in those documents was inconsistent with or contradicted prior statements made by claimant. Consequently, at the time the insurer had a duty to disclose the documents, it apparently had no reasonable basis to believe the documents constituted impeachment evidence. The documents were apparently withheld in case claimant testified to the contrary at the hearing. I believe this is unacceptable "gamesmanship" that is contrary to the Legislature's stated goal of providing a "fair and just administrative system" that "reduces litigation and eliminates the adversarial nature of the compensation proceedings." See ORS 656.012(2)(b).

I would further note that, in adopting amendments to the Board's rules regarding "discovery" and "impeachment" (OAR 439-007-0015 and 438-007-0017), we have emphasized that the carrier's entitlement to withhold documents for impeachment purposes must be based on the circumstances as they exist at the time the carrier is required to provide discovery and cannot be based on speculation that the documents might become "impeachment" evidence. (WCB Admin. Order 3-1997; December 10, 1997). For these reasons, I agree with the ALJ that Exhibits 3A and 3B should not have been admitted.

In the Matter of the Compensation of
**JEFFREY T. KNUDSON, Claimant**
Own Motion No. 94-0439M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Doblie & Associates, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation requests reconsideration of our November 18, 1997 Own Motion Order Reviewing Carrier Closure, in which we set aside SAIF's September 18, 1997 Notice of Closure as premature. With its request for reconsideration, SAIF submits additional information.

In order to consider SAIF's motion, we abated our November 18, 1997 order and granted claimant 14 days within which to respond to SAIF's motion. Having received claimant's response, we proceed with our reconsideration.

SAIF's September 18, 1997 Notice of Closure closed claimant's claim with an award of temporary disability compensation from July 11, 1994 through September 9, 1997. SAIF declared claimant medically stationary as of July 15, 1997. In our prior order, we relied on the opinions of two of claimant's treating physicians, Dr. Henrickson, M.D., and Dr. Trusheim, neurologist, in determining that claimant was not medically stationary when his claim was closed. After reconsideration, based on the following reasoning, we continue to conclude that claimant was not medically stationary as of the date his claim was closed.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the September 18, 1997 Notice of Closure considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 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 7, 12 (1980).

Claimant's low back injury claim was reopened in July 1994. Since that time, claimant underwent two lumbar spine surgeries. In addition, claim participated in a chronic pain program from August 24, 1997 to September 1, 1997, during which time he treated with Dr. Bowar, M.D. After completion of chronic pain program, Dr. Bower recommended additional psychological counseling to help claimant cope with his limitations due to the back injury. (September 12, 1997 letter from Dr. Bower to Dr. Salib). Dr. Bowar also noted that follow up in "Aftercare" was planned.

In a letter dated October 28, 1997, Dr. Henrickson noted that claimant had entered a chronic pain rehabilitation program on August 24, 1997, a six month follow-up program was recommended, and claimant continued to follow up with Dr. Bowar regarding that program. Dr. Henrickson opined that "it is reasonable to expect further material improvement from further medical therapy over the passage of time."

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). Here, we find that Dr. Henrickson's October 28, 1997 opinion meets those requirements.

In this regard, the record shows that claimant's condition did not change from the date of the September 18, 1997 claim closure through the date of Dr. Henrickson's October 28, 1997 opinion. Specifically, claimant was treated for chronic low back pain on September 22, 1997, only four days after his claim was closed, and October 1, 1997. (Chart notes dated September 22, 1997 and October 1, 1997). That was the same condition for which claimant was receiving treatment before claim closure. Therefore, we find that Dr. Henrickson's October 28, 1997 opinion relates back to claimant's condition at the time of claim closure, less than six weeks earlier.

In our initial order, we also relied on comments Dr. Trusheim made in his July 16, 1997 chart note. Specifically, although Dr. Trusheim stated that claimant had essentially reached "medical stability," he also stated that claimant was improving with medication and he would be manipulating

claimant's medications to try to further improve claimant's situation. We found that Dr. Trusheim's opinion, read as a whole, established there was a reasonable expectation of material improvement in claimant's condition with medical treatment.

On reconsideration, both SAIF and claimant provide further information regarding Dr. Trusheim's opinion. Claimant informs us that he saw Dr. Trusheim only twice and did not see him after July 16, 1997. SAIF submits a copy of Dr. Trusheim's December 8, 1997 response to its December 4, 1997 inquiry. In that response, Dr. Trusheim opines that claimant is medically stable. However, in rendering that opinion, Dr. Trusheim addressed claimant's current condition, and his treatment "at present."

Claimant raises the question as to whether Dr. Trusheim is able to render a valid opinion regarding claimant's medically stationary status at claim closure when he last examined claimant two months before his claim was closed. We need not address that question because we find Dr. Trusheim's December 8, 1997 letter unpersuasive for another reason. Dr. Trusheim does not address the relevant question of whether claimant was medically stationary at claim closure. Therefore, we do not rely on Dr. Trusheim's opinions.

Thus, the only persuasive opinion regarding claimant's medically stationary status is provided by Dr. Henrickson. Based on that opinion, we continue to find that claimant's claim was prematurely closed.

Accordingly on reconsideration, as supplemented herein, we adhere to and republish our prior order effective this date. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**JOB G. LOPEZ, Claimant**
Own Motion No. 97-0561M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable lumbosacral strain injury. Claimant's aggravation rights expired on June 13, 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 has responded to SAIF's contention by letter dated December 16, 1997. In his response, claimant pointed out that he had been participating in a vocational training program until December of 1996. He contends he was forced to quit the training because of his current condition. He also states that he did not work nor seek work through August of 1997 when he sought treatment with Dr. Kaesche. Claimant states that Dr. Kaesche recommended surgery at that time but claimant initially refused it in favor of steroid injections. When that course of treatment proved unsuccessful, claimant contacted Dr. Kaesche and apprised Dr. Kaesche of his decision to undergo surgery.

By his own admission, claimant has not worked nor sought work since December of 1996 through the present. Although claimant contends he quit his vocational training program due to his compensable condition, he fails to provide medical evidence which would support this contention. Claimant further fails to provide medical evidence that would support his contention that he was unable to work or seek work due to his compensable condition since December 1996. Claimant has the burden of proof on this issue and must provide evidence, such as 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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In the Matter of the Compensation of
**RAY PERYMAN, Claimant**
Own Motion No. 97-0518M
OWN MOTION ORDER ON RECONSIDERATION
Bischoff & Strooband, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our November 28, 1997 Own Motion Order in which we declined to reopen his 1985 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 December 29, 1997, we abated our November 28, 1997 order, and allowed SAIF 14 days in which to file a response to the motion. We have received SAIF's response and proceed with our reconsideration.

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

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).

With his request for reconsideration, claimant submitted a December 12, 1997 letter from Dr. Pletz, his attending physician. Dr. Pletz opined that claimant "is not capable of working or even seeking work due to his present and future disabilities from his work-related injury." While this statement may be sufficient to satisfy that portion of the Dawkins criteria which requires claimant to show that he is not working or seeking work due to the work-related injury, claimant still bears the burden of proving that although he cannot work and/or seek work as a result of his compensable injury, he is willing to work.

Although Dr. Pletz states that claimant "has not been working but has been willing to work," we do not find this sufficient evidence of claimant's willingness to work. In this regard we have previously held that statements offered by persons other than the claimant are not sufficient evidence of

claimant's willingness to work. See Marlene J. Andre, 48 Van Natta 404 (1996) (assertions made by claimant's attorney were not sufficient to support the claimant's contentions regarding a willingness to work); Richard A. Wright, 46 Van Natta 84 (1994) (bare assertions of counsel regarding the claimant's willingness to work did not constitute evidence sufficient to meet the burden of proof). Claimant has not submitted any other evidence which might support his willingness to work and/or seek work.

Under these circumstances, we continue to find that claimant was not in the work force at the time of his disability.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our November 28, 1997 order in its entirety. The parties' rights of appeal and reconsideration shall begin to run from the date of this order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**EFREN QUINTERO, Claimant**
Own Motion No. 97-0288M
THIRD OWN MOTION ORDER ON RECONSIDERATION
Robert E. Nelson, Claimant Attorney
Scheminske, et al, Defense Attorneys

Claimant submits a response to the insurer's December 15, 1997 motion for abatement and reconsideration of our October 6, 1997 Own Motion Order, as reconsidered on December 2, 1997. With his response, claimant submits a request for assessed attorney fees for his counsel's efforts in obtaining authorization for reopening of claimant's own motion claim. We treat these submissions as a request for reconsideration of our prior orders.

Claimant sustained a compensable low back strain injury on January 26, 1979. His aggravation rights expired on January 26, 1984. On October 6, 1997, we issued an order declining to authorize reopening claimant's own motion claim for payment of temporary disability compensation because he failed to establish that he was in the work force at the time of disability. Specifically, although claimant had established that he was unable to work due to the compensable injury at the time of disability, he failed to establish that he nevertheless was willing to work. Claimant requested reconsideration and submitted evidence regarding his willingness to work.

On December 2, 1997, after abating our prior order and receiving the insurer's response to claimant's motion for reconsideration, we issued an Own Motion Order on Reconsideration authorizing reopening of the own motion claim, finding that claimant had proved he was in the work force at the time of disability. In addition, pursuant to OAR 438-015-0010(4) and 438-015-0080, we awarded an out-of-compensation attorney fee in the amount of 25 percent of the increased temporary disability compensation awarded under our order, not to exceed $1,050, payable by the insurer directly to claimant's attorney.

On December 22, 1997, in response to the insurer's motion for reconsideration, we issued a second order on reconsideration that adhered to our October 6, 1997 Own Motion Order, as reconsidered on December 2, 1997. Thus, we have determined that claimant has met all necessary requirements for reopening his own motion claim and have authorized such reopening.

By motion dated December 24, 1997, and received by the Board on December 29, 1997, claimant submitted a response to the insurer's request for reconsideration of our December 2, 1997 order. Specifically, claimant stated that the Board "has acted properly and with due consideration of the entire record." Because our December 22, 1997 Own Motion Order on Reconsideration has already dealt with the merits of the insurer's request for reconsideration, we do not revisit that issue. However, claimant's attorney also submitted an affidavit itemizing the time spent on this own motion matter and requesting $1,965 in assessed attorney fees. Attorney fees that are paid by the carrier are classified as "assessed" fees. ORS 656.386(1); OAR 438-015-0005(2). For the following reasons, we are unable to grant claimant's request for an assessed fee.

Entitlement to attorney fees in workers' compensation cases is governed by statute. Unless specifically authorized by statute, attorney fees cannot be awarded. Forney v. Western States Plywood, 297 Or 628 (1984). Attorney fees that are paid out of the increased compensation secured by the attorney are classified as "approved" fees or "out-of-compensation" fees. ORS 656.386(2); OAR 438-015-0005(1). OAR 438-015-0080 provides that attorney fees in own motion cases are to be paid out of the claimant's increased temporary disability compensation, which the claimant's attorney has been instrumental in obtaining for the claimant. As discussed above, we have awarded "out-of-compensation" fees for claimant's attorney's services in obtaining compensation for claimant in this own motion claim.

Claimant contends that he is also entitled to an assessed fee for his attorney's services in this own motion matter. However, claimant cites no statutory authority authorizing us to award an assessed fee in our own motion capacity under the facts of this case and we can find none. ORS 656.386(1), 656.382(1) and (2) are the statutes that might provide authorization for assessed attorney fees in the present case. However, we find that those statutes do not apply to the facts of this own motion case.

First, to the extent that claimant is requesting an assessed attorney fee pursuant to ORS 656.382(2) for prevailing over the insurer's request for reconsideration of our December 2, 1997 order, we are unable to grant that request.

ORS 656.382(2) provides:

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

In Donald E. Woodman, 44 Van Natta 2429 (1992), on recon 45 Van Natta 4 (1993), we interpreted former ORS 656.382(2)[1] and determined that the language of former ORS 656.382(2) provided for an assessed attorney fee on review to the Board only in regard to services rendered in an appeal of a Referee's order. Because the carrier's request for review was made directly to the Board in its own motion jurisdiction, we found that the carrier's request was not a request for review as that phrase was used in former ORS 656.382(2). Therefore, we determined that former ORS 656.382(2) did not provide a basis for award of an assessed fee within the Board's own motion jurisdiction. Tony E. Alfano, 45 Van Natta 205 (1993).

Here, the same reasoning applies to the insurer's request for reconsideration of our December 2, 1997 order. Because claimant's aggravation rights have expired on his January 26, 1979 low back injury claim, his claim is within the Board's own motion jurisdiction. ORS 656.278(1); Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988). Thus, in order to obtain temporary disability benefits on his 1979 injury claim, claimant's sole remedy is to petition the Board for own motion relief. ORS 656.278(1)(a). This petition process is initially handled by the carrier in that the carrier must process any claim for additional compensation for a worsened condition filed after the expiration of a claimant's aggravation rights as a request for own motion relief. OAR 438-012-0020. In doing so, the carrier is required to notify claimant and the Board in writing whether it recommends that the claim be "reopened" or "denied." OAR 438-012-0030(1). The Board then determines whether the own motion claim meets the requirements for reopening pursuant to ORS 656.278 and the Board's own motion rules. The Board authorizes reopening only if those requirements are met.[2] Thus, procedures within the

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[1] Although ORS 656.382(2) was amended in 1995, those amendments simply renamed "Referees" as "Administrative Law Judges." Therefore, our interpretation of former ORS 656.382(2) remains in effect.

[2] This is true even where the carrier voluntarily reopens an own motion claim. Although such voluntary reopening is permitted under ORS 656.278(5), if the claim does not meet the requirements for reopening pursuant to ORS 656.278 and the Board's own motion rules, the Board will not authorize reopening. Elizabeth A. Shields, 47 Van Natta 2089 (1995).

Board's own motion jurisdiction are not tied to an order of an Administrative Law Judge (ALJ) or review of any such order. Therefore, claimant's petition to the Board for own motion relief and the carrier's recommendation regarding that petition are not requests for review as that phrase is used in ORS 656.382(2). Thus, claimant is not entitled to an assessed fee pursuant to ORS 656.382(2). Debra D. Robinson, 49 Van Natta 786 (1997).

Second, to the extent that claimant is requesting an assessed attorney fee pursuant to ORS 656.386(1), we are unable to grant that request.

ORS 656.386(1)[3] provides, in part:

> "In all cases involving denied claims where a claimant finally prevails against the denial in an appeal to the Court of Appeals or petition for review to the Supreme Court, the court shall allow a reasonable attorney fee to the claimant's attorney. In such cases involving denied claims where the claimant prevails finally in a hearing before an Administrative Law Judge or in a review by the Workers' Compensation Board, then the Administrative Law Judge or board shall allow a reasonable attorney fee. * * * * * For purposes of this section, a 'denied claim' is a claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation." (Emphasis added).

We have previously held that a carrier's recommendation against reopening the own motion claim is not a "denied claim" within the terms of former ORS 656.386(1). See Charles E. Trento, 46 Van Natta 1506 (1994) (holding that the claimant was not entitled to an assessed fee under former ORS 656.386(1) because the carrier's recommendation that the proposed surgery in a pre-1966 own motion injury claim be disallowed was not a decision denying a claim for compensation). We need not address the issue of whether an own motion recommendation constitutes a "denied claim" under the currently applicable version of ORS 656.386(1) because we conclude that the statute is not applicable to an own motion claim on other grounds.

In construing a legislative enactment, our first task is to discern the legislature's intent. If the language of the statute is unambiguous, ordinarily we apply it according to its plain meaning, without resort to legislative history. Satterfield v. Satterfield, 292 Or 780 (1982). Here, we find the language of ORS 656.386(1) clearly refers to awards of assessed attorney fees relating to Board review of ALJs' orders. In this regard, the first sentence of ORS 656.386(1) requires awards of assessed attorney fees where the claimant prevails in appeals to the courts. In the second sentence, ORS 656.386(1) refers back to "such cases" where the claimant prevails in a hearing or "in a review by the Workers' Compensation Board," requiring assessed fees in those cases, too. We find that the clear language of the ORS 656.386(1) refers to an award of assessed fees by the Board on appeal of an ALJ's order. Thus, like ORS 656.382(2), ORS 656.386(1) applies to services rendered in a Board review of an ALJ's order.

Because the parties' requests for own motion relief [the insurer's initial recommendation regarding claimant's request for own motion relief and the insurer's request for reconsideration of the Board's December 2, 1997 order] were made directly to the Board in its own motion jurisdiction, we find that those requests were not requests for review as that phrase was used in ORS 656.386(1). Therefore, ORS 656.386(1) does not provide a basis for award of an assessed fee within the Board's own motion jurisdiction. ORS 656.278; see Gerald L. Billings, 43 Van Natta 399 (1991) (applying an earlier version of ORS 656.386(1), the Board found former ORS 656.386(1) authorized it to award an assessed fee only if the claimant finally prevailed in a rejected case "in a review by the [B]oard itself;" thus, the Board found that it could award an assessed fee under former ORS 656.386(1) only in the exercise of its reviewing authority pursuant to ORS 656.295).

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[3] 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. 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). However, other than renumbering the above quoted language to ORS 656.386(1)(a) and (b), that language remained the same in the 1997 revisions. Therefore, it is not necessary to determine which version of ORS 656.386(1) might apply to the present case.

Thus, there is no statutory basis for an assessed fee award under the facts of this case. Consequently, we are without authority to award an assessed fee in our own motion jurisdiction. Claimant's attorney's fee is limited to the out-of-compensation fee awarded by our December 2, 1997 order.

Accordingly, our October 6, 1997 order, as reconsidered on December 2, 1997 and December 22, 1997, is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our prior orders effective this date. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**THOMAS J. STUCKEY, Claimant**
WCB Case No. 96-10097
ORDER ON REVIEW
Cummins, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Nichols' order that upheld the self-insured employer's denial of claimant's current low back condition. In its brief on review, the employer objects to claimant's offer of new documentary and testimonial evidence that is not in the record developed at hearing. We treat claimant's offer as a request for remand for the introduction of new evidence. On review, the issues are remand and compensability.

We deny the request for remand and adopt and affirm the ALJ's order.

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

Here, the proffered evidence includes a medical questionnaire completed by claimant and statements made by claimant in his pro se brief regarding his low back symptoms both before and after the May 1995 injury. In addition, claimant offers to obtain a supporting medical opinion from his former treating physician. Claimant has not established that this evidence was not obtainable with due diligence at the time of hearing. Moreover, our consideration of the medical questionnaire and statements in claimant's brief would not affect our decision in this case. Consequently, we conclude that remand is not warranted.

ORDER

The ALJ's order dated May 16, 1997 is affirmed.

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In the Matter of the Compensation of
**RICARDO CHAVEZ, Claimant**
WCB Case No. 97-00656
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Lipton's order which: (1) determined that it could not "cease" payment of temporary total disability benefits pursuant to ORS 656.325(5)(b); and (2) awarded temporary disability from September 26, 1996 through February 25, 1997. In his respondent's brief, claimant contests that portion of the ALJ's order that declined to award penalties and attorney fees for the employer's allegedly unreasonable claim processing. On review, the issues are temporary disability, claim processing, penalties and attorney fees. We affirm.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

We begin by briefly recounting the background of the claim. Employed as a carpenter, claimant sustained a compensable neck injury on February 29, 1996 when drywall sheets fell, striking him on the upper back and neck. The employer's processing agent (GAB) accepted the claim on April 8, 1996 as a nondisabling contusion/hematoma/abrasion of the neck. (Ex. 7-1). Claimant returned to his regular work, but was placed on light duty for a time because of a non-work related pneumothorax condition.

In September 1996, claimant was transferred to a job at a Reynolds facility that involved hanging aluminum siding. On September 26, 1996, claimant left his employment. There was conflicting testimony at the hearing as to why claimant left this employment. Claimant testified that the Reynolds work was too heavy for him to perform and that the employer laid him off when it could not provide light duty. (Trs. 17-19). The employer's witnesses, on the other hand, testified that claimant's employment was terminated for poor attitude and work performance. (Trs. 67, 79, 80, 82, 98, 102,108).

On October 9, 1996, GAB reclassified the claim to "disabling" and, on October 10, 1996, began paying temporary total disability effective September 26, 1996. (Exs. 29, 34A). Later that month, GAB requested case management services from a vocational consultant for the purpose of clarifying lifting/carrying restrictions in anticipation of establishing alternative duty with the employer, as well as obtaining a vocational evaluation. (Ex. 33).

Temporary disability payments continued until December 19, 1996. (Ex. 34A). On December 20, 1996, GAB wrote claimant to advise him that his entitlement to temporary disability would immediately cease based on the fact that his employment was terminated for reasons unrelated to the compensable injury. (Ex. 34AA). Claimant requested a hearing, contesting the termination of his temporary total disability benefits.

The claim was subsequently closed on March 28, 1997 by Determination Order that awarded temporary disability from April 4, 1996 through February 25, 1997 and 14 percent unscheduled permanent disability. GAB then wrote claimant on April 3, 1997 and stated that it was deducting the temporary disability paid on the claim against the permanent disability award. (Ex. 43).

The ALJ determined that the employer had improperly ceased paying temporary total disability pursuant to ORS 656.325(5)(b) because it had not complied with all the requirements of the statute.[1] However, the ALJ declined to assess a penalty for unreasonable claim processing.

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[1] ORS 656.325(5)(b) provides:

"If the worker has been terminated for violation of work rules or other disciplinary reasons, the insurer or self-insured employer shall cease payments pursuant to ORS 656.210 and commence payments pursuant to ORS 656.212 when the attending physician approves employment in a modified job that would have been offered to the worker if the worker had remained employed, provided that the employer has a written policy of offering modified work to injured workers."

Temporary Disability

On review, the employer contends that ORS 656.325(5)(b) does not apply and that claimant is not entitled to temporary disability because he was fired for reasons unrelated to his compensable injury. Specifically, the employer asserts that it could not "cease" paying temporary total disability within the meaning of the statute when it was not paying, and claimant was not entitled to, temporary disability on September 26, 1996, the date claimant's employment was terminated. For the following reasons, we agree with the ALJ that ORS 656.325(5)(b) was applicable and that the employer did not comply with its requirements prior to ceasing the payment of temporary total disability.

In Jerilyn J. Hendrickson, 49 Van Natta 1208, 1209 (1997), we observed that ORS 656.325(5)(b) applies in the context of temporary total disability. We explained that, when an injured worker who is otherwise entitled to or receiving temporary total disability is fired for violating a work rule or other disciplinary reasons, the carrier may cease paying temporary total disability and begin paying temporary partial disability if the statutory requirements are satisfied. We stated in Hendrickson that, because the claimant was not entitled to (and the employer was not paying) temporary total disability benefits when she was fired for reasons unrelated to her claim, the statute was not applicable.

Here, when claimant left work on September 26, 1996, his claim was classified as nondisabling and he was performing regular work at full wages. No physician had authorized temporary disability. However, after claimant's termination from employment, Dr. Lipp, claimant's attending physician, authorized claimant to be off work until light duty work was available. (Ex. 27A). Dr. Lipp later stated that claimant was working outside his physical limitations at the Reynolds job. (Ex. 40-2). In apparent response to Dr. Lipp's authorization, the employer began paying temporary total disability. In December 1996, the employer advised claimant that it was "ceasing" the payment of temporary disability. (Ex. 34A). Under these circumstances, we find that ORS 656.325(5)(b) was applicable.

We acknowledge that language in Hendrickson suggests the time of termination of employment (for violation of a work rule or for other disciplinary reasons) is dispositive and a claimant must be receiving temporary total disability in order for the statute to apply. Hendrickson, 49 Van Natta at 1209. However, our decision in Hendrickson was made in the context of an "enforcement" proceeding regarding an unappealed Order on Reconsideration and its award of temporary partial disability. Thus, by its terms, ORS 656.325(5)(b) did not apply. Consequently, our comments in Hendrickson on the mechanics of the statute were dicta.

Moreover, the actual cessation of temporary total disability under ORS 656.325(5)(b) does not correspond to the date of employment termination, but rather does not occur until "the attending physician approves employment in a modified job that would have been offered to the worker if the worker had remained employed...." In addition, there is nothing in the statutory language that requires the receipt of, or entitlement to, temporary total disability on the date of the termination of employment.

Accordingly, we conclude that payment of temporary total disability on the date of employment termination is not required as long as the claimant was entitled to receive temporary total disability when the carrier "ceased" payment of temporary total disability pursuant to ORS 656.325(5)(b).

Inasmuch as we have determined that ORS 656.325(5)(b) is applicable, we now proceed to a determination of whether the employer failed to comply with the statutory requirements for cessation of temporary disability. In Deanna L. Rood, 49 Van Natta 285, 286 (1997), we held that, in order for a carrier to cease paying temporary total disability pursuant to ORS 656.325(5)(b), the attending physician must approve the same modified job that would have been offered to the worker had the worker not been terminated. We found that it is not sufficient for the attending physician to merely release the worker to modified employment; the physician must review and consent to the specific modified job.

In this case, claimant's attending physician did not approve a specific modified job that would have been offered to claimant had he remained employed. Therefore, we agree with the ALJ that the employer did not comply with the requirements of ORS 656.325(5)(b). Id. at 286. Consequently, the employer lacked authority under ORS 656.325(5)(b) to cease temporary total disability benefits, even assuming that claimant was terminated for violation of work rules or other disciplinary reasons on September 26, 1996.

Penalties and Attorney Fees

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

Attorney Fees on Review

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

ORDER

The ALJ's order dated May 19, 1997 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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In the Matter of the Compensation of
**DUSTIN L. CROMPTON, Claimant**
Own Motion No. 97-0523M
OWN MOTION ORDER ON RECONSIDERATION
Glen J. Lasken, Claimant Attorney

Claimant requests reconsideration of our December 11, 1997 Own Motion Order, in which we declined to reopen his claim for the payment of temporary disability compensation because he failed to establish that he was in the work force at the time of disability. With his request for reconsideration, claimant submitted additional information regarding the work force issue.

In order to consider claimant's motion, we abated our December 11, 1997 order and granted the self-insured employer 14 days within which to respond to claimant's motion. Having received a response from Sedgwick, the employer's claims processing agent, and claimant's reply to that response, we proceed with our reconsideration.

We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). Claimant has the burden of proof on this issue. ORS 656.266. Where a claimant meets his burden of proof, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. Id.

However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). Here, claimant must prove that he was in the work force on March 12, 1997, when his low back condition worsened requiring surgery. A claimant is deemed to be in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, but is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989). Claimant has the burden of proving he was in the work force at the time of disability. ORS 656.266.

As a result of a work injury occurring on December 7, 1990, claimant sustained a compensable disabling lumbar disc protrusion, left L4-5, injury. Claimant's aggravation rights have expired on that injury. On March 12, 1997 and April 22, 1997, claimant underwent surgery for a recurrent herniated disc at L4-5. The April 22, 1997 surgery also included a lumbar fusion due to the recurrent herniation. In our initial order, we found that the employer did not contest either compensability of claimant's current condition or appropriateness of the treatment rendered for that condition. Therefore, based on the unrebutted July 16, 1997 opinion letter from claimant's treating surgeon, Dr. Treible, we found that claimant met his burden of proving a worsening of the compensable low back injury that required surgery. ORS 656.278(1)(a).

On reconsideration, Sedgwick contends that it has not received any medical documentation regarding the 1997 surgeries or an aggravation request from Dr. Treible. Sedgwick also contends that prior authorization was not requested for those surgeries. Finally, Sedgwick states that, based on claimant's attorney's August 6, 1997 letter, they were under the impression that they would be billed for the medical costs associated with the two surgeries and to date they have not been billed.

We do not find that these contentions regarding claims processing matters affect our prior decision that claimant has established a worsening of his compensable condition requiring surgery. ORS 656.278(1). In the first place, the record shows that claimant's attorney sent Sedgwick a copy of Dr. Treible's July 16, 1997 letter regarding the 1997 surgeries. (Letters from claimant's attorney to Sedgwick dated July 24, 1997 and August 6, 1997). Sedgwick makes no argument that it did not receive a copy of Dr. Treible's July 16, 1997 letter. Therefore, Sedgwick's contention that it has not received any medical documentation regarding the 1997 surgeries is questionable.

More importantly, claims processing is the responsibility of the carrier, not claimant. ORS 656.262(1); OAR 438-012-0020(1). Therefore, it is the carrier's responsibility to investigate the claim. If the carrier did not receive an expected billing regarding surgeries performed in March and April of 1997, it was the carrier's responsibility to pursue the matter. Such claims processing matters do not affect compensability of a claim where, as here, the carrier does not challenge compensability.

In addition, Sedgwick's contention that it had not received an aggravation request from Dr. Treible does not affect this own motion claim. The requirements of ORS 656.278 apply to claims, like claimant's, for which aggravation rights have expired. Such claims are within our own motion jurisdiction. Unlike aggravation claims under ORS 656.273, no specific form is required to file a request to reopen an own motion claim, although the request must be in writing. OAR 438-012-0001(1); 438-012-0020(3) and (4); Gregory P. Jeffries, 49 Van Natta 1282 (1997). Here, claimant's attorney's letters dated July 24, 1997 and August 6, 1997 constitute a written request for reopening claimant's claim under ORS 656.278.

Therefore, we continue to find that claimant met his burden of proving a worsening of the compensable low back injury that required surgery. ORS 656.278(1)(a).

Regarding the work force issue, we continue to find that Dr. Treible's unrebutted opinion establishes that claimant was unable to work at the time Dr. Treible first examined him on March 11, 1997. With his request for reconsideration, claimant submitted an affidavit stating that he was working at Precision Images as of the middle of 1996 and "was attempting to find other work when [his] condition worsened in 1997." The employer challenged claimant's general statements regarding the work force issue, arguing that "it appears that [claimant] was not working at the time of the alleged aggravation and we have no indication of the efforts made by him to obtain employment at that time." Without submitting any supporting evidence regarding claimant's work search, claimant's attorney replied that the "fact that [c]laimant had been working and was continuing to look for work satisfies the requirement the [c]laimant be in the 'work force.'"

As noted above, we have found that claimant's compensable condition worsened rendering him unable to work as of March 11, 1997. Although claimant states that he was looking for work from mid-1996 until the time his condition worsened, he provides no evidence supporting that statement. Furthermore, given the employer's position, claimant's general statement that he was "looking for work" is not unchallenged. In addition, claimant's attorney's unsupported assertions are not sufficient to establish that claimant was in the work force at the time of disability. Earl J. Prettyman, 46 Van Natta 1137 (1994). The burden of proof regarding the work force issue lies with claimant. ORS 656.266. Consequently, we do not find claimant's attorney's unsupported assertions or claimant's challenged general statements in his affidavit, without more, meet his burden of proving he was in the work force at the time of disability. See Dawkins, 308 Or at 258.

Accordingly, our December 11, 1997 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our prior orders effective this date. The parties' rights of appeal and reconsideration shall run from the date of this order. We will reconsider this order if further evidence is forthcoming within 30 days after the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
**CLINTON L. McCORD, Claimant**
WCB Case No. 97-03832
ORDER ON REVIEW
Philip Garrow, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that dismissed claimant's request for hearing for lack of jurisdiction. On review, the issue is jurisdiction and, if the Hearings Division has jurisdiction, claim preclusion and, if the claim is not precluded, compensability. We reverse the ALJ's order, reinstate claimant's request for hearing, and set aside the insurer's denial of claimant's current low back condition.

## FINDINGS OF FACT

The insurer accepted claimant's injury claim for a September 29, 1990 lumbar strain.

A June 4, 1991 Determination Order closed the claim without a permanent disability award.

In November 1991, claimant experienced low back pain after lifting a television at home. He was diagnosed as having L2-3 and L5-S1 disc herniations and surgery was recommended.

The insurer denied claimant's aggravation claim and his claim for low back treatment and/or disability.

Pursuant to claimant's hearing request regarding the denial, a hearing convened on September 30, 1992. However, claimant's request for hearing was dismissed with prejudice because claimant failed to appear.

In June 1996, claimant sought treatment for increased low back pain. He filed an aggravation claim.

By letter dated April 30, 1997, the insurer denied compensability of, and responsibility for, claimant's then-current low back condition. Claimant requested a hearing.

## CONCLUSIONS OF LAW AND OPINION

### Jurisdiction

Relying on SAIF v. Shipley, 147 Or App 26, rev allowed 326 Or 57 (1997), the ALJ concluded that since claimant's request for hearing concerned only medical services, the Hearings Division lacked jurisdiction over the dispute. For the reasons set forth below, we disagree.

Subsequent to the ALJ's order, we issued our Order on Reconsideration in Jacqueline J. Rossi, 49 Van Natta 1844 (1997). In Rossi, we held that the Hearings Division had jurisdiction over a medical services dispute where the claimant was seeking to establish the compensability of a new "combined" condition under ORS 656.005(7)(a)(B). We distinguished this situation from the court's decision in Shipley, where the claimant sought only medical services for a compensable condition, reasoning that because the dispute concerned the compensability of a new condition it necessarily involved the denial of an "underlying claim." See Logan A. Adams, 49 Van Natta 2056 (1997) (where the dispute involved a claim for medical services and a claim for an unaccepted condition which gave rise to the need for those services, the denial was a denial of the underlying claim and the Hearings Division retained jurisdiction over the medical services/compensability dispute); Terrell G. Lee, 49 Van Natta 2041, 2041 (1997).

Here, as in Rossi, Adams, and Lee, claimant is seeking to establish the compensability of a new "combined" condition, *i.e.*, the accepted low back strain and one or more disc conditions. Thus, although the dispute concerns a claim for medical services, the claim is also for the condition(s) that gave rise to the need for those services. The insurer has denied the claim with a formal denial, which is

a denial of the underlying claim. Pursuant to ORS 656.245(6), the Hearings Division retains jurisdiction over the medical services/compensability dispute in this case which involves a formal denial of the compensability of the underlying claim (*i.e.*, a denial of the condition that gave rise to the need for treatment). Rossi, 49 Van Natta at 1845. For these reasons, we reinstate claimant's request for hearing and proceed to consider the insurer's claim preclusion defense.

Claim preclusion

The insurer argues that claimant's claim is precluded because it is the same claim which it denied in 1992. Thus, because claimant could have litigated the claim in 1992 (but his request for hearing from the 1992 denial was dismissed with prejudice), the insurer contends that claimant's current claim is foreclosed by claim preclusion. We disagree.

The current claim is only precluded if it is the same as the 1992 claim. See Liberty Northwest Ins. Corp. v. Rector, 151 Or App 693 (1997); Johnny J. Forrest, 45 Van Natta 1798, 1799 (1993) (claim precluded where the claimant failed to show that his condition had changed since dismissal of his prior request for hearing regarding the same condition). Thus, the question, for claim preclusion purposes, is whether claimant's low back condition has changed since the 1992 dismissal order. See Liberty Northwest Ins. Corp. v. Bird, 99 Or App 560 (1989), rev den 309 Or 649 (1990); Raymond R. Bird, 42 Van Natta 1292, 1293 (1990), aff'd mem Bird v. Liberty Northwest Ins. Corp., 106 Or App 364 (1991) ("when a claim for medical services is reasserted after being once denied, the question is whether the claimant's condition has changed so as to have created a new set of operative facts that previously could not have been litigated."). Based on the medical evidence and claimant's low back history, we find that claimant's condition has changed.

Claimant has had low back problems ever since the 1990 work injury. His symptoms have waxed and waned, with several relapses over the years. A comparison of claimant's 1991 MRI, his 1992 myelogram, and his 1997 MRI revealed that claimant's L2-3 disc protrusion became smaller, but his L5-S1 degenerative changes were more prominent in 1997 then they had been in 1992. (Ex. 40; see Exs. 10, 11-1, 20, 45-2-3, 45-5). In addition, claimant's 1992 need for treatment arose from his L2-3 disc condition, while his current need for treatment arises from his L5-S1 condition. (See Exs. 25, 43). Under these circumstances, we find that claimant's low back condition has changed since his 1992 request for hearing was dismissed. Thus, because claimant's current claim could not have been litigated at the prior proceedings, it is not now precluded. See Rector 151 Or App 698-99 (quoting Bird at 564); James M. Reeves, 45 Van Natta 1766 (1993). Accordingly, we proceed to the merits.

Compensability

The insurer argues that the opinion of claimant's treating physician is unpersuasive because it is based on an inaccurate and incomplete history. We disagree.

Dr. Belza has treated claimant since December 1991 and recorded claimant's history of low back symptoms and findings consistently over the years. Dr. Belza specifically noted claimant's 1991, 1993, and 1995 exacerbations and their circumstances. (Exs. 14-2, 33, 33B-2). Considering claimant's lack of low back problems before the 1990 work injury and his subsequent continuing symptoms, Dr. Belza opined that the 1990 injury was the major contributing cause of claimant's current need for treatment. (Ex. 52).

The contrary medical evidence is provided by Drs. Phipps and Waldrum, who reviewed claimant's history and examined him on April 9, 1997. The examiners opined that, although claimant's work injury "certainly contributes" to his current problems, the 1991 off work incident was "potentially just as significant." (Ex. 45-4). We do not find the examiners' conclusion persuasive, in light of Dr. Belza's opinion which is more consistent with claimant's clinical course.

The record reveals that claimant's radicular symptoms began before the 1991 lifting incident at home. (See Exs. 8-1, 9-1, 14-2, 15-1, 24). Considering the seriousness of the work injury (claimant was off work for three months) and claimant's subsequent ongoing radicular symptoms, we find Dr. Belza's opinion well-reasoned and based on an accurate history. See Somers v. SAIF, 77 Or App 259 (1986). Accordingly, because we find no reason to discount that opinion, we rely on it and conclude that claimant's current low back condition is compensable. See Weiland v. SAIF, 64 Or App 810 (1983).

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $4,500 payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issues, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated August 22, 1997 is reversed. Claimant's request for hearing is reinstated. 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 a $4,500 attorney fee, payable by the insurer.

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In the Matter of the Compensation of
**WILLIAM G. BROWN, Claimant**
WCB Case Nos. 96-06894, 96-03540 & 96-01291
ORDER ON REVIEW (REMANDING)
Welch, Bruun, et al, Claimant Attorneys
Lane, Powell, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Tenenbaum's order that set aside its partial denial of claimant's current left shoulder acromioclavicular joint condition. In his respondent's brief, in light of the ALJ's determination that his accepted left biceps condition was stationary at claim closure, claimant seeks a permanent disability award for that condition. On review, the issues are extent of unscheduled permanent disability and compensability. We affirm in part, vacate in part, and remand in part.

FINDINGS OF FACT

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

Claimant is a male. (See O&O p. 2).

On February 8, 1994, the insurer accepted claimant's injury claim for a January 20, 1994 "Bicepts [sic] rupture, left shoulder," which occurred when claimant caught a sixty pound motor with his left arm to keep it from falling to the floor.

CONCLUSIONS OF LAW AND OPINION

Claimant has two left shoulder conditions, which are medically separable and distinct: A ruptured left biceps tendon and a combined condition involving his January 20, 1994 work injury and preexisting acromioclavicular joint arthritis.

Compensability (Current Left Shoulder Condition)

We agree with the ALJ that claimant has carried his burden regarding his current left shoulder condition. However, we reach this result based on the following reasoning.

Claimant sustained a compensable left biceps tendon rupture on January 20, 1994.

The issue is whether claimant's current left shoulder condition is compensable.[1]

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[1] Claimant's current need for treatment arises solely from his acromioclavicular joint condition.

It is undisputed that claimant had preexisting left shoulder conditions (arthritis and a Type II acromiom) which contribute to his current condition, diagnosed as symptomatic acromioclavicular joint arthritis. Therefore, claimant is subject to the "major contributing cause" standard of proof under ORS 656.005(7)(a)(B).

Considering the number of potential causes identified for claimant's condition and 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). 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); Argonaut Insurance Company v. Mageske, 93 Or App 698 (1988).

The evidence regarding the etiology of claimant's left shoulder condition is provided by Dr. Puziss, treating surgeon, and Drs. Rich, Gambee, Gardner, Marble, and Fuller, examining physicians.

Dr. Puziss and the examining physicians agree that claimant had no left shoulder problems before the January 1994 injury, but they disagree regarding the nature and significance of claimant's clinical course thereafter.

Dr. Puziss examined claimant on October 25, 1995 and diagnosed chronic left rotator cuff tendinitis, subacromial bursitis, severe impingement, left acromioclavicular arthritis,[2] and a historical biceps tendon rupture, "asymptomatic in the arm, but possibly symptomatic in the shoulder." (Ex. 49-3). Dr. Puziss requested authorization for a left arthroscopic acromioplasty, debridement and distal clavical resection with possible open procedure (depending on surgical findings). (Id). He opined that claimant injured his left shoulder at the time of the tendon rupture, noting that claimant's shoulder remained "persistently and considerably symptomatic." (Id).

On December 22, 1995, Dr. Puziss examined claimant and responded to Dr. Marble's opinion that claimant needed no further treatment. Noting claimant's multiple ongoing left shoulder findings, Dr. Puziss stated:

> "If the patient had a significant enough injury to rupture the long head of the biceps tendon then it is certainly possible (and, in fact, very likely) the patient could have injured other structures within the shoulder joint. Indeed he has. He has a chronic rotator cuff tendinitis and his painful popping suggests an internal derangement such as excessively long biceps anchor or torn labrum. Indeed the arthrogram CT scan has demonstrated possible anterior labral tear." (Ex. 54-2; see Exs. 61a, 62).

On February 23, 1996, Dr. Puziss opined that claimant's need for left shoulder surgery "is based on his original injury, this injury being the major and in fact only contributing factor to his need for treatment." (Ex. 56a).

On April 17, 1997, Dr. Puziss performed surgery on claimant's left shoulder, specifically an arthroscopic debridement of supraspinatus tear and labrum excision; open left rotator cuff repair and acromioplasty; open left distal clavicle resection and bursectomy. (Ex. 66A, see Ex. 68).

On April 18, 1997, Dr. Puziss again stated that claimant's 1994 work injury was the major contributing cause of his current condition. He noted that claimant has more significant arthritis in his right acromioclavicular joint, but only the left shoulder is symptomatic. Under these circumstances, Dr. Puziss reasoned that the left shoulder work injury worsened claimant's non-dominant left acromioclavicular joint arthritis condition. (Ex. 67-1-2). Based on claimant's history and this reasoning, Dr. Puziss concluded that claimant's left shoulder problems are related to his specific injury, rather than to natural degeneration. (Ex. 67-1).

The examining physicians opined that claimant does not have an injury-related left shoulder condition (other than the ruptured biceps tendon), for two reasons. First, they believed that claimant did not have symptoms specific to his left shoulder (i.e., other than those associated with the ruptured tendon) immediately or soon after the work injury. Therefore, they reasoned that claimant probably did not otherwise injure his shoulder when he ruptured his left biceps tendon.

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[2] By April 1995, Dr. Vigeland, former treating physician, suspected that claimant's ongoing left shoulder problems were due to post-traumatic arthritis. (Exs. 37, 38).

However, because the record is replete with contemporaneously recorded post-injury left shoulder symptoms which were consistent with Dr. Puziss' ultimate diagnosis, we find that the examiners' history was materially inaccurate in this regard. (See Exs. 3, 4, 6-10, 12, 13, 19-21, 24, 25, 28). Accordingly, because the examiners' causation opinion is based on an inaccurate history, it is not persuasive.[3]

The examiners also reasoned that claimant's left shoulder condition is not injury-related, because his left shoulder post-injury x-ray, arthrogram, and CT-arthrogram findings were "normal" or inconclusive. However, inasmuch as Dr. Puziss' diagnoses of claimant's left shoulder condition was confirmed by surgical observations, we do not find the examiners' impression that claimant's problems are nonorganic or nonexistent to be persuasive. (See Exs. 31-7, 44-8, 48-6-8; 54-2, 63-8, 63-10, 65-31). Moreover, the lack of an earlier definitive diagnosis is not fatal to the claim. See Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988).

Under these circumstances, we find that Dr. Puziss' opinion is the most complete and most consistent with claimant's particular history and his clinical course (including the lack of shoulder problems before the injury and ongoing left-only problems after the work injury). See Donna C. Kuzelka, 49 Van Natta 775 (1997) (Where the treating doctor's opinion was the most consistent with claimant's history, it was the most persuasive). Because we find no reason to discount Dr. Puziss' well-reasoned opinion, we rely on it and conclude that claimant has established that his January 20, 1994 work injury was the major contributing cause of his current need for treatment for his left shoulder. See Weiland, 64 Or App at 814.

Extent of Unscheduled Permanent Disability (Left Shoulder Biceps Condition)

Claimant's January 20, 1994 injury claim was closed by a February 12, 1996 Determination Order which found claimant medically stationary as of October 19, 1995.

Claimant requested reconsideration and a medical arbiter's examination (as well as a temporary rule to address his disability).

A March 20, 1996 Order on Reconsideration set aside the Determination Order as premature.

The insurer requested a hearing, contending that the claim was not prematurely closed.

The ALJ determined that claimant's left biceps injury claim was not prematurely closed. Claimant has not requested review of that portion of the ALJ's order. However, he requests remand to the Director so that his left biceps condition may be rated under the standards.

We lack authority to remand to the Director under these circumstances. See Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993).

However, where the claimant was entitled to examination by a medical arbiter and none had been appointed due to a finding of premature closure, following reversal of the premature closure finding, we have previously held that the extent issue should be deferred until the claimant had an opportunity to renew his or her request for an arbiter's examination. Linda M. Cross, 45 Van Natta 2130 (1993). Under such circumstances, once the arbiter's report is prepared, the parties can proceed with the hearing regarding the permanent disability issue. Id.

Here, because claimant requested an arbiter's examination (and he has not since waived his right to that examination), we conclude that the appropriate remedy is the same as in Cross. Id. at 2132; see Juan Ramirez, 49 Van Natta 2117 (1997).

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[3] Dr. Fuller also opined that claimant's post-injury shoulder symptoms were not geographically consistent with his subsequently identified acromioclavicular joint findings. (See Exs. 65-34-35). However, because claimant did have widespread left shoulder symptoms and findings after the work injury (and Dr. Puziss discovered corroborating evidence of left shoulder injury during surgery), we do not find Dr. Fuller's opinion persuasive.

Accordingly, we remand this extent of permanent disability issue to the ALJ to await the parties' pursuit of appointment of a medical arbiter by the Department. When the parties are ready to proceed to hearing on the extent of permanent disability issue, they should contact ALJ Tenenbaum to continue with the proceedings regarding this issue.

Inasmuch as the insurer appealed the ALJ's order and we have not reduced or disallowed claimant's compensation as granted by the ALJ's order, claimant's attorney is 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 $2,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's counsel's statement of services and claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated August 25, 1997 is vacated in part and affirmed in part. That portion which pertains to the Order on Reconsideration is vacated and this portion of the case is remanded to ALJ Tenenbaum for further proceedings consistent with this order. The remainder of the order is affirmed. For services on review regarding the compensability issue, claimant's counsel is awarded an assessed attorney fee of $2,000, payable by the insurer.

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In the Matter of the Compensation of
**CLIFFORD C. DOOLIN, Claimant**
WCB Case No. 97-03793
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

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

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

The ALJ relied on Dr. Huffman's opinion in concluding that claimant's bilateral hearing loss condition was compensable as an occupational disease. On review, SAIF argues that Dr. Huffman's opinion did not address the correct legal standard because he subtracted out contribution from presbycusis in determining the major contributing cause of claimant's hearing loss. See Henry F. Downs, 48 Van Natta 2094, on recon 48 Van Natta 2200 (1996) (to establish a compensable occupational disease claim, a worker must prove that the major contributing cause of his overall hearing loss was work-related noise exposure).

After reviewing Dr. Huffman's opinion, we are persuaded that he believed that the major portion of claimant's hearing loss was due to work-related noise exposure rather than presbycusis or other causes. In the body of his report, Dr. Huffman stated that claimant had a neurosensory hearing loss bilaterally which was, on a more likely than not basis, due to industrial noise exposure. Dr. Huffman further stated that the hearing loss was probably "mostly due to noise exposure." Although Dr. Huffman subtracted out the presbycusis factor at the end of his report, it appears that he was doing so to determine the extent of claimant's ratable hearing loss. Under such circumstances, we find this case to be distinguishable from Downs. In Downs, the persuasive medical evidence established that the major contributing cause of the claimant's hearing loss was presbycusis. By contrast, in this case, the persuasive evidence from Dr. Huffman establishes that the major portion of claimant's hearing loss is due to industrial noise exposure.

SAIF also argues that it is not clear whether Dr. Huffman had the correct history because his report did not contain claimant's work history. We find no indication in this record that Dr. Huffman relied on an incorrect history in rendering his opinion.

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 August 7, 1997 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by SAIF.

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In the Matter of the Compensation of
**RONALD C. FULLER, Claimant**
WCB Case No. 96-04233
ORDER ON RECONSIDERATION (REMANDING)
Pozzi, Wilson, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Claimant has requested reconsideration of our December 4, 1997 Order on Review which: (1) found that the SAIF Corporation was entitled to a postponement of a scheduled hearing in order to obtain a "post-denial" insurer-arranged medical examination (IME); and (2) remanded this case to Administrative Law Judge Tenenbaum for further proceedings. Specifically, claimant contends that our decision neglected to address the effect of OAR 436-060-0135 on our reasoning. In order to fully consider claimant's motion, we abated our prior order and granted SAIF an opportunity to respond. Having received SAIF's response, we proceed with our reconsideration.

Claimant asserts that our decision is inconsistent with the Director's rules concerning suspension of benefits for failure to cooperate pursuant to ORS 656.262(15). Specifically, claimant notes that OAR 436-060-0135(3) provides that the Director will consider requests for suspension of benefits pursuant to ORS 656.262(15) "only in claims where there as been no determination of compensability made."

As noted in our prior order, this matter does not involve a suspension of benefits, which is solely within the purview of the Director. See ORS 656.262(15); ORS 656.325(1). Rather, the issue is whether SAIF is entitled to have this matter postponed pursuant to the Board's rules of practice and procedure. The fact that the Director has promulgated rules that do not allow for the suspension of benefits where there are no benefits due is consistent with prior case law.[1] See Ring v. Paper Distribution Services, 90 Or App 1148 (1988). That does not address the issue, however, of whether a carrier is entitled to a postponement of a hearing where the claimant refuses to attend a reasonably scheduled IME. Consequently, we do not find claimant's argument grounds for changing our prior conclusion.

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[1] The fact that the former version of the Director's "suspension of benefits" rule extended to "post-denial" conduct, whereas the current version is limited to a claimant's "pre-denial" conduct, has no effect on our decision. In adopting the current version of this rule, the Workers' Compensation Division concluded in its Order of Adoption that "[t]he rule change is necessary to encourage insurers to fully investigate a claim prior to acceptance or denial and is a better application of the statutory language." In doing so, the Division further noted that the former rule "conflicts with the WCB's administration of litigation claims and several protective orders have been issued." Considering that the rule is designed to address requests for the suspension of benefits, we would agree that it is a better application of the statutory language for the Director to limit the scope of the rule to a claimant's "pre-denial" conduct. As noted in Ring, because no benefits would be paid on a denied claim, there would be nothing to suspend for a claimant's alleged non-cooperation. Moreover, because it is the Board's function to address issues arising at the Hearings Division, it is understandable that the Director would limit the scope of the rule to "pre-denial/pre-litigation" conduct. In any event, whatever the basis for the change in the Director's rule, the fact remains that the rule addresses an issue (suspension of benefits) that is different from the issue posed in this case (postponement of a hearing). Moreover, the current version of the rule is expressly limited to "pre-denial" conduct. Inasmuch as the rule does not address the question presently before us, it has no effect on our holding.

Finally, in our prior order, we indicated that when the 1995 amendments were made to ORS 656.262, our prior precedent unequivocally provided that an injured worker was required to attend a reasonably scheduled "post-denial" IME. We further indicated that the legislative changes did not clearly indicate the scope of its application. In light of this, we found no legislative intent to alter, whether direct or indirect, the preexisting precedent relating to post-denial attendance at reasonably scheduled IMEs. Inasmuch as we find that the statutory changes to ORS 656.262 did not alter our prior precedent, it necessarily follows that rules promulgated pursuant to that provision likewise do not alter our prior precedent. Therefore, we continue to conclude that a claimant's failure to attend a "post-denial" IME may be grounds for a postponement under our applicable administrative rules.

Accordingly, as supplemented herein, we adhere to and republish our December 4, 1997 Order on Review.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**EMERY E. GRIM, JR., Claimant**
WCB Case No. 96-09604
ORDER ON REVIEW
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

Claimant, pro se,[1] requests review of that portion of Administrative Law Judge (ALJ) Michael Johnson's order that upheld the insurer's denial of his injury claim for contusions of the left hip, chest wall and left thigh and a low back injury. In his brief, claimant refers to additional medical evidence obtained after the hearing. 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 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 Exhibit in the first sentence to read "(Ex. AA)." In the third full paragraph on page 4, we change the Exhibit in the fourth sentence to read "(Ex. 12)." In the last sentence on page 4, we change the Exhibits to read "(Exs. 20, 25B)."

Remand

In his brief on review, claimant contends that additional objective findings were obtained after hearing and he indicates that we should allow additional evidence from Drs. McAuley and Chau. 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 offered no reasons why the proffered medical evidence was unobtainable with due diligence at the time of his January 14, 1997 hearing. We note that the record contains reports from Drs. McAuley and Chau. (Exs. 29a, 30, 31, 32, 35, 36, 37). Furthermore, the proffered evidence will not likely affect the outcome of the case. Therefore, we deny claimant's request for remand.

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[1] Although claimant was represented at hearing, he is proceeding pro se on review.

Compensability

We adopt and affirm the ALJ's order regarding compensability.

ORDER

The ALJ's order dated June 3, 1997 is affirmed.

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In the Matter of the Compensation of
**KIM P. NICHOLS, Claimant**
WCB Case Nos. 96-09169, 96-09141 & 96-07540
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Bock and Hall.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) set aside SAIF's denial of claimant's claim for an April 12, 1996 low back injury; (2) directed SAIF to recalculate claimant's temporary disability rate to include a 7 cent per mile payment; (3) awarded a $5,000 attorney fee for claimant's counsel's services in setting aside the denial of the April 12, 1996 low back injury claim; and (4) awarded a $1,000 attorney fee for claimant's counsel's services in obtaining a pre-hearing rescission of SAIF's denial of claimant's injury claim for blurred vision. On review, the issues are compensability, rate of temporary disability, and attorney fees.

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

On review, SAIF argues that the ALJ should not have relied on Dr. Amstutz because his opinion "is not persuasive as he had an incorrect history of a crucial fact." Specifically, SAIF argues that Dr. Amstutz based his opinion regarding the cause of the L4-5 disc herniation on an incorrect belief that claimant had no right leg symptoms as a result of a prior 1991 low back injury at a previous employer.

After reviewing Dr. Amstutz' opinion, we are not persuaded that he had an incorrect history regarding claimant's prior right leg symptoms. As SAIF argues, there are some limited references in the medical reports of leg symptoms in relation to the 1991 injury. However, Dr. Amstutz had an opportunity to review the medical record and he indicated that: "There was no evidence of significant radicular signs throughout any of [claimant's] previous evaluations." (Ex. 39-1).

Based on Dr. Amstutz' review of claimant's prior medical records, and his conclusion that there were no "significant radicular signs" in claimant's prior evaluations, we conclude that Dr. Amstutz was aware of the limited leg symptoms, but did not consider them to be significant. Thus, we are not persuaded that Dr. Amstutz possessed an incorrect history regarding claimant's prior low back injury.

SAIF argues that the combined attorney fee for claimant's counsel's services with regard to the denial of the L4-5 disc condition and the pre-hearing rescission of the "blurred vision" denial is excessive. The ALJ awarded claimant's attorney $5,000 for his services in setting aside the denial of the L4-5 disc condition and $1,000 for his services in obtaining rescission of the blurred vision denial. We do not agree that the attorney fees are excessive.

In determining whether the attorney fee awards are 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.

Here, as SAIF notes in its brief, the case was more complex and time consuming than a typical workers' compensation case. It involved complex medical and legal issues. The record consisted of 46 exhibits. There were two depositions. Four witnesses testified and the hearing lasted approximately 4 hours.

In addition, the value of the interest and the result obtained for claimant is considerable. In this regard, claimant will now receive benefits, including surgery, for the L4-5 disc herniation. Likewise, claimant will also receive benefits for the blurred vision claim. As SAIF concedes, claimant's attorney generated several medical reports. The attorneys involved in this case were skilled and experienced and the claim was vigorously defended. In addition, there was a real risk in both the low back and blurred vision claims that claimant's counsel might go uncompensated. After considering these factors, we conclude that the $5,000 and $1,000 attorney fees are reasonable assessed fees for claimant's counsel's services regarding the denials.

Claimant's attorney is entitled to an assessed fee for services on review regarding the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We have not considered claimant's counsel's services regarding the ALJ's attorney fee awards. See Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated May 23, 1997, as amended on May 27, 1997, is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by SAIF.

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January 22, 1998 Cite as 50 Van Natta 103 (1998)

In the Matter of the Compensation of
**HOWARD H. LEATHERMAN, Claimant**
Own Motion No. 66-0102M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

On January 16, 1998, the SAIF Corporation submitted claimant's request for medical services related to his November 7, 1963 industrial injury. SAIF recommends reopening of claimant's claim to provide "compensable medical services" until these services are no longer required.

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, the Board has been granted own motion authority to authorized medical services for compensable injuries occurring before January 1, 1966. ORS 656.278(1). Diagnostic medical services are compensable when the services are necessary in order to determine whether a causal relationship exists between a compensable condition and a current conditions. Cordy A. Brickey, 44 Van Natta 220 (1992).

Claimant compensably injured his left knee in 1963, requiring several surgeries. In 1991, claimant underwent a Miller-Galante II total knee arthroplasty of the left knee. Following claimant's total knee replacement, Dr. Freudenberg, claimant's attending physician, opined that claimant's prognosis was good provided claimant attend yearly office visits and x-rays to be sure claimant does not develop loosening nor wear. SAIF requests this reopening to provide claimant with his "prescribed" yearly visit and x-rays. We find that the requested medical services are reasonable and necessary for treatment of the compensable left knee injury.

Accordingly, we authorize the reopening of claimant's claim to provide for the December 11, 1997 visit and x-rays. By this Order, the claim is again closed.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**GLEN W. RICE, Claimant**
WCB Case Nos. 96-08600, 96-04451 & 96-00121
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney
Lundeen, et al, Defense Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Spangler's order that: (1) set aside its denial of claimant's right knee degenerative arthritis as premature; and (2) set aside its denial of claimant's injury claim for a right knee meniscus tear. On review, the issues are premature denial and 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 did not file a claim for right knee degenerative arthritis. Instead, we find that claimant did file a claim for right knee degenerative arthritis.

## CONCLUSIONS OF LAW AND OPINION

### Premature Denial

The ALJ found that claimant did not file a claim for his right knee degenerative arthritis and therefore set aside SAIF's denial of that condition as premature. On review, SAIF argues that, although claimant did not file a specific claim for degenerative arthritis, his right knee claim was sufficiently broad to be reasonably interpreted as encompassing the degenerative arthritis, as well as the meniscal tear. It argues, therefore, that its denial of degenerative arthritis was not premature. We agree.

In March 1996, claimant filed an injury (801) claim form with his employer, Christensen Electric ("Christensen"), for right knee "PAIN" which he described as having a "GRADUAL ONSET." (Ex. 18). The claim form was apparently forwarded to Christensen's insurer at that time, Liberty Northwest Insurance Corporation. Later in March 1996, claimant also filed a Worker's Report of Injury with Christensen, which described his injury as "knee problem, always sore, no strength in the knee." (Ex. 20-2). Several months later, in July 1996, an employer-prepared copy of claimant's 801 claim form was forwarded to SAIF, which insured Christensen prior to October 1, 1995. (Ex. 23).

Prior to filing the right knee claim, claimant had been receiving treatment from Dr. Teal for a medial meniscal tear, which included surgery in August 1995. Due to persistent right knee pain, and after filing his claim for right knee "pain," claimant was referred to Dr. Blake for an orthopedic consultation in May 1996. Based on x-rays showing moderately advanced arthritis in the right knee, Dr. Blake reported to Dr. Teal that the meniscus problem had resolved but that the "arthritic problem [was] taking over." (Ex. 23). Dr. Blake suggested the possibility of further surgery but reported that claimant did not want to go through the prolonged recovery involved with the surgery. (Id.) Dr. Blake diagnosed "OSTEOARTHRITIS OF RIGHT KNEE CAUSING PERSISTENT SYMPTOMS" and indicated that claimant wanted to delay further treatment for the right knee until he was a suitable candidate for a total knee replacement. (Ex. 24).

Based on our review of the aforementioned claim documents, we find that claimant filed a claim for a condition that was described in very general terms: It is located in claimant's right knee and causes "pain" and loss of strength. Given the general description of claimant's claimed right knee condition, and the contemporaneous medical reports attributing claimant's right knee symptoms to degenerative arthritis, we conclude that SAIF could reasonably interpret the claim to encompass the right knee degenerative arthritis. See Reynolds Metals v. Mendenhall, 133 Or App 428, 434 (1995) (a claim for a generally described low back condition could be interpreted to encompass a bulging lumbar disc condition); Weyerhaeuser Co. v. Warrilow, 96 Or App 34 (1989) (a claim for a generally described neck condition could be reasonably interpreted to encompass a degenerative cervical disc condition). Under these circumstances, we find it was not premature for SAIF to issue a denial of the degenerative arthritis. Id.

The ALJ set aside SAIF's denial of the degenerative condition as an improper "precautionary" denial, reasoning that a "precautionary" denial is permissible only if the insurer has a previously accepted claim and wishes to avoid confusion over the scope of its acceptance. However, rather than characterizing SAIF's denial as a "precautionary" denial, we find that claimant filed a written request for compensation for a right knee condition that he described broadly enough to include the degenerative condition. Therefore, we conclude that claimant filed a "claim" for the degenerative right knee condition within the meaning of ORS 656.005(6).

Finally, the ALJ stated that claimant "made clear at the hearing that he was not making a claim for his degenerative condition." However, based on our review of the hearing transcript, we find no statement by claimant, either personally or through counsel, that he was not making a claim for the degenerative condition. (Tr. 4-6). On the contrary, claimant agreed with the ALJ's statement that claimant was appealing SAIF's September 11, 1996 denial. Because the denial was of both the meniscal tear and the degenerative condition, and there is no indication in the record that claimant was not pursuing a claim for the degenerative condition, we conclude that claimant maintained his claim for the degenerative condition at hearing and that SAIF's denial was not premature.

Turning to the merits of the degenerative arthritis condition, we find no persuasive medical evidence relating the condition to work exposure. Dr. Blake, the consulting orthopedist who diagnosed the degenerative condition, did not relate the condition to claimant's employment. (Exs. 23, 24). Dr. Mayhall, examining physician, was the only medical expert to give an opinion as to the cause of the degenerative condition. He opined that the progressive degenerative arthritis was "idiopathic" and was probably not related to any specific trauma at work. (Ex. 26-5). He also could not say whether claimant's employment was the major contributing cause of the degenerative arthritis. (Id.) Based on this record, therefore, we conclude that the right knee degenerative arthritis is not compensable, and SAIF's denial of that condition shall be upheld.

Compensability

The ALJ set aside SAIF's denial of the right knee medial meniscus tear, finding that claimant's work activities were the major contributing cause of the torn meniscus. On review, SAIF challenges the ALJ's finding.

The medical evidence regarding causation of the medial meniscus tear is divided between the opinion of Dr. Teal, who supports compensability of the tear, and that of Dr. Mayhall, who does not. Dr. Teal, treating orthopedic surgeon, stated that on-the-job activities were the major contributing cause of the medial meniscus tear. (Ex. 16). He added that he knew of no other activity that would cause the condition. (Id.)

Dr. Mayhall, examining physician, diagnosed a "degenerative" meniscal tear and opined that the condition was due to "idiopathic" and progressive degenerative arthritis. (Ex. 26-5). He could not state with reasonable medical probability that work was the major contributing cause of the meniscal tear. (Id.)

When the expert medical evidence is divided, we rely on medical opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). As the treating surgeon, Dr. Teal had the opportunity to examine claimant's right knee pathology, including any degeneration, during surgery and, thus, had the most complete information upon which to base his opinion. See Argonaut Insurance Co. v. Mageske, 93 Or App 698, 702 (1988). Moreover, Dr. Teal's opinion was well reasoned. Contrary to SAIF's assertion, in formulating his causation opinion, Dr. Teal did not rely solely on the fact that the meniscus tear occurred after claimant began work activities. Rather, Dr. Teal actually considered claimant's electrician work activities and concluded that those activities "more than likely would account for the vast majority of [claimant's] physical findings which necessitated treatment." (Ex. 14). Dr. Teal also considered the absence of any off-the-job activity which could have caused the condition. (Ex. 16). Because Dr. Teal's opinion was well-reasoned and based on more complete information, we defer to his opinion over that of Dr. Mayhall. See Somers, 77 Or App at 263 (1986). Accordingly, we agree with the ALJ's finding that the claim for medial meniscus tear is compensable.[1]

[1] SAIF does not challenge the ALJ's conclusion that, if the right knee meniscus tear is compensable, responsibility for that condition is assigned to SAIF under the last injurious exposure rule.

ORDER

The ALJ's order dated January 16, 1997 is reversed in part and affirmed in part. The portion of the order that set aside SAIF's denial of right knee degenerative arthritis as premature, is reversed. SAIF's denial of right knee degenerative arthritis is reinstated and upheld. The remainder of the order is affirmed. Claimant's attorney is awarded an assessed fee of $1,500, to be paid by SAIF.

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In the Matter of the Compensation of
**IGNACIO SAUCEDO, Claimant**
WCB Case No. 96-08061
ORDER ON REVIEW
Max Rae, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Martha Brown's order that upheld the insurer's denial of claimant's claim for a lumbosacral strain/sprain and degenerative disc disease at L4-5 and L5-S1. Claimant also moves for remand to the ALJ for the purpose of developing the record under common law negligence and the Employer's Liability Act. On review, the issues are compensability and remand.

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

We agree with the ALJ that, whether the standard of proof is material or major contributing cause, claimant failed to meet his burden of proving a compensable low back injury. ORS 656.266. As the ALJ found, because claimant's treating physicians based their causation opinions on an inaccurate history regarding the duration and onset of claimant's low back complaints, their opinions are not persuasive. Somers v. SAIF, 77 Or App 259 (1986). (Exs. 2, 4, 19, 20A).

On review, claimant argues that Dr. Hartwell, treating chiropractor, had a reliable account of claimant's low back complaints following the May 15, 1996 work incident. Therefore, claimant argues, we should find Dr. Hartwell's causation opinion persuasive and also find adequate the history relied upon by Dr. Malos, treating surgeon. We disagree.

Although Dr. Hartwell had a history of claimant's May 15, 1996 low back pain, that history itself was inaccurate. Dr. Hartwell reported that claimant recovered with aspirin and rest overnight. (Ex. 2). However, claimant testified that he had ongoing low back pain which had not resolved by the May 31, 1996 work incident. In addition, in rendering his causation opinion, Dr. Hartwell specifically relied on this inaccurate history of claimant not having any prior back or leg pain and being pain free when he came to work on May 31, 1996. (Ex. 19). Finally, Dr. Malos had a history of claimant having no prior back pain before the May 31, 1996 incident and relied on that history in rendering his causation opinion. Thus, we agree with the ALJ that there is no persuasive medical opinion that supports compensability.

Claimant requests that, if we find that he has not established a compensable claim, we remand the case to the ALJ so that claimant may develop the record regarding theories of liability under common law negligence and the Employer's Liability Act. We deny claimant's motion for remand for the following reasons.

We may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See ORS 656.295(5). To warrant remand, the moving party must show good cause or a compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). A compelling basis exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988).

Here, we are not persuaded that development of alternative theories of liability outside of the workers' compensation system is likely to affect the outcome of this workers' compensation claim.

During his testimony at hearing, claimant attempted to develop a record regarding theories of liability under common law negligence and the Employer's Liability Act. (Tr. 23-24). In support of that attempt, claimant argued that, since the Workers' Compensation Act is the exclusive remedy for work injuries, it follows that the Workers' Compensation Act provides the exclusive remedy for violations of the Employer's Liability Act. Id. Therefore, claimant argued, he must be permitted to develop the record pursuant to ORS 654.035 to show that the employer could have done more to prevent the May 31, 1996 work incident. Id. The ALJ sustained the insurer's objection to introducing such evidence on the grounds of relevance. Id.

On review, claimant renews his argument in support of his request for remand. Specifically, claimant contends that we must provide common law and Employer's Liability Law remedies within the workers' compensation system in order to interpret amended ORS 656.018, the "exclusive remedy" statute, in a manner that does not violate the remedy clause of Article I, section 10 of the Oregon Constitution, which provides, in part: "[E]very man shall have remedy by due course of law for injury done him in his person, property, or reputation." We disagree.

Under ORS Chapter 656, the Hearings Division and the Board have jurisdiction only over "matters concerning a claim." ORS 656.283(1); 656.295; 656.708. Matters concerning a claim are "those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue." ORS 656.704(3); EBI Companies v. Kemper Group Insurance, 92 Or App 319, 322, rev den 307 Or 145 (1988) (Board lacked jurisdiction over a reimbursement dispute between two carriers, because the dispute was not a "matter concerning a claim"). Given this statutory limitation, we do not have jurisdiction to decide (much less to develop a record regarding) any question concerning other theories of liability. See Steven D. Windsor, 48 Van Natta 973 (1996) (Board lacked jurisdiction to address an alleged violation of ORS Chapter 677 because that issue was not a "matter concerning a claim").

In other words, our jurisdiction is limited to "matters concerning a claim" within the workers' compensation statutes under ORS Chapter 656. Any findings as to common law and/or Employer's Liability Law theories of liability would have no effect on determination of compensability or any other "matter concerning a claim" under the applicable workers' compensation statutes. Therefore, there is no compelling basis to remand the case to the ALJ for development of the record regarding such theories. Accordingly, we deny claimant's motion for remand.

ORDER

The ALJ's order dated May 5, 1997 is affirmed.

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January 22, 1998 Cite as 50 Van Natta 107 (1998))

In the Matter of the Compensation of
**LARRY D. SIMMONS, Claimant**
WCB Case No. 97-04696
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that dismissed claimant's hearing request for lack of jurisdiction. On review, the issues are jurisdiction and attorney fees.

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

The ALJ dismissed claimant's hearing request regarding an attorney fee under ORS 656.386(2) for his counsel's efforts in obtaining a Determination Order finding that his nondisabling injury claim had become disabling. Relying on Julie A. Johnson, 48 Van Natta 29 (1996), the ALJ reasoned that the Hearings Division lacked authority or jurisdiction to approve claimant's request for an attorney fee, as

his order did not create any compensation for claimant. We agree with the ALJ's decision, and add the following reason.

Subject matter jurisdiction depends solely upon whether a decision-making body has the authority to make an inquiry and exists when a statute authorizes that body to do something about the dispute. SAIF v. Roles, 111 Or App 597 (1992). The award of attorney fees in workers' compensation matters is governed by statute. Forney v. Western States Plywood, 297 Or 628, 632 (1984). ORS 656.386(2), the statute under which claimant claims entitlement to attorney fees in this case, provides: "In all other cases [i.e., other than those involving a "denied claim," see Stephenson v. Meyer, 150 Or App 300 (1997)], attorney fees shall be paid from the increase in the claimant's compensation, if any, except as otherwise expressly provided in this chapter." (Emphasis added).

ORS 656.385(5) provides in part:

> "Notwithstanding any other provision in ORS 656.382 or 656.386, an Administrative Law Judge or the Workers' Compensation Board may not award penalties or attorney fees for matters arising under the review jurisdiction of the director."

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 Director of the Department of Consumer and Business Services for determination pursuant to ORS 656.268."

ORS 656.268(11) provides that, upon receipt of a request made pursuant to ORS 656.262 or ORS 656.277, the Department shall determine whether the claim is disabling or nondisabling. Thus, the Board does not have original jurisdiction to determine whether claimant's claim has become disabling. Rather, jurisdiction lies with the Director. See Christine A. Degrauw, 44 Van Natta 91 (1992), rev'd on other grounds DeGrauw v. Columbia Knit, Inc., 118 Or App 277 (1993). Therefore, because this matter arose under the review jurisdiction of the Director, neither the ALJ nor the Board has jurisdiction to award an approved attorney fee under ORS 656.386(2).[1] ORS 656.385(5).

ORDER

The ALJ's order dated October 16, 1997 is affirmed.

[1] Where a claimant requests a hearing from a Department's decision that a claim is properly classified as nondisabling and an ALJ reverses that decision and finds the claim to be disabling, the ALJ would be authorized to award an attorney fee payable from the increased compensation resulting from the ALJ's order. However, as previously noted, the "increased compensation" in this case arose from the Department's "classification" decision. Thus, neither the ALJ nor the Board has authority to grant an "out-of-compensation" attorney fee award under such circumstances.

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January 23, 1998 Cite as 50 Van Natta 108 (1998)

In the Matter of the Compensation of
**LINDA K. DICKENSON, Claimant**
WCB Case No. 96-05441
ORDER DENYING RECONSIDERATION
Welch, Bruun, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

On January 9, 1998, we issued an Order on Review that: (1) found that the SAIF Corporation was entitled to a postponement of a scheduled hearing in order to obtain a "post-denial" insurer-arranged medical examination (IME); (2) vacated Administrative Law Judge Spangler's decision that denied the postponement motion and set aside SAIF's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome; and (3) remanded for further proceedings. In reaching our decision, we relied on the reasoning expressed in Ronald C. Fuller, 49 Van Natta 2067 (1997). Noting that Fuller has been withdrawn for reconsideration, claimant seeks abatement of our decision until issuance of "another decision in Ronald C. Fuller."

On January 22, 1998, we issued our Order on Reconsideration in Ronald C. Fuller, 50 Van Natta 100 (1998), which adhered to our prior holding regarding a claimant's refusal to attend a "post-denial" IME and the impact of such a refusal on a carrier's motion for postponement of a scheduled hearing. In light of our reconsideration order in Fuller, claimant's request for reconsideration is denied. The parties' rights of appeal shall continue to run from the date of our January 9, 1998 order.

IT IS SO ORDERED.

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January 22, 1998 Cite as 50 Van Natta 109 (1998)

In the Matter of the Compensation of
**DONALD W. WAGNER, Claimant**
WCB Case No. 66-0450M
OWN MOTION ORDER
Phil H. Ringle, Jr., Claimant Attorney
Saif Legal Department, Defense Attorney

On January 19, 1998, the SAIF Corporation submitted claimant's request for medical benefits relating to his compensable injury. SAIF recommended that claimant's claim remain open until medical services are no longer required. SAIF also requested we review the file for authorization for time loss benefits.

Medical Services

Because claimant's industrial injury occurred prior to January 1, 1966, ORS 656.245, which provides lifetime medical services for compensable injuries, does not apply to that injury. William A. Newell, 35 Van Natta 629 (1983). However, the Board has been granted own motion authority to authorize medical services and temporary disability compensation for compensable injuries occurring before January 1, 1966. See ORS 656.278(1).

On July 21, 1997, Dr. Kaesche, claimant's treating physician, recommended bilateral total knee replacements. SAIF requested reopening of claimant's claim for authorization for payment for an independent medical examination to "assess the extent of curative treatment and provide a second opinion regarding the current diagnoses and current recommendations." On November 26, 1997, we issued an Own Motion Order authorizing the requested medical service and by that same order closed the claim.

Claimant underwent an independent medical examination on November 17, 1997. Dr. Duwelius, who conducted the IME, opined that claimant would indeed benefit from bilateral knee replacements at this time. Thus, relying on Dr. Kaesche's opinion which is supported by Dr. Duwelius' findings, we conclude that claimant's compensable injury is causally related to the accepted condition.

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 which requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In that case, we are authorized to award temporary disability compensation beginning the date claimant is hospitalized or undergoes surgery. See Id.

However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. Weyerhaeser 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, 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 submitted a January 7, 1998 affidavit from Craig Buche in support of claimant's contention that he was in the work force at the time of his disability. We find that Mr. Buche's affidavit sufficiently evidences that claimant was in the work force at the time of the disability relating to his compensable injury.

Accordingly, claimant's claim is reopened to provide medical services that are found to be reasonable and necessary and causally related to the compensable injury. We authorize the payment of temporary disability compensation beginning the date claimant is hospitalized for surgery. Authorization for compensable medical services shall continue on an ongoing basis for an indefinite period of time, until there is a material change in treatment or other circumstances. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**SAMUEL S. GARBER, Claimant**
WCB Case Nos. 96-06257, 96-01910, 95-13580 & 95-09850
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
VavRosky, et al, Defense Attorneys
Meyers, Radler, et al, Defense Attorneys
James B. Northrop (Saif), Defense Attorney
Thaddeus J. Hettle, Defense Attorney

Reviewed by Board Members Bock and Haynes.

The SAIF Corporation, on behalf of Noe Plumbing Inc. (SAIF/Noe), requests review of those portions of Administrative Law Judge (ALJ) Michael Johnson's order that: (1) set aside its compensability/responsibility denial of claimant's occupational disease claim for a right trigger finger condition; (2) assigned joint responsibility for claimant's right trigger finger condition to SAIF/Noe, SAIF/Advanced Plumbing and Heating (SAIF/Advanced) and TIG; (3) upheld Willamette Industries' (Willamette) compensability/responsibility denial of the same condition; and (4) awarded a $1,000 attorney fee payable by SAIF/Noe for claimant's counsel's services in obtaining a pre-hearing rescission of SAIF/Noe's denial of claimant's bilateral carpal tunnel syndrome (CTS) claim. SAIF/Advanced and TIG cross-request review of those portions of the ALJ's order that: (1) set aside their respective compensability/responsibility denials of claimant's occupational disease claims for a right trigger finger condition; (2) upheld Willamette's denial of the same condition; and (3) granted separate $1,000 attorney fee awards for claimant's counsel's services in obtaining rescission of pre-hearing denials issued by SAIF/Advanced and TIG of claimant's bilateral CTS claim. On review, the issues are compensability, responsibility and attorney fees. We reverse in part and affirm in part.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

Claimant began to work at Willamette in the mid 1980s. In March 1987, claimant began doing general clean up. While claimant worked at the clean up job, his right middle finger would occasionally "lock." Claimant sought treatment for the right middle finger symptoms while employed by Willamette. Claimant also began experiencing symptoms of bilateral carpal tunnel syndrome while employed by Willamette. Claimant continued to work for Willamette until the early 1990s.

In early 1994, claimant became employed as an apprentice plumber. In January 1994, he went to work for Advanced. The work was not steady, so in late February 1994, claimant went to work full-time with Noe. Claimant considered Noe to be his primary employer, but also worked at Advanced during "slack time" at Noe. Both Noe and Advanced worked in new construction. In all of claimant's plumbing work, he was required to use hand tools including wrenches and manual pipe cutters. He used several power vibrating tools such as a reciprocating saw and an electric drill.

As claimant worked for the two plumbing employers, his bilateral upper extremity symptoms worsened. Claimant was treated by Dr. Sulkosky, who diagnosed bilateral carpal tunnel syndrome and "trigger finger, right long finger."

In late December 1995, claimant went to work full-time for MacMillan (TIG). MacMillan performed primarily residential remodeling. At that point, the actual time claimant had worked for Noe was approximately 18 months and the approximate time he had actually worked for Advanced was four to five months. Claimant's hand usage at MacMillan was less than at his previous plumbing employments and he did not repetitively do the same manual activity as he had in his earlier employments.

Claimant filed claims for his right trigger finger condition with Willamette, SAIF/Noe, SAIF/Advanced and TIG. Each carrier denied compensability of and responsibility for the right long trigger finger condition.[1]

The ALJ concluded that claimant's right trigger finger condition was compensable and assigned joint responsibility for that condition to SAIF/Noe, SAIF/Advanced and TIG. The ALJ awarded attorney fees totaling $3,000, payable by SAIF/Noe, SAIF/Advanced and TIG jointly, for claimant's counsel's services regarding the compensability and responsibility denials of the right trigger finger condition. In addition, the ALJ awarded separate $1,000 attorney fee awards for claimant's counsel's services in obtaining a pre-hearing rescission of the denials of compensability for claimant's bilateral CTS condition against SAIF/Noe, SAIF/Advanced and TIG. Finally, the ALJ awarded a $1,500 attorney fee for claimant's counsel's active and meaningful participation at hearing regarding responsibility for the carpal tunnel syndrome claim.

Compensability

The ALJ found that claimant had established compensability of his right trigger finger condition as an occupational disease. Specifically, the ALJ relied on Dr. Button's opinion to find that claimant's work activities were the major contributing cause of a pathological worsening of claimant's right trigger finger condition.

Several physicians addressed the cause of claimant's right trigger finger condition. Dr. Fuller, examining physician, opined that the condition was idiopathic. Dr. Nolan, examining physician, opined that the etiology of claimant's trigger finger condition was unknown. Dr. Nolan could not say whether claimant's current work was the major cause of the worsening of the condition, but believed that it could be.

Dr. Sulkosky, claimant's attending physician, indicated that there was a possibility that the trigger finger condition was idiopathic, but he believed that the condition was caused by claimant's work activities. He explained that, in his experience, a number of people who do heavy, hard manual labor, type jobs develop a contusion to the tendon that is just under the metacarpal head. With this contusion, the tendon will get a fusiform swelling and with continued inflammation can start hanging up on the alpha one pulley, thus giving a "triggering." Because claimant had "callosities" on his hands, Dr. Sulkosky opined that this was probably a good part of claimant having nodules on the second, third and fourth fingers. On this basis, Dr. Sulkosky did not believe the trigger finger condition was developmental.

Dr. Button, an examining physician, also addressed the cause of claimant's trigger finger condition. He opined:

> "In respect to etiology of trigger digits, it is statistically far more frequent in the middle-aged/aging population. Without any identifiable, commonly-associated medical conditions causative of the process in this individual, by exclusion it could be placed within an idiopathic category. There is some speculation that people may be inherently born with somewhat of a snug or tight tunnel that would make them predisposed to develop the condition, coupled with excessive mechanical loading. In this instance, with the fact that he is right-handed dominant and the trigger occurring on that side, without question in the long finger and some intimation that a similar incipient process is developing in other fingers, physical demand factors are very important in the pathophysiologic advancement of the mechanical impingement."

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[1] The carriers ultimately conceded compensability of the bilateral carpal tunnel syndrome claim and the ALJ found Willamette responsible for that condition. The portion of the ALJ's order finding Willamette responsible for the bilateral carpal tunnel syndrome claim has not been contested on review.

After reviewing the medical opinions in this record, we are most persuaded by the opinion of Dr. Button. We find his opinion to be the most thorough and well reasoned regarding the causation of the trigger finger condition. Thus, we rely on his opinion in deciding the compensability issue. Somers v. SAIF, 77 Or App 259, 263 (1986) (when there is a dispute between medical experts, we rely on those medical opinions which are both well-reasoned and based on complete information).

At the conclusion of his report, Dr. Button opined that: "Thus, the pathologic changes on EMG/NCS correspond with this individual's increase in symptomatology, in particular claimant's change of occupations into plumbing is the major contributing factor relative to the advancement of the conditions." (Emphasis added). Because of his use of the plural, we interpret Dr. Button's opinion to mean that both the carpal tunnel syndrome and the trigger finger conditions were pathologically worsened by the plumbing work.

Based on his opinion, it is apparent that Dr. Button considered claimant's trigger finger condition to be idiopathic, but also believed that the condition had been worsened pathologically by his plumbing activities. Under ORS 656.802(2)(b), if the occupational disease claim is based on a 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 interpret Dr. Button's opinion to mean that claimant's plumbing employment was the major contributing cause of a pathological worsening of his trigger finger condition. In this regard, Dr. Button explained that physical demand factors are important in the pathophysiologic advancement of the trigger finger condition. In addition, Dr. Button believed that the plumbing work was the major contributing factor in the advancement of the condition.

Although he does not expressly say as much, we are also persuaded, based on his report, that Dr. Button believed that claimant's work activities were the major contributing cause of his "combined" condition. See Liberty Northwest Insurance Corp. v. Cross, 109 Or App 109 (1991) (It is not required that medical evidence consist of a specific incantation or that it mimic the statutory language). Thus, even if claimant's trigger finger condition or tendency to develop that condition was preexisting, we conclude that Dr. Button's opinion is sufficient to establish compensability of that condition. Moreover, Dr. Button's opinion is supported by the opinion of Dr. Sulkosky, who also believed that the trigger finger condition was caused by claimant's work activities.

Responsibility

With regard to responsibility for the right trigger finger condition, the ALJ found that claimant's employment for SAIF/Noe's, SAIF/Advanced's and TIG's insureds was concurrent. Consequently, the ALJ found all three carriers jointly responsible for claimant's right trigger finger condition. For the following reasons, we disagree with the ALJ's analysis.

In Tina R. Flansberg, 45 Van Natta 1031 (1993), we found that employment that overlapped, but did not simultaneously cease, was not "simultaneous." Thus, we concluded that the concurrent employment rationale expressed in Colwell v. Trotman, 47 Or App 855 (1980), was inapplicable. Here, as in Flansberg, we conclude that claimant's employment was not "simultaneous" and that, consequently, the concurrent employment rationale of Trotman is inapplicable.

Claimant was employed at Willamette from 1980 to 1990, at SAIF/Noe from February 1994 to May 1996, at SAIF/Advanced from January 1994 to mid-1995 and at TIG's insured from December 1995 to February 1996. Thus, although claimant's employment for three of the employers, SAIF/Noe, SAIF/Advanced and TIG's insured, overlapped, it was not simultaneous in that claimant began and ended his employment for each of the employers at different times. Thus, we conclude that the concurrent employment rationale does not apply. Rather, we conclude that claimant's claim is properly characterized as an occupational disease claim arising from "successive" rather than concurrent employments. Tina R. Flansberg, 45 Van Natta at 1031. We, therefore, apply the last injurious exposure rule in order to assign liability among the three potentially liable employers/insurers.

The last injurious exposure rule provides that, where a worker proves that an occupational disease was caused by work conditions that existed when more than one carrier was on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise

Cascade Corp. v. Starbuck, 296 Or 238, 241 (1984); Meyer v. SAIF, 71 Or App 371, 373 (1984), rev den 299 Or 203 (1985). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982).

If a claimant receives treatment for a compensable condition before experiencing time loss due to the condition, the date the claimant first began to receive treatment related to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim, unless the subsequent employment contributes independently to the cause or worsening of the condition. Timm v. Maley, 125 Or App at 401. The dispositive date is the date the claimant first sought treatment for symptoms of the compensable condition, even if the condition was not correctly diagnosed until later. SAIF v. Kelly, 130 Or App 185, 188 (1994).

Here, based on the medical record, claimant first sought medical treatment for the symptoms of his trigger finger condition in 1987.[2] At that time, Willamette was on the risk. Thus, initial responsibility for the trigger finger condition is assigned to Willamette. Willamette can shift responsibility to a later carrier, however, if employment conditions during a later carrier's period of coverage independently contributed to the cause or worsening of the condition. Timm, 125 Or App at 401. To shift responsibility for an occupational disease to a later employer, the earlier employer must prove that the later employment conditions actually contributed to a worsening of the condition. Oregon Boiler Works v. Lott, 115 Or App 70 (1992).

Claimant has bilateral carpal tunnel syndrome as well as triggering of the right long finger. Responsibility for the carpal tunnel syndrome was decided by the ALJ and that portion of the ALJ's order has not been contested. Dr. Button offered an opinion that addressed the etiology and pathology of both the trigger finger and the carpal tunnel syndrome. At the conclusion of his report, Dr. Button opined that claimant's change of occupations into plumbing is the major contributing factor relative to the advancement of the "conditions." (Ex. 71). Dr. Button also stated that he could not fractionate the contribution between the various plumbing firms for which claimant has worked.

The ALJ interpreted Dr. Button's opinion to be that the later plumbing employments actually contributed to a worsening of claimant's trigger finger condition as well as the carpal tunnel syndrome. TIG argues that the ALJ misread Dr. Button's report and that the doctor's conclusion that the plumbing work caused a worsening or "advancement" referred only to the carpal tunnel condition. As we previously indicated when addressing compensability, we disagree with TIG's interpretation of Dr. Button's report.

Based on our review of Dr. Button's opinion, we are persuaded that he was referring to both conditions, trigger finger and well as carpal tunnel syndrome, when he opined that claimant's plumbing work had advanced the "conditions." In this regard, Dr. Button had addressed both conditions in his opinion and used the plural when he indicated that the plumbing work had contributed to the advancement of the conditions. Preceding Dr. Button's conclusion, he had explained, in a thorough and persuasive manner, how both carpal tunnel syndrome and trigger digits can be pathologically worsened by physical demand factors. Although he addressed the conditions separately in the body of his report, his ultimate conclusion pertained to both conditions.

As we stated earlier, we find Dr. Button's opinion to be persuasive because of his thorough and well-reasoned explanation of the pathology and causation of the trigger finger condition. Based on our review of the totality of Dr. Button's opinion, we find that the each of the plumbing employments actually contributed to a worsening of claimant's trigger finger condition. Thus, we find that Willamette has succeeded in shifting responsibility forward to the plumbing employments. Based on Dr. Button's opinion, we find that claimant's plumbing work independently contributed to a worsening of claimant's condition. Thus, we find that SAIF/Noe can shift responsibility to SAIF/Advanced and SAIF/Advanced can shift responsibility to TIG. Although we recognize that the trigger finger condition had been diagnosed and surgery recommended before claimant commenced his employment with TIG's insured, the medical evidence nonetheless establishes that the plumbing employment independently contributed to a worsening of claimant's condition. Thus, we find that TIG is responsible for the trigger finger condition.

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[2] Claimant sought treatment from Dr. Newby for a catching sensation in his right middle finger. (Ex. 24). At that time, Dr. Newby did not believe the catching sensation was trigger finger. Dr. Sulkosky later indicated that, based on chart notes, claimant had trigger finger since 1986 or 1987.

Attorney Fees

SAIF/Noe and SAIF/Advanced argue that the combined attorney fees awarded by the ALJ, which totaled $7,500, are excessive. In addition, SAIF/Advanced asserts that it did not deny compensability of claimant's bilateral carpal tunnel syndrome claim and should not be assessed an attorney fee pursuant to ORS 656.386(1) for claimant's counsel's services in obtaining a pre-hearing rescission of the denial of that condition. Claimant argues that the attorney fees awarded by the ALJ were reasonable and that SAIF/Advanced did deny compensability of claimant's carpal tunnel syndrome.

The ALJ awarded a $2,000 attorney fee under ORS 656.386(1) for claimant's counsel's services in prevailing over the carriers' denials of claimant's right trigger finger condition and a $1,000 attorney fee pursuant to ORS 656.308(2)(d) for claimant's counsel's appearance and active and meaningful participation in finally prevailing against the denial of responsibility for the right trigger finger condition. Because the ALJ found SAIF/Noe, SAIF/Advanced and TIG jointly responsible for this condition, the fees were to be jointly paid by these carriers.

On review, we have found TIG solely responsible for the right long trigger finger condition. Accordingly, TIG shall pay the attorney fee awarded by the ALJ under ORS 656.386(1) and ORS 656.308(2)(d). After consideration of the factors set out in OAR 438-015-0010(4), we find the $2,000 fee for counsel's services in overcoming the compensability denial and the $1,000 fee for overcoming the responsibility denial of the right trigger finger condition to be reasonable. 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).

The ALJ also awarded separate $1,000 attorney fees for counsel's services in obtaining a pre-hearing rescission of the compensability denials issued by SAIF/Noe, SAIF/Advanced and TIG of claimant's bilateral carpal tunnel syndrome. SAIF/Advanced asserts that it did not deny compensability of the carpal tunnel syndrome claim and should not be responsible for a fee under ORS 656.386(1).

SAIF/Advanced's February 12, 1996 denial denied that claimant's work activities at Advanced were the major contributing cause of the development of claimant's upper extremity conditions. The denial contained notice of hearing provisions and did not indicate that a "307" order had been requested. In addition, in its June 5, 1996 "Order Denying Paying Agent Pursuant to ORS 656.307," the Department stated that SAIF/Advanced indicated that it had denied compensability of the carpal tunnel claim. Based on this evidence, we conclude that SAIF/Advanced denied compensability. In other words, we find that SAIF/Advanced denied the claim on the express ground that claimant's upper extremity conditions were not compensable or otherwise did not give rise to an entitlement to compensation. See ORS 656.386(1).

There is no contention that claimant's attorney was not instrumental in obtaining rescissions of the denials prior to hearing. Rather, the carriers only argue that the combined $3,000 fee for claimant's counsel's services in obtaining pre-hearing rescissions of the compensability denials is excessive.

In determining a reasonable fee, 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 issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that any attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Claimant's attorney filed hearing requests on claimant's behalf regarding the carpal tunnel syndrome denials and obtained at least one medical opinion from Dr. Sulkosky regarding the carpal tunnel condition. The case involved complex medical and legal issues. The value of the interest and benefit secured for claimant was significant in that claimant required surgery for the condition. In addition, there was a risk that claimant's counsel might go uncompensated.

After considering these factors, we find that $1,000 is a reasonable attorney fee for claimant's counsel's services in the obtaining pre-hearing rescission of each of the denials. Accordingly, we affirm these portions of the ALJ's order.

Finally, the ALJ awarded a $1,500 attorney fee pursuant to ORS 656.307(5) for claimant's counsel's services at hearing regarding the carpal tunnel syndrome claim. There is no assertion that a fee is not warranted under ORS 656.307(5). After considering the factors cited above, we find that $1,500 is a reasonable fee for claimant's attorney's services regarding the responsibility issue. See Dean Warren Plumbing v. Brenner, 150 Or App 422 (1997) ($1,000 attorney fee limitation of ORS 656.308(2)(d) for finally prevailing against a responsibility denial is not applicable to a proceeding convened under ORS 656.307).

Claimant's attorney is entitled to an assessed fee for services on review payable by TIG. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $1,500, payable by TIG. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services devoted on review to the attorney fee issues. Dotson v. Bohemia, Inc., 80 Or App 233 (1986). Furthermore, in the absence of extraordinary circumstances, his attorney fee award regarding the responsibility issue is limited to the $1,000 award granted by the ALJ's order. See Foster-Wheeler Constructors v. Smith, 151 Or App 155 (1997); Liberty Northwest Insurance Corporation v. Gordineer, 150 Or App 136 (1997). Finally, claimant is not entitled to an attorney fee for services on review insofar as this case pertains to the proceeding under ORS 656.307. See ORS 656.307(5); Lynda C. Prociw, 46 Van Natta 1875 (1994).

## ORDER

The ALJ's order dated February 27, 1997 is reversed in part and affirmed in part. That portion of the ALJ's order which assigns responsibility for claimant's right trigger finger condition jointly to SAIF/Noe, SAIF/Advanced and TIG is reversed. The denials of SAIF/Noe and SAIF/Advanced regarding the trigger finger condition are reinstated and upheld. TIG's denial remains set aside and the claim is remanded to TIG for processing according to law. The ALJ's awards of a $2,000 attorney fee pursuant to ORS 656.386(1) and a $1,000 attorney fee pursuant to 656.308(2)(d) regarding claimant's right trigger finger condition shall be paid by TIG. The remainder of the ALJ's order is affirmed. For services on Board review, claimant's attorney is awarded $1,500, payable by TIG.

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In the Matter of the Compensation of
**LARRY L. LEDIN, Claimant**
WCB Case No. 93-13841
ORDER ON REMAND (REMANDING)
Hollander & Lebenbaum, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. SAIF v. Ledin, 149 Or App 94 (1997). The court has reversed our prior order that affirmed the Administrative Law Judge's (ALJ's) order that set aside the SAIF Corporation's denial of claimant's consequential condition claim for a right knee condition. The court has remanded for reconsideration. On remand, the parties have submitted supplemental briefs. We now proceed with our reconsideration.

## FINDINGS OF FACT

Claimant suffered a compensable injury in 1976 when a saw kicked back and hit him in the face. Claimant's claim was accepted as disabling. (Ex. 4). Following treatment for the injury and closure, claimant developed vision problems, headaches and neck pain.

In 1978, a myelogram showed defects in claimant's cervical spine. Dr. Danielson believed those defects were secondary to the industrial trauma and he felt that claimant had a herniated disc or a root avulsion with a traumatic cyst formation. (Ex. 8A). The parties then entered into a stipulation on August 18, 1978, reopening the claim for payment of temporary total disability. The parties agreed "that claimant be provided medical care and treatment as necessary for the treatment of his cervical condition and other sequelae arising out of his injury[.]" (Ex. 9).

Dr. Danielson performed two surgeries in September and October 1978 and found that claimant's neck condition was caused by a neurilemmoma, rather than a cyst or a disc. (Exs. 10, 12). Dr. Danielson reported that the neurilemmoma probably preexisted the 1976 injury, but the injury had precipitated and aggravated the condition. (Ex. 14). Claimant's claim was closed with an award of permanent disability for the cervical condition. (Exs. 18, 19).

In 1986, claimant developed recurrent neck pain and headaches. Dr. Silver diagnosed a recurrent neurofibroma.[1] (Ex. 19A). In 1988, Dr. Silver recommended surgery because the neurilemmoma had enlarged. (Ex. 19DDD). After the surgery, claimant developed right femoral neuropathy. (Id.)

In May 1993, claimant sought treatment for right knee discomfort. Dr. Berselli diagnosed a grade III tear of the posterior horn medial meniscus. (Exs. 38, 39, 42). He recommended surgery.

On November 3, 1993, SAIF denied the claim on the following grounds:

> "You filed a claim for a work-related injury to your face which occurred on or about July 26, 1976, while employed at [the employer]. The claim has been accepted for facial laceration and hyperextension of the neck and benefits were provided according to law.
>
> "We have recently received information that you are seeking treatment for a tear of the right medial meniscus which you feel is related to your July 26, 1976 injury. After reviewing the information in your file, we are unable to pay for your current treatment because the July 26, 1976 injury is not the major contributing cause of your condition. Your current condition is related to treatment for a neurilemmoma which preexisted the injury of 1976. Therefore, we must issue this partial denial." (Ex. 45).

Claimant requested a hearing challenging the "denial" and "compensability."

## CONCLUSIONS OF LAW AND OPINION

During opening statements at hearing, claimant argued that, because both parties agreed that the knee condition was related to the neurilemmoma, the only issue to litigate was whether the neurilemmoma was related to the original facial injury and the subsequent surgeries. (Tr. 7). SAIF argued that its denial did not concede that the treatment for the neurilemmoma was the major contributing cause of the knee condition and that, if its denial did make such a concession, SAIF moved to amend its denial. (Tr. 8). Claimant objected to the amendment. (Tr. 10). The ALJ sustained the objection, reasoning that, based on Tattoo v. Barrett Business Service, 118 Or App 348 (1993), carriers are not allowed to amend their denials at hearing. The ALJ ultimately set aside SAIF's denial. The Board adopted and affirmed the ALJ's order.

The Court of Appeals held that the Board had read Tattoo too broadly. SAIF v. Ledin, 149 Or App at 98. The court noted that in Tattoo, it held that "employers are bound by the express language of their denials" and the testimony of the claims examiner was irrelevant. The court noted that it did not hold that an insurer may not amend its denial at hearing.

The court also concluded that its holding in SAIF v. Mize, 129 Or App 636 (1994), was not controlling. The court acknowledged that, in Mize, it cited Tattoo in holding that a carrier could not assert that its acceptance had been contingent on its appeal when the acceptance did not specify any such contingency. However, the court noted that the Mize case had not addressed the ability of an insurer to amend a denial at hearing.

Thus, in Ledin, the court concluded that because neither Tattoo nor Mize addressed the ability of an insurer to amend its denial at hearing, the Board's reliance on those cases for that proposition was in error. 149 Or App at 98. The court remanded for reconsideration.

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[1] In later reports, Dr. Silver referred to a neurilemmoma rather than a neurofibroma. (Exs. 19B, 19DDD).

In his supplemental brief on remand, claimant contends that substantive amendments to denials at hearing are not permissible and he would be prejudiced if we allow SAIF to amend its denial.

To begin, we disagree with claimant's contention that substantive amendments to denials at hearing are not permissible. In Gregg Muldrow, 49 Van Natta 1866 (1997), the ALJ allowed the carrier's counsel to amend the denial to include compensability. The ALJ denied the claimant's attorney's request to reset the case or hold the record open to allow him to respond to the compensability issue. On review, the claimant requested that the Board remand to the ALJ to allow him to present evidence regarding the compensability issue.

We relied on SAIF v. Ledin and determined that the carrier was not precluded from amending its denial at hearing. 49 Van Natta at 1867. 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.

In the present case, we conclude, based on SAIF v. Ledin and Gregg Muldrow, that SAIF 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 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 SAIF's amended denial at hearing. The ALJ allowed the parties to submit written arguments as to whether SAIF should be permitted to amend its denial. In claimant's June 6, 1995 letter, he argued that SAIF should not be allowed to amend its denial. He contended that allowing SAIF to amend its denial would "change the entire complexion of the case requiring the claimant to secure additional medical and lay evidence[.]" (Ct. record at 16). Thus, although claimant did not specifically request a continuance, he indicated that if the ALJ allowed SAIF to amend its denial, he would need a continuance to obtain additional evidence. On review, claimant argues that if the amendment had been allowed, he would have had to request a continuance. He contends that he would be severely prejudiced if SAIF is allowed to amend its denial.

Based on Ledin and Muldrow, and consistent with OAR 438-006-0036, we conclude that SAIF should be allowed to amend its denial. We also construe claimant's comments at hearing and on review to mean that, if SAIF is allowed to amend its denial, the hearing should be continued and the record reopened to permit claimant an opportunity to respond to the newly raised issue. Inasmuch as original authority to consider motions for continuance of hearings rests with the ALJ (with our appellate review authority based on an "abuse of discretion" standard, see Sandra L. Booker, 48 Van Natta 2533 (1996)), we find it appropriate to remand this case to the ALJ for consideration of claimant's motion to continue the hearing based on SAIF's amended denial.

Accordingly, we vacate the ALJ's order dated August 21, 1995, and remand this case to ALJ Mills 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.[2]

IT IS SO ORDERED.

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[2] Because we are remanding the case to the ALJ, we do not address the remaining issues. The parties may direct their arguments regarding those issues to the ALJ on remand.

In the Matter of the Compensation of
**SANTIAGO RODRIGUEZ, Claimant**
WCB Case No. 97-06681
CORRECTED ORDER OF DISMISSAL
Steven M. Schoenfeld, Claimant Attorney
Norman Cole (Saif), Defense Attorney

Claimant has requested review of Administrative Law Judge (ALJ) Podnar's order that dismissed claimant's request for hearing based on lack of jurisdiction. Because the record does not establish that the request was timely filed with the Board, we dismiss.

## FINDINGS OF FACT

On December 2, 1997, the ALJ issued an order that dismissed claimant's request for hearing. The ALJ did so after finding that the carrier disapproved only medical services without denying the underlying claim. Thus, the ALJ concluded that the Hearings Division lacked jurisdiction over the claim.

In a letter dated January 2, 1998, claimant's attorney, on behalf of claimant, requested Board review of the ALJ's letter. The letter was "hand delivered" and received by the Board on January 5, 1998.

## 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 December 2, 1997 order was Thursday, January 1, 1998, a holiday. Therefore, January 2, 1998, was the final day to perfect a timely request for review of the ALJ's order. See Anita L. Clifton, 43 Van Natta 1921 (1991). Although claimant's letter was dated January 2, 1998, it was not received by the Board until January 5, 1998, more than 30 days from the ALJ's December 2, 1997 order. Consequently, claimant's request for review was not timely "filed" with the Board and must be dismissed.

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
**DARREL L. ALLEN, Claimant**
WCB Case No. 96-04235
ORDER DENYING RECONSIDERATION
Aller & Morrison, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

The self-insured employer requests reconsideration of our May 29, 1997 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order which set aside its denial of claimant's low back injury claim. The employer requests remand for admission and consideration of "post-hearing" medical reports. Claimant has submitted a response, contending that the employer's motion should be denied. The employer's reply has been received.

In support of its request, the employer contends that the "post-hearing" evidence establishes that claimant is not credible. As a result, the employer argues that Dr. Golden, treating surgeon, had an inaccurate history and his opinion concerning causation should be found unpersuasive.

We note at the outset that the employer has also requested judicial review of our May 29, 1997 Order on Review. ORS 656.295(8). Furthermore, the 30-day period within which to withdraw and reconsider our order has expired. Thus, jurisdiction of this matter rests with the court. ORS 656.295(8); ORS 656.298(1); Haskell Corporation v. Filippi, 152 Or App 117 (1998); SAIF v. Fisher, 100 Or App 288 (1990). Nevertheless, at any time subsequent to the filing of a petition for judicial review and prior to the date set for hearing, we may withdraw an appealed order for purposes of reconsideration. See ORS 183.482(6); ORAP 4.35; Glen D. Roles, 43 Van Natta 278 (1991). This authority is rarely exercised. Carole A. VanLanen, 45 Van Natta 178 (1993). We deny the employer's motions for reconsideration and remand in this case, for the following reasons.

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.

The proffered post-hearing evidence consists of: June 2, 1997 and June 8, 1997 emergency room records regarding neck pain (5 and 8 pages, respectively); and 1997 emergency room records regarding low back pain, dated July 5, 14, 17, 22, 24, 26, 27, and 31 (9, 4, 6, 3, 3, 5, 7, 9 pages, respectively), August 11 (4 pages), September 9 (5 pages), and November 6 (1 page).

The employer essentially argues, based on the above proposed evidence, that claimant's alleged "post-hearing" inconsistencies should persuade us that Dr. Golden's "pre-hearing" history (as provided by claimant) is inaccurate.[1] We disagree.

We find no material or relevant inconsistencies between claimant's testimony and the proffered evidence or between Dr. Golden's history regarding claimant and the proffered evidence.[2] Moreover, we do not see how these documents bear upon claimant's credibility at and before the 1996 hearing or how they would suggest that Dr. Golden's history regarding claimant's "pre-hearing" low back condition was inaccurate (because the documents do not address claimant's condition at or before the 1996 hearing[3]). See Barbara Cooper-Townsend, 47 Van Natta 2381, 2382 (1995) (employer's credibility

[1] We adopted the ALJ's order which found no reason not to defer to Dr. Golden's "pre-hearing" opinion, because it is well-explained and based on a correct history.

[2] We note that the proffered evidence pertains primarily to 1997 "post-hearing" events.

[3] We acknowledge that in several of the "post-hearing" 1997 emergency room reports, claimant related the origin of his back complaints to a variety of sources other than the work incident and ensuing surgery. Yet, a number of these references merely misidentified the date of the surgery and the location of the hospital where the surgery was performed. In the absence of evidence that claimant actually underwent an unreported surgery, we do not consider such references significant. Likewise, to the extent claimant attributed his complaints to a congenital condition, this "lay" opinion has no persuasive force regarding this medically complex issue.

argument unpersuasive where there was no showing of relevance or materiality) (citing Taylor v. Multnomah School District No. 1, 109 Or App 499, 501 (1991) and Westmoreland v. Iowa Beef Processors, 70 Or App 642 (1984)); see also Nelson v. SPARC Enterprises, 115 Or App 568, 571 (1992) (distinguishing Taylor v. Multnomah School District No. 1, 109 Or App 499).

Under these circumstances, we conclude that, even if the proffered evidence was admitted, it would not likely affect the outcome of the case. Thus, there is no compelling basis for remand. See Noe Barrera-Ortiz, 46 Van Natta 1483, 1484 (1994) (where the proposed post-hearing evidence did not address claimant's condition at the relevant time, there was no compelling reason to justify remand).[4]

Accordingly, the employer's motion for reconsideration is denied. The issuance of this order neither "stays" our prior order nor extends the time for seeking review. International Paper Company v. Wright, 80 Or App 444 (1986).

IT IS SO ORDERED.

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[4] We find this case distinguishable from others where remand was justified to admit "post-hearing" evidence (which was unobtainable "pre-hearing") where a witness recanted his testimony or because the proposed evidence established the claimant's lack of credibility regarding material events. See Robert D. Blanchfield, Jr., 44 Van Natta 2139, on recon 44 Van Natta 2276 (1992); Jose L. Cervantes, 41 Van Natta 2419 (1989). Here, neither claimant nor any other witness has altered or contradicted claimant's reporting of events or symptoms before or after the work incident.

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In the Matter of the Compensation of
**MARIA R. ASTORGA, Claimant**
WCB Case No. 97-01446
ORDER ON REVIEW
Stanley Fields, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

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

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

Claimant contends that, because her initial claim was classified as nondisabling, she need only prove a "symptomatic worsening" in order to establish a compensable aggravation. We disagree. See Robert S. Wiggett, 49 Van Natta 1307 (1997) (deciding whether the claimant proved an "actual worsening" pursuant to SAIF v. Walker, 145 Or App 294 (1996), when the last award of compensation did not provide permanent disability).

ORDER

The ALJ's order dated June 4, 1997 is affirmed.

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In the Matter of the Compensation of
**BONNIE J. BROWN, Claimant**
WCB Case No. 96-11364
ORDER ON REVIEW
Cole, Cary & Wing, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Biehl, Bock and Moller.

The insurer requests review of Administrative Law Judge (ALJ) Mongrain's order that set aside its denial of claimant's right shoulder 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

On September 13, 1996, claimant, an aide in a nursing home, allegedly experienced an acute onset of pain in the right shoulder/neck area as she attempted to help transfer a patient from a chair. Citing SAIF v. Nehl, 148 Or App 101 (1997), the ALJ set aside the insurer's denial. The ALJ determined that the injury claim was compensable under ORS 656.005(7)(a)(B) because the September 13, 1996 incident was the "immediate cause" of claimant's need for treatment.

On review, the insurer contends that the ALJ applied an incorrect legal analysis in determining the compensability issue. The insurer asserts that claimant must establish more than the "immediate cause" of the need for treatment in order to prove a compensable claim under ORS 656.005(7)(a)(b). Arguing that the medical evidence does not satisfy claimant's burden of proving that the alleged September 1996 incident was the major contributing cause of claimant's need for treatment, the insurer contends that the ALJ improperly set aside its denial. The insurer's contentions notwithstanding, we affirm.

In Nehl, the court found that the "immediate" cause of the claimant's need for treatment was the work injury and, consequently, the treatment was compensable. Id. at 106. We subsequently discussed whether the holding in Nehl overruled Dietz v. Ramuda, 130 Or App 397, 401 (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). However, we found that Nehl did not overrule the major contributing cause standard set forth in Dietz. See Gregory C. Noble, 49 Van Natta 764 (1997).

In Noble, we concluded that Nehl held that a claimant is not required to prove that a work injury is the major contributing cause of the entire combined condition; rather, he or she must prove that the work injury is the major contributing cause of the need for treatment of the combined condition. We further found that, in reaching that compensability determination, the standard for proving major contributing cause, as articulated by Dietz, remains unchanged. Noble, 48 Van Natta at 767.

Subsequent to our decision in Noble, the court allowed reconsideration in Nehl and determined that the concluding sentence in its initial decision regarding "immediate cause" misstated the test contemplated by ORS 656.005(7)(a)(B) and replaced that sentence with the following:

> "We conclude that, regardless of the extent of claimant's underlying condition, if claimant's work injury, when weighed against his preexisting condition, was the major cause of claimant's need for treatment, the combined condition is compensable." Nehl, 149 Or App at 315.

In light of the court's reconsidered opinion in Nehl and our decision in Noble, we disagree with the ALJ's reliance on the "immediate cause" standard in the initial Nehl opinion. However, we nevertheless conclude that claimant sustained her burden of proving that the September 13, 1996 incident was the major contributing cause of the need for treatment of the combined condition under ORS 656.005(7)(a)(B).

There are three medical opinions that address causation: those of Dr. Whitney, the attending physician, Dr. Gabert and Dr. Farris. We agree for the reasons cited by the ALJ that the opinions of Dr. Gabert and Dr. Farris are unpersuasive. We would also add that Dr. Gabert's opinion that an off-the-job motor vehicle accident in February 1996 was the major contributing cause of claimant's need for treatment is also unpersuasive because it is conclusory. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980) (unexplained medical report discounted). This leaves only Dr. Whitney's opinion.

The insurer argues that Dr. Whitney's opinion is unpersuasive because it is speculative and not based on medical probability. See Lenox v. SAIF, 54 Or App 551, 554 (1981) (To prove medical causation, a medical opinion must be based on medical probability). We agree that Dr. Whitney's final litigation report does contain expressions of medical possibility rather than medical probability. (Ex. 51). However, Dr. Whitney previously concluded that the September 13, 1996 incident was the major contributing cause of claimant's need for surgery. (Ex. 46). We agree with the ALJ that Dr. Whitney's opinion is the most consistent with the most probable history of claimant's symptoms.[1] Moreover, we conclude that Dr. Whitney's reports establish that he sufficiently weighed the alleged work injury against the preexisting condition as required by Nehl. (Exs. 41, 42, 45, 46, 50, 51). Based on our review of Dr. Whitney's opinion as a whole, we find that it satisfies claimant's burden of proof under ORS 656.005(7)(a)(B).[2]

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

## ORDER

The ALJ's order dated July 10, 1997 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,000, to be paid by the insurer.

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[1] Claimant experienced right shoulder symptoms in 1993, but testified that they resolved and that she was asymptomatic prior to the September 1996 incident. (Trs. 7-9). The ALJ determined that claimant's testimony was credible based on her demeanor. We accept the ALJ's credibility finding and conclude that claimant's history supports the ALJ's reasoning. See International Paper Co. v. McElroy, 101 Or App 61, 64 (1990).

[2] We note that even Dr. Farris suggested that, as a result of the September 1996 incident, claimant sustained a mild strain of her right shoulder superimposed on a preexisting right shoulder condition. (Ex. 47-9).

**Board Member Moller dissenting.**

I agree with the majority's conclusion that the ALJ applied an incorrect legal standard in determining the compensability issue. However, I disagree with the majority's finding that Dr. Whitney's opinion is sufficient to satisfy claimant's burden of proof under ORS 656.005(7)(a)(B). For this reason, I must dissent.

There are two medical reports from Dr. Whitney that provide an explanation of his opinion on the causation issue. The first, Dr. Whitney's February 11, 1997 report (Ex. 46), briefly reviews claimant's medical history and states that the September 1996 work incident "combined" with claimant's preexisting condition to cause an increase in symptoms. Dr. Whitney concludes by stating: "Finally, given the medical history it appears that the injury in 1996 was the major contributing cause for her need for surgery, based on a preexisting condition." (emphasis supplied).

Unlike the majority, I do not find Dr. Whitney's conclusion persuasive since it is vague and does not satisfy the standard of Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev den 321 Or 416 (1995), which specifically requires an evaluation of the relative contribution of different causes of an injury in deciding which is the primary cause.

Dr. Whitney's final report of March 31, 1997 (Ex. 51) is, as the majority concedes, characterized by expressions of medical possibility, not probability. Moreover, Dr. Whitney's opinion is expressed in terms of "precipitating" or "immediate" cause, as typified by Dr. Whitney's concluding sentence: "There is no evidence that there was a major injury to his (sic) area, however with the preexisting condition even a small injury could have pushed her over the top." See SAIF v. Nehl, 148 Or App 101, on recon 149 Or App 309, 311 (1997) (work injury must be more than "immediate" cause of need for treatment under ORS 656.005(7)(a)(B)); Dietz v. Ramuda, 130 Or App at 401, 402 (the "precipitating" cause of an injury may or may not be the "major contributing cause"). Thus, I would conclude that, either individually or viewed as a whole, Dr. Whitney's medical reports do not satisfy claimant's burden of proof under ORS 656.005(7)(a)(B).

Accordingly, I would reverse the ALJ's order based on the above application of the correct legal standard to the facts of this case. Because the majority misapplies the proper legal standard, I must dissent.

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January 27, 1998 Cite as 50 Van Natta 123 (1998)

In the Matter of the Compensation of
**CORRINE BIRRER, Claimant**
WCB Case No. 97-0466M
OWN MOTION ORDER ON RECONSIDERATION
Schneider, et al, Claimant Attorneys
Argonaut Insurance Co., Insurance Carrier

Claimant requests reconsideration of our November 6, 1997 Own Motion order. Specifically, claimant contends that we erred in declining to award a penalty for the insurer's allegedly unreasonable failure to recommend the payment of temporary disability benefits.

As noted in our prior order, a penalty pursuant to ORS 656.262(11) may not be assessed unless there are "amounts then due" on which to base the penalty. Moreover, when a claim is under the Board's Own Motion jurisdiction, there is no compensation due until the Board issues an order authorizing the reopening of the claim. See John D. McCollum, 44 Van Natta 2057 (1992). Because the conduct claimant alleges to be unreasonable occurred before the Board reopened claimant's claim, there was not any compensation due to claimant at that time. Consequently, there could not be unreasonable resistance to the payment of compensation as a result of the insurer's alleged action or inaction. In light of such circumstances, we are not authorized to award a penalty.[1]

Accordingly, we withdraw our November 6, 1997 order. On reconsideration, as supplemented herein, we adhere to and republish our November 6, 1997 order in its entirety. The parties' rights of appeal and reconsideration shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] In reaching this conclusion, we would note that there would appear to be no authority prohibiting a worker from bringing a carrier's alleged noncompliance with a statute or rule to the attention of the Director for consideration of a civil penalty. See ORS 656.745(2)(b).

In the Matter of the Compensation of
**EDINE E. BUSCHER, Claimant**
WCB Case No. 95-11982
ORDER ON RECONSIDERATION
Schneider, et al, Claimant Attorneys
VavRosky, et al, Defense Attorneys

On November 14, 1997, we abated our October 17, 1997 Order on Review which reversed an Administrative Law Judge's (ALJ's) order that: (1) found that the self-insured employer was precluded from denying claimant's left leg conditions; (2) set aside its denial of claimant's current left leg conditions; (3) set aside its aggravation denial for the same conditions; and (4) awarded a penalty for a late payment of a permanent disability award. We took this action in response to claimant's request for reconsideration. Having received the employer's response and claimant's reply brief, we proceed with our reconsideration.

In her request for reconsideration, claimant asserts that the employer did not contest the ALJ's penalty award and, accordingly, seeks reinstatement of that portion of the ALJ's order. In addition, in light of the "post-ALJ order" adoption of amended ORS 656.262(10), claimant requests remand for the taking of additional evidence. We address each issue in turn.

At hearing, the parties stipulated that the benefits awarded by the October 27, 1995 Order on Reconsideration were paid on January 23, 1996. The ALJ assessed a penalty against the employer pursuant to ORS 656.262(11), finding that there was no explanation for the payment of claimant's permanent disability award more than 30 days after the date of the award. The employer did not raise the penalty issue on review, nor did it respond to claimant's contention on reconsideration that the ALJ's penalty assessment should be reinstated. We accordingly modify our prior order to affirm the ALJ's opinion on the penalty issue.

In June 1994, the employer accepted a right calf strain. Claimant subsequently sought treatment for her left lower leg. The employer issued a Notice of Closure which awarded no permanent disability benefits. Claimant requested reconsideration, and an October 27, 1995 Order on Reconsideration awarded 13 percent scheduled permanent disability for the left lower leg. Claimant requested a hearing.

Claimant sought additional treatment for her left lower leg, and subsequently filed an aggravation claim, which the employer denied on the basis that claimant's current condition was not compensably related to the original injury. Claimant appealed the denial. At hearing, claimant withdrew her appeal of the Order on Reconsideration.

The ALJ found that the Order on Reconsideration had become final without the employer having appealed the left leg conditions rated therein. Applying Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996), and Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), the ALJ concluded that claimant's left lower leg conditions had become compensable components of the claim and that claimant had established a compensable aggravation.

Subsequent to the ALJ's order, the 1997 Legislature amended ORS 656.262(10) to provide that the failure to appeal a reconsideration order shall not preclude a carrier from denying compensability of a condition rated therein, provided that the condition has not been formally accepted. In addressing compensability of claimant's left leg conditions, we applied amended ORS 656.262(10), and determined on the merits that those conditions had not been formally accepted and, based on the medical evidence, were not compensable.

Prior to hearing, claimant decided that she would rely on Messmer, because the compensability of her left leg conditions would be established as a matter of law. Claimant accordingly waived her right to depose Drs. Kaesche and Dickinson and did not obtain additional medical evidence in support of her claim from Dr. Wells, nor call any witnesses. (Claimant's Request for Reconsideration, p 2). On reconsideration, claimant asserts that we should remand the case to the ALJ for admission and consideration of this additional 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. A compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of the hearing; and (3) is reasonably likely to affect the outcome. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

We find no compelling reason to remand. First, the evidence claimant seeks to present on remand was obtainable at the time of hearing. Moreover, claimant has acknowledged that she could have gone forward on the merits at hearing, but chose not to do so. Although claimant concedes this point, she asserts that her decision to rely solely on Messmer was reasonable at the time. In other words, claimant is arguing that she is no longer relying on a procedural argument, as she did at hearing, and instead wants to retry the case on a factual basis. Thus, because claimant seeks to assert a different theory, she contends that she should be allowed to submit additional evidence in support of her current theory.

The choice not to present evidence on the merits at hearing was claimant's to make. The reasonableness of the choice is not before us. Although claimant now wishes to reconsider her decision as a result of a statutory change, we do not find that her decision not to pursue her compensability claim on the merits constitutes a compelling reason to remand. Under such circumstances, we do not find the record incompletely or insufficiently developed and we find no compelling reason for remand. See Karen Hudson, 48 Van Natta 453 (no compelling reason to remand where the claimant made a tactical decision not to pursue an occupational disease theory at hearing, based on prior statutes); Robert E. Mullaney, 48 Van Natta 84 (1996) (no compelling reason to remand for admission of documents where the claimant abandoned his reliance on Messmer and sought to assert a new theory on review); see also Clifford E. Clark, 47 Van Natta 2310 (1995) (remand denied where new law and law in effect at time of hearing provided that a disabling claim could be established with evidence that a permanent disability award was likely, but record does not contain evidence that would satisfy old standard).

Claimant next contends that it is fundamentally unfair to deny remand to enable claimant to meet an evidentiary burden she did not have at the time of hearing. We disagree.

As previously discussed, the evidence was obtainable at the time of hearing and claimant had the option of pursuing her claim under either a procedural or a factual theory, or both. Claimant elected, for strategic and tactical reasons, to limit the pursuit of her claim to a procedural theory. She now wishes to assert a factual theory and introduce evidence concerning that theory. However, the record does not establish that she was prevented from presenting such evidence at hearing. Consequently, the denial of her request to relitigate her claim is not fundamentally unfair.

Accordingly, on reconsideration, as supplemented and modified herein, we adhere to and republish our October 17, 1997 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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January 27, 1998 Cite as 50 Van Natta 125 (1998)

In the Matter of the Compensation of
**CALI A. DEMING, Claimant**
WCB Case No. 97-07887
ORDER ON REVIEW
Meyers, Radler, et al, Claimant Attorneys

Reviewed by Board Members Moller and Hall.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Peterson's order that dismissed her request for hearing concerning her aggravation claim for a left ankle, right ribs and right hip injury. On review, the issues are dismissal and aggravation.

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

In her request for review, claimant indicates that she has become ill from fibromyalgia and chronic fatigue syndrome, as well as requiring medical treatment and disability for ruptured brace implants, which she relates to her compensable work injury. At this time, it does not appear that claimant has asserted a "new medical condition" claim for those conditions. Pursuant to ORS 656.262(7)(a), claimant may assert such a claim at any time. If and when claimant makes such a claim, and if those conditions are denied by the insurer, claimant may then request a hearing concerning the compensability of those conditions.

In addition, if claimant's compensable conditions (left ankle, right ribs, and right hip) have worsened requiring surgery or hospitalization, claimant may request Own Motion relief, in the form of temporary disability compensation, from the Board pursuant to ORS 656.278.

ORDER

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

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January 27, 1998 Cite as 50 Van Natta 126 (1998)

In the Matter of the Compensation of
**DONALD G. GAUL, Claimant**
WCB Case No. 97-06543
ORDER DENYING MOTION TO DISMISS
Sheridan & Bronstein, Defense Attorneys

Claimant, pro se, has requested Board review of Administrative Law Judge (ALJ) Davis' November 24, 1997 Order of Dismissal. Asserting that claimant's then-attorney withdrew his hearing request, the insurer seeks dismissal of his appeal. The motion is denied.

FINDINGS OF FACT

On August 14, 1997, claimant, through his then-attorney, filed a hearing request regarding the insurer's July 2, 1997 denial. On November 7, 1997, prior to the scheduled hearing, claimant's then-attorney withdrew claimant's hearing request on claimant's behalf. The ALJ's Order of Dismissal issued on November 24, 1997. The ALJ's order contained a notice advising the parties of appeal rights on the order.

On December 23, 1997, the Board received claimant's December 15, 1997 letter requesting review of the ALJ's order. The letter indicated that copies had been mailed to the employer and the insurer, among others.

A computer-generated acknowledgment of claimant's request for review was mailed by the Board on January 8, 1998. Copies were mailed to all parties to the proceeding and their representatives.

CONCLUSIONS OF LAW AND OPINION

The insurer moves to dismiss claimant's request for review on the apparent basis that, because his hearing request was withdrawn, the Board lacks jurisdiction to review this matter. We disagree.

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 must be mailed to all parties to the proceeding before the ALJ. ORS 656.295(2). "Party" means a claimant for compensation, the employer of the injured worker at the time of injury, and the insurer, if any, of such employer. ORS 656.005(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 v. King, 63 Or App 847, 852 (1983).

Here, the 30th day after the ALJ's November 24, 1997 order was December 24, 1997. Because claimant's request for review was received by the Board on December 23, 1997, it was timely filed with the Board. See ORS 656.289(3), 656.295(2); OAR 438-005-0046(1)(a). Furthermore, claimant's

handwritten request for review indicates that copies of the request were mailed to the insurer and the employer. Inasmuch as no contention has been made that the employer did not receive claimant's request for review, we find that the other parties to the proceeding were timely served with claimant's request for review, in compliance with ORS 656.295(2).

Because claimant timely filed his review request with the Board, and timely served the parties with copies of his request, we are authorized to examine the propriety of the ALJ's decision to dismiss claimant's hearing request. See Elvia H. Hillner, 49 Van Natta 567, recon 49 Van Natta 584 (1997); Mike D. Sullivan, 45 Van Natta 990 (1993); Donald L. Lowe, 41 Van Natta 1873 (1989). The cases cited by the insurer to support its motion are inapposite. None of those cases stands for the proposition that a claimant's withdrawal of a hearing request deprives the Board of appellate jurisdiction to review the ALJ's dismissal order pursuant to a timely request for review. See Elvia H. Hillner, 49 Van Natta 567, on recon 49 Van Natta 584 (1997).

Accordingly, the insurer' s motion is denied. Because no hearing was convened in this matter, no transcript is available. Consequently, the following briefing schedule shall be implemented.

Claimant's appellant's brief (his written argument explaining why he disagrees with the ALJ's decision and what action he wants the Board to take) must be filed within 21 days from the date of this order. Claimant also should mail a copy of his brief to the insurer's attorney. The insurer's respondent's brief must be filed within 21 days from the date of mailing of claimant's brief. Claimant may file a reply brief (that responds to arguments made in the insurer's respondent's brief) within 14 days from the date of mailing of the insurer's brief. Thereafter, this case will be docketed for review.

IT IS SO ORDERED.

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January 27, 1998 Cite as 50 Van Natta 127 (1998)

In the Matter of the Compensation of
**DARREN D. HAYES, Claimant**
WCB Case Nos. 96-03826 & 96-02800
ORDER REPUBLISHING ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney
Hoffman, Hart & Wagner, Defense Attorneys

It has come to our attention that a copy of our November 12, 1997 Order on Review was not mailed to one of the parties on review. Inasmuch as we find that our prior order has not become final[1], we conclude that we have authority to republish our order.

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

All notices of proceedings required to be sent under ORS 656.262, 656.265, 656.268 to 656.289, 656.295 to 656.325, 656.382 to 656.388 and ORS 656.263 shall be sent to the employer and the insurer, if any. ORS 656.263. The Board may republish an order if it finds that it failed to mail a copy of its prior

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[1] We note that, on December 18, 1997, Wal-Mart mailed its Petition for Judicial Review to the Court of Appeals. Moreover, it has been more than 30 days since the Board issued its order in this matter. Had our appealed order been valid, we would lack authority to alter our decision. See ORS 656.295(8); ORS 656.298(1); SAIF v. Fisher, 100 Or App 288 (1990). Nevertheless, because our prior order was not valid, we retain authority to issue a decision. See Haskell Corporation v. Filippi, 152 Or App 117 (1998) (Although a petition for judicial review of a Board order had already been filed when the Board withdrew its order within 30 days of the order's mailing, the Board retained authority to issue a reconsideration order). Alternatively, even if jurisdiction rests with the court, we have authority to reconsider our decision because oral argument has not been scheduled. See ORS 183.482(6). Under such circumstances, this order would alternatively constitute notice of the Board's withdrawn order. ORAP 4.35.

order to a party. Berliner v. Weyerhaeuser Company, 92 Or App 264, 266-67 (1988); Mary J. Gates, 42 Van Natta 1813 (1990). "Party" means a claimant for compensation, the employer of the injured worker at the time of the injury and the insurer, if any, of such employer. ORS 656.005(21).

Here, in response to Wal-Mart's request for review, we affirmed the Administrative Law Judge's (ALJ's) order that: (1) found that the Hearings Division had jurisdiction over claimant's aggravation claim; (2) set aside Wal-Mart's denial of claimant's aggravation claim for a left shoulder condition; (3) awarded interim compensation; and (4) assessed a penalty for unreasonable claims processing.

Our November 12, 1997 order issued with only one WCB number (WCB No. 96-03826) listed under the caption, although the case involved claimant's claims with two employers (Wal-Mart, whose claim was administered by AIG, and Bob Fix Excavating, whose claim was insured by SAIF). Furthermore, the order provided that copies were sent to only one employer (Bob Fix) and its insurer, the SAIF Corporation, under WCB No. 96-03826. Accordingly, the second employer (Wal-Mart) and its claims processor (AIG) (WCB Case No. 96-02800), were omitted from the list of parties who were mailed copies of our order.

Consequently, because we neglected to mail a copy of our order to a party, we conclude that our order is not final and we retain jurisdiction to republish our decision. See Berliner v. Weyerhaeuser Company, supra; Mary J. Gates, supra. Accordingly, we find that our November 12, 1997 order was not properly mailed to Wal-Mart or its claims processor (AIG), who are parties in interest to the proceeding. ORS 656.005(21); 656.263; 656.295(7), (8). Therefore, notwithstanding the fact that copies of our November 12, 1997 order were mailed to claimant and one employer (and its insured), we conclude that the order is not final and we retain jurisdiction over this matter. ORS 656.295(8); Berliner v. Weyerhaeuser Company, supra; Mary J. Gates, supra.

Therefore, with the aforementioned corrections and supplementations, we republish our November 12, 1997 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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January 30, 1998 Cite as 50 Van Natta 128 (1998)

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

Claimant requests reconsideration of our January 16, 1998 Own Motion Order, in which we declined to reopen his claim for the payment of temporary disability compensation because he failed to establish that he was in the work force at the time of disability.

Claimant has obtained counsel, and requests that the Board extend the within which counsel may review claimant's claim file and obtain "the evidence you have required in your January 16, 1998 Own Motion Order." We grant claimant's request, and abate our prior order. The claimant shall be allowed 30 days from the date of this order to submit further evidence and argument. The employer is requested to file a response within 14 days from the date of mailing of the claimant's argument. Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**LINDA A. RAADE, Claimant**
WCB Case No. 96-08780
ORDER ON REVIEW (REMANDING)
Cole, Cary & Wing, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Hall and Moller.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Livesley's order that: (1) declined to postpone claimant's scheduled hearing to compel claimant to attend a "post-denial" medical examination; and (2) set aside SAIF's denial of claimant's occupational disease claim for a low back condition. On review, the issues are postponement and compensability. We vacate and remand.

## FINDINGS OF FACT

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

Claimant filed a claim on June 21, 1996 for an occupational disease involving her low back and hips. (Ex. 3). Claimant attended an insurer-arranged medical examination (IME) on July 24, 1996. (Ex. 5). SAIF denied the claim on July 31, 1996. On September 27, 1996, claimant requested a hearing. On October 4, 1996, the Hearings Division notified the parties that the hearing was scheduled for December 9, 1996.

On November 26, 1996, SAIF filed a Motion for Suspension of Hearing. Claimant had notified SAIF, through her attorney, that she would not attend a second IME that SAIF had scheduled for December 4, 1996. The ALJ denied SAIF's motion for Suspension of the Hearing orally on December 3, 1996 and in his order.

## CONCLUSIONS OF LAW AND OPINION

After denying SAIF's motion to postpone the hearing, the ALJ set aside its denial. SAIF requested review, contending that postponement of the hearing was warranted.

Subsequent to the ALJ's order, we issued our decision in Ronald C. Fuller, 49 Van Natta 2067 (1997). There, we held that a carrier's motion to postpone a hearing should have been granted because the claimant refused to attend a "post-denial" IME. Between the issuance of the carrier's aggravation denial and the convening of the scheduled hearing, the carrier made arrangements for an IME. When the claimant refused to attend the "post-denial" IME, the carrier moved for postponement of the hearing. The ALJ denied the motion, held the hearing, and set aside the carrier's denial. The carrier requested Board review, contending that extraordinary circumstances beyond its control justified postponement of the hearing.

We agreed with the carrier's contention. Citing Ring v. Paper Distribution Services, 90 Or App 148 (1988), and Gary E. Frazier, 47 Van Natta 1313, on recon 47 Van Natta 1401, second recon 47 Van Natta 1508 (1995), we acknowledged that, when a claim has been denied, there is no compensation to be paid and, thus, no sanctions (i.e., there is no compensation for the Director to suspend) are available under ORS 656.325(1) for a claimant's failure to attend an IME. Nonetheless, as noted by the Ring court, we stated that a claimant's failure to attend an IME could result in dismissal of the claimant's hearing request if such a failure constituted an unjustified delay under its dismissal rules. Consistent with that rationale, we determined that a claimant's failure to attend a "post-denial" IME may be grounds for a postponement of a scheduled hearing under OAR 438-006-0081(4).

In reaching our conclusion, we found it unnecessary to decide whether the "investigation cooperation" requirements of ORS 656.262(14) were limited to "pre-denial" investigations. In doing so, we reasoned that, even if the statute was so limited, it did not affect the precedential authority of such "pre-262(14)" decisions as David M. Foote, 45 Van Natta 270 (1993), Myron E. Blake, 39 Van Natta 144 (1987), and Victoria Napier, 34 Van Natta 1042 (1982), which had granted postponements based on a

claimant's failure to attend an IME. Consistent with "the modest level of cooperation" required by ORS 656.325(1), the statutory policy directive of ORS 656.012 to provide a "fair and just administrative system," and in the interests of achieving substantial justice under ORS 656.283(7), we continued to adhere to our long-standing holdings that a claimant's failure to attend a "post-denial" IME may be grounds for a postponement of a scheduled hearing.

Inasmuch as the sole basis for claimant's objection to the carrier's postponement motion in Fuller was his position that he was not required to attend the IME, we vacated the ALJ's order and remanded with instructions to reconvene the hearing once claimant attended the IME. Because no other objection had been raised, we emphasized that, in that particular case, there was no need for the ALJ to determine whether the carrier had exercised due diligence in arranging for the IME. In this regard, we noted that, under OAR 438-006-0081(4), incomplete case preparation is not grounds for a postponement unless the ALJ finds that completion of the record could not be accomplished with due diligence.

Here, in addition to her contention that there was no statutory authority for a post-denial IME, claimant also argues that SAIF's motion to compel attendance at the IME was made only three days prior to the hearing and five months after the denial was issued. Claimant asserts that SAIF had sufficient time to investigate its claim earlier and she objects to attending the IME on this basis. OAR 438-006-0081(4) provides that incomplete case preparation is not grounds for a postponement unless the Administrative Law Judge finds that completion of the record could not be accomplished with due diligence. We interpret claimant's arguments as a contention that SAIF did not demonstrate "due diligence" under OAR 438-006-0081(4). Because the ALJ did not take evidence on whether SAIF exercised due diligence warranting a postponement, we find the record incompletely developed concerning this issue. Consequently, we conclude that remand is appropriate. ORS 656.295(5).

In light of our holding in Fuller, and because we find the record incompletely developed regarding whether due diligence has been established under OAR 438-006-0081(4) to justify a postponement, we vacate the ALJ's order and remand this case to ALJ Livesley. Accordingly, the ALJ's order dated January 14, 1997 is vacated. This matter is remanded to ALJ Livesley for further proceedings consistent with this order. Specifically, the ALJ should reopen the record and take evidence regarding whether due diligence has been shown under OAR 438-006-0081(4), such that a postponement should be granted. If the ALJ finds that a postponement is not warranted, the ALJ shall issue a final appealable order addressing the issues. If the ALJ finds that a postponement is warranted, a hearing will presumably be rescheduled after claimant's attendance at a reasonably scheduled IME. Following the completion of the hearing and the closure of the record, the ALJ shall issue a final appealable order addressing the issues. The further proceedings may proceed in any manner that the ALJ deems achieves substantial justice. ORS 656.283(7).

IT IS SO ORDERED.

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In the Matter of the Compensation of
**ALBERT NACOSTE, JR., Claimant**
WCB Case No. 97-00935
ORDER ON REVIEW
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Moller and Hall.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Hoguet's order that dismissed claimant's request for hearing for lack of jurisdiction. On review, the issue is dismissal.

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

In asking for review of the ALJ's order, claimant states that he wants the Board to "reopen" his claim because his compensable condition has worsened. As the ALJ discussed, claimant's aggravation rights expired because it is more than five years after the 1976 closure. Thus, the Board, in its "own motion" capacity, has exclusive jurisdiction to decide whether the claim should be "reopened." ORS 656.278(1)(a); Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988). Consequently, the ALJ correctly decided that he did not have jurisdiction to decide claimant's request to "reopen" the claim.

We acknowledge claimant's request for help with his claim. Because the ALJ did not have the authority to resolve claimant's request to "reopen" the claim, we must affirm the ALJ's decision.[1]

ORDER

The ALJ's order dated August 21, 1997 is affirmed.

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[1] As noted in our May 15, 1997 Own Motion Order and June 4, 1997 Own Motion Order on Reconsideration, where a claimant's aggravation rights have expired, the claim can only be reopened where 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). If in the future claimant suffers a worsening of his compensable condition which requires surgery or hospitalization, he can request SAIF to reopen his claim at that time. Thereafter, SAIF is required to submit a recommendation to the Board concerning claimant's request. However, if claimant's compensable condition does not require surgery or hospitalization, there is no basis under Oregon Workers' Compensation Law to reopen his claim.

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In the Matter of the Compensation of
**NEREYDA GOMEZ, Claimant**
WCB Case Nos. 96-07448 & 96-02801
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
L. Thomas Clark, Attorney
Jerome P. Larkin (Saif), Defense Attorney
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The noncomplying employer (NCE) requests review of Administrative Law Judge (ALJ) Michael Johnson's order that: (1) set aside its responsibility denial of claimant's claim for a right wrist tendonitis condition; and (2) upheld Dentist's Benefits Insurance Corporation's responsibility denial of claimant's claim for the same condition. On review, the issue is responsibility.

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

We agree for the reasons given in the ALJ's order that the last injurious exposure rule applies to this case and that initial responsibility rests with the NCE as the employer on the risk at the time claimant sought medical treatment. See Timm v. Maley, 125 Or App 396, 401 (1993) (if worker receives treatment before experiencing time loss, the date that the worker first began to receive treatment is determinative for assigning initial responsibility).

The NCE can shift responsibility to the prior employer by showing that claimant's work activity at an earlier employer was the sole cause of claimant's wrist condition, or that it was impossible for conditions while the noncomplying employer was on the risk to have caused that condition. See Roseburg Forest Products v. Long, 325 Or 305 (1997); FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App at 374.

The only medical evidence regarding the effect on claimant's condition of the work while the NCE was on the risk, comes from Dr. Thayer, who treated claimant's condition. He stated: "I have no way to objectively prove that her condition worsened as a result of her continued employment. I have no way to objectively prove that it got any better either. My opinion is that would [sic] appear that there was no dramatic change to her work load or work station, therefore, there hadn't been much of a change." (Ex. 24).

Based on this medical evidence, we agree with the ALJ's conclusion that the NCE has not shown that it was "impossible" for conditions while the NCE was on the risk to have caused the condition and

the medical evidence does not establish that claimant's employment was the "sole cause" of the condition.[1] Under such circumstances, we affirm the ALJ's order.

ORDER

The ALJ's order dated May 20, 1997, as corrected on May 28, 1997, is affirmed.

[1] Dr. Thayer had previously opined that the "approximate 3 hours of work at [claimant's] normal office duties did not make any independent contribution to her tenosynovitis." In light of Dr. Thayer's subsequent opinion that he could not say that the work for the NCE did or did not worsen the condition, we find that the record does not establish that claimant's prior employment solely caused the condition or that it was impossible for claimant's short period of work for the NCE to have caused the condition.

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In the Matter of the Compensation of
**KENNETH L. GREEN, Claimant**
WCB Case No. 97-02171
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Davis' order that increased claimant's scheduled permanent disability award for hearing loss from 5 percent (3 degrees) for the right ear, as awarded by an Order on Reconsideration, to 19.84 percent (38.09 degrees) for a combined binaural hearing loss. In his brief on review, claimant requests sanctions under ORS 656.390 for the self-insured employer's allegedly frivolous request for review. On review, the issues are extent of scheduled permanent disability and sanctions.

We adopt and affirm the order of the ALJ and decline to impose sanctions.

Pursuant to ORS 656.390(1), the Board may impose an appropriate sanction upon the employer's attorney if the employer's request for review was frivolous or was filed in bad faith or for the purpose of harassment. Pursuant to ORS 656.390(2), "frivolous" means the matter is not supported by substantial evidence or is initiated without reasonable prospect of prevailing. The employer has presented a colorable argument on review that is sufficiently developed so as to create a reasonable prospect of prevailing on the merits. While the employer's argument on review did not ultimately prevail, we cannot say it is "frivolous." Jack B. Hooper, 49 Van Natta 669 (1997); Donald M. Criss, 48 Van Natta 1569 (1996). Accordingly, we deny claimant's request for sanctions.

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 permanent disability issue is $1,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue, the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated August 4, 1997 is affirmed. For services on review, claimant is awarded an assessed fee of $1,000, to be paid by the employer. Claimant's request for sanctions is denied.

In the Matter of the Compensation of
**LEWIS J. HENDERSON, Claimant**
WCB Case No. 97-01941
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Bethlahmy's order that upheld the SAIF Corporation's denial of his bilateral medial and lateral epicondylitis condition. On review, the issue is compensability.

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

On review, claimant asserts that SAIF's March 3, 1997 denial of bilateral medial and lateral epicondylitis constitutes, at least in part, an improper "back up" denial because SAIF had previously (in 1992 or 1993) accepted a claim for right epicondylitis as a nondisabling injury. We find, for the reasons set forth below, that this "back up" denial issue was not properly raised at hearing. We therefore decline to consider the argument on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991) (Board may decline to consider an issue raised for the first time on appeal).

Although there is evidence indicating that SAIF accepted a nondisabling right elbow injury in 1992 or 1993, the record contains no documentation of, or medical records concerning, this prior claim. (See Exs. 3-6, 6-12, Tr. 7-8). Furthermore, in his opening statement at hearing, claimant's counsel referred to this prior accepted claim (Tr. 4), but did not assert that SAIF's March 3, 1997 denial constituted an impermissible "back up" denial, or that claimant's current occupational disease claim involved a condition that had previously been accepted. On the contrary, claimant's counsel stated that the two questions before the ALJ were: (1) whether or not the diagnosis of lateral and medial epicondylitis is correct; and, if so, (2) whether that condition is caused by claimant's work. (Tr. 4-5).

Fundamental fairness dictates that parties have a reasonable opportunity to present evidence on an issue. See Gunther H. Jacobi, 41 Van Natta 1031 (1989). If claimant believed that SAIF's denial included an impermissible "back up" denial of a previously accepted condition, he should have articulated that point at hearing. As it stands, SAIF had no notice of the "back up" denial issue and therefore did not have the opportunity to present evidence in response to that theory. Moreover, if we were to find that SAIF's denial constituted a "back up" denial, SAIF would be significantly prejudiced since it would then have the burden to prove that claimant's right elbow epicondylitis was not compensable under ORS 656.262(6). Consequently, we decline to consider claimant's late-raised "back up" denial argument on review. See Robert L. Tegge, 47 Van Natta 1973 (1995); see also Dixie L. Stanton, 49 Van Natta 295 (1997).

ORDER

The ALJ's order dated June 26, 1997 is affirmed.

In the Matter of the Compensation of
**DAVID L. PORTER, Claimant**
WCB Case Nos. 96-06637 & 96-05772
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Nancy J. Meserow, Defense Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

John Deere Ins. Co./GAB (Deere) requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) set aside its denial of claimant's aggravation claim for a low back condition; and (2) upheld American Hardware Ins. Co./Crawford & Company's (American's) denial of claimant "new injury" claim for the same condition. On review, the issues are compensability and responsibility.

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

Claimant sustained a compensable low back injury on December 19, 1992 which was accepted by the employer's former insurer, Deere, as an L5-S1 herniated disc with radiculopathy, left. In May of 1994, the employer changed its workers' compensation coverage to American. Claimant's 1992 claim was closed in November 1993 with an award of scheduled and unscheduled permanent disability.

In February 1995, claimant sought treatment for his low back and filed a claim for aggravation of the 1992 injury with Deere. Claimant also subsequently filed a claim for a new injury or occupational disease with American. Both carriers issued denials of compensability (Deere denied an aggravation of the 1992 accepted injury) and responsibility and claimant appealed the denials.

The ALJ found that claimant had established a compensable aggravation of the 1992 compensable injury accepted by Deere. Finding that claimant had not sustained a new compensable injury or disease involving the same condition, the ALJ found that responsibility for claimant's low back condition remained with Deere and set aside Deere's denial.

On review, Deere argues that the ALJ erred in relying on Dr. Gritzka's opinion regarding compensability rather than the opinions of Drs. Malos, Berger, O'Neill and English. Deere argues that Dr. Malos, as claimant's treating physician and surgeon, is more persuasive. Deere also argues that Dr. Gritzka's opinion should be given less deference since he only examined claimant once two years after the aggravation claim was filed. Deere also takes issue with the ALJ's statement that Dr. Gritzka was the only physician to compare 1993 and 1996 films.

Dr. Malos treated claimant for the 1992 compensable injury and performed claimant's 1993 low back surgery, a left L5-S1 microlumbar laminotomy, medial factectomy and decompression of the L5 and S1 nerve roots. Dr. Malos also evaluated claimant for his current low back problems on referral from Dr. Berger. Dr. Malos has opined that claimant's current problem is a new problem which is unrelated to his 1992 injury and subsequent surgery. Consulting physician, Dr. O'Neill and attending physician, Dr. Berger, also have opined that claimant's current problem is due to noncompensable degenerative disease and not to the 1992 compensable injury. Dr. Weller, examining physician, initially attributed claimant's condition to the 1992 injury, but later changed his opinion and attributed the condition to degenerative changes caused by the preexisting degenerative condition.

Dr. Gritzka opined that the source of claimant's current disability and need for treatment was the 1992 compensable injury. He indicated that the 1992 injury and resulting herniated disc at L5-S1 remained the major contributing cause of claimant's need for treatment. Specifically, Dr. Gritzka believed that claimant's present symptoms were the result of postoperative scarring, entrapment and compromise of the left L5 nerve root. Dr. Gritzka explained why he believed that it was more likely that claimant's present symptoms resulted from the 1992 injury and surgery rather than the fragment at L3-4 identified by the other physicians as the possible cause of claimant's symptoms. Dr. Gritzka also opined that claimant's condition represented a pathological worsening of the conditions attributed to the 1992 injury.

When there is a dispute between medical experts, we rely on those medical opinions which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). After reviewing the record, we agree that Dr. Gritzka's medical opinion is the best explained and most well-reasoned medical opinion in the record. We also find that Dr. Gritzka's opinion is based on complete and accurate information.[1] We recognize that Dr. Malos has treated claimant's low back condition for many years and has performed claimant's prior surgery. However, because we find that the causation issue involves expert analysis, rather than expert external observation, we do not give special deference to the conclusions of the treating physicians. Hammons v. Perini, 43 Or App 299 (1979). Instead, we rely on the most well-reasoned medical opinion which, in this case, we have determined to be that of Dr. Gritzka.[2]

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. ORS 656.273(1). Based on Dr. Gritzka's opinion that claimant has sustained a pathological worsening of the conditions attributed to the 1992 injury, we agree with the ALJ that claimant has established a compensable worsening of his 1992 claim with Deere. See SAIF v. Walker, 145 Or App 294, 305 (1996) (An "actual worsening" may be established by direct medical evidence of a pathological worsening).

Because there is no persuasive evidence that claimant has sustained a new compensable injury involving the same condition, we agree with the ALJ that responsibility for claimant's current low back condition remains with Deere. See ORS 656.308(1).

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

ORDER

The ALJ's order dated April 17, 1997 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by Deere.

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[1] We disagree with Deere's argument that Dr. Gritzka's opinion was based on an inaccurate belief that claimant's prior surgery involved the L4-5 level. Based on our review of his report, Dr. Gritzka understood that the 1993 surgery involved the L5-S1 level.

[2] We note that Dr. O'Neill (Exs. 66-3; 68-2), and possibly other physicians, compared claimant's 1993 and 1996 diagnostic studies, and that the ALJ's statement that "only" Dr. Gritzka compared these studies may not be completely accurate.

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In the Matter of the Compensation of
**STANLEY P. SOMERVILLE, Claimant**
Own Motion No. 97-0494M
ORDER POSTPONING ACTION ON OWN MOTION REQUEST
Bottini, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

The insurer has submitted claimant's request for temporary disability compensation for claimant's compensable injury. Claimant's aggravation rights expired on March 30, 1995. The insurer recommends against reopening on the grounds that surgery or hospitalization is not reasonable and necessary for the compensable injury. Pursuant to ORS 656.327, this medical services issue is within the Director's jurisdiction. The insurer has requested Director's review of the requested medical treatment. (Medical Review Case No. 12464).

It is the Board's policy to postpone action until pending litigation on related issues has been resolved. Therefore, we defer action on this request for own motion relief and request that the Director send to the Board a copy of the appealable order(s) issued under ORS 656.327 regarding this medical services issue.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**GERALD P. WENZINGER, Claimant**
WCB Case No. 96-01212
ORDER DENYING MOTION TO DISMISS
Moscato & Hallock, Defense Attorneys

Claimant, pro se, has requested review of Administrative Law Judge (ALJ) Neal's order that upheld the self-insured employer's denial of his claim for a left middle finger condition. Noting that copies of claimant's request for review were not timely served on the employer or its claims processing agent, the employer moves to dismiss claimant's appeal. The motion is denied.

## FINDINGS OF FACT

Claimant requested a hearing regarding the employer's denial of his claim for a left middle finger condition. Following the hearing, the ALJ issued an Opinion and Order dated December 9, 1997 upholding the denial. Copies of the order were mailed to claimant, the employer, the claims processing agent, and the attorney for the employer and its claims processing agent.

On January 6, 1998, claimant mailed to the Board, by certified mail, his Request for Board Review. Claimant's request was accompanied by a Certificate of Service certifying that a copy of the request had been mailed to the attorney for the employer and its claims processing agent on January 6, 1998.

## CONCLUSIONS OF LAW AND OPINION

In support of its motion to dismiss, the employer contends that copies of claimant's request for review were not timely served on the employer and its claims processing agent. The employer also contends that timely service of claimant's request for review on its attorney did not comply with the requirement in ORS 656.295(2) that copies of the request for review be mailed to all parties to the proceeding before the ALJ.

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

"Party" means a claimant for compensation, the employer of the injured worker at the time of injury, and the insurer, if any, of such employer. ORS 656.005(21). Attorneys are not included within the statutory definition of "party." Robert Casperson, 38 Van Natta 420, 421 (1986). However, in the absence of prejudice to a party, timely service of a request for review on the attorney for the party is sufficient compliance with ORS 656.295(2) to vest jurisdiction with the Board. King, 63 Or App at 850-51; Nollen v. SAIF, 23 Or App 420, 423 (1975), rev den (1976); Nancy C. Prevatt-Williams, 48 Van Natta 242 (1996); Harold E. Smith, 47 Van Natta 703, 704 (1995); Daryl M. Britzius, 43 Van Natta 1269 (1991).

Here, the 30th day after the ALJ's order was January 8, 1998. Based on claimant's unrebutted January 6, 1998 Certificate of Service, we are persuaded that the employer's attorney was copied with the request for Board review prior to the expiration of the aforementioned 30-day period. Because the

employer does not contend that it has been prejudiced by not directly receiving a copy of the request for review, we hold that claimant's timely service by mail upon the employer's attorney was adequate compliance with ORS 656.295(2). See King, 63 Or App at 850-51; Nollen, 23 Or App at 423; Nancy C. Prevatt-Williams, 48 Van Natta at 243; Harold E. Smith, 47 Van Natta at 704.

The employer cites Berliner v. Weyerhaeuser Company, 92 Or App 264 (1988), as authority for the proposition that timely service on a party's attorney is not adequate compliance with ORS 656.295(2). However, after reviewing Berliner, we find nothing in the court's opinion that overrules prior case law holding that, in the absence of a showing of prejudice, timely service of an appeal on a party's attorney is adequate compliance with ORS 656.295(2). See King, 63 Or App at 850-51; Nollen, 23 Or App at 423; Nancy C. Prevatt-Williams, 48 Van Natta at 243; Harold E. Smith, 47 Van Natta at 704. Accordingly, appellate jurisdiction over this matter was properly vested with the Board. Consequently, the employer's motion to dismiss claimant's appeal is denied.

Finally, enclosed with claimant's and the employer's copies of this order are copies of the hearing transcripts. Furthermore, the following briefing schedule has been implemented. Claimant's appellant's brief (his written argument explaining why he disagrees with the ALJ's decision and what action he wants the Board to take) must be filed with the Board within 21 days from the date of this order. (Claimant is reminded to also mail a copy of his brief to the employer's attorney.) The employer's respondent's brief must be filed within 21 days from the date of mailing of claimant's brief. Claimant's reply brief must be filed within 14 days from the date of mailing of the employer's brief. Thereafter, this case will be docketed for Board review.

IT IS SO ORDERED.

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January 29, 1998 Cite as 50 Van Natta 137 (1998)

In the Matter of the Compensation of
**CYNTHIA M. BRADLEY, Claimant**
WCB Case No. C8-00072
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Roger D. Wallingford, Claimant Attorney
Hoffman, et al, Defense Attorneys

Reviewed by Board Members Bock and Hall.

On January 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 her compensable injury. We approve the proposed disposition.

The first page of the CDA lists two dates of injury: May 16, 1996 and May 14, 1997. Based on the Department of Consumer and Business Services' records, the May 14, 1997 claim is in denied status. Furthermore, the Board's records confirm that the 1997 claim has been resolved by a disputed claim settlement (DCS). Finally, the substance of the CDA is addressed solely to the 1996 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 date of injury of the May 14, 1997 denied claim, the agreement itself disposes of only the May 16, 1996 claim. Under such circumstances, notwithstanding the reference to the May 14, 1997 denied claim, we interpret the agreement as pertaining only to the May 16, 1996 accepted claim.

The agreement, as interpreted herein, 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 $2,250, payable to claimant's counsel, is also approved.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**ALAN L. ANDREWS, Claimant**
WCB Case No. 96-11375
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Lipton's order that: (1) set aside its denial of claimant's aggravation claim for an accepted low back condition; and (2) awarded claimant's counsel an attorney fee for obtaining acceptance of the L5-S1 disc herniation. On review, the issues are aggravation and attorney fees. We affirm in part and modify in part.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following change. In the first sentence of the first paragraph, we change the date to "December 7, 1994."

## CONCLUSIONS OF LAW AND OPINION

### Aggravation

We adopt and affirm the ALJ's reasoning and conclusion that claimant has established compensability of the L4-5 disc herniation.

### Attorney Fees

The ALJ set aside the employer's denial of claimant's L4-5 disc herniation and upheld the denial of the L5-S1 disc herniation. Nevertheless, the ALJ awarded a $3,000 attorney fee to claimant's attorney for obtaining acceptance of the L5-S1 disc herniation.

The employer contends that, even if the L4-5 disc herniation is compensable, claimant is not entitled to an attorney fee for a condition that was not accepted. The employer argues that claimant did not appeal the ALJ's order and is not entitled to an attorney fee for the L4-5 condition. We disagree.

The Board has de novo review authority and is free to make any disposition of the case it deems appropriate, including reaching issues that were before the ALJ but not raised by the parties on review. See ORS 656.295(5), (6); Destael v. Nicolai Co., 80 Or App 596 (1986). Accordingly, because the ALJ awarded an attorney fee and the employer has requested Board review of the ALJ's order, we are authorized to consider all issues addressed by the ALJ's order.

We agree with claimant that the ALJ's order contains a typographical error in that the attorney fee should be awarded for the L4-5 disc herniation, rather than the L5-S1 disc herniation. Consequently, we correct the ALJ's order to read: "Claimant's counsel is awarded $3,000 as a result of obtaining acceptance of the L4-5 disc herniation and the reopening of the claim."

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the aggravation issue is $1,000, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review regarding the attorney fee award. Dotson v. Bohemia, Inc.,80 Or App 233, rev den 302 Or 35 (1986).

## ORDER

The ALJ's order dated June 19, 1997 is affirmed in part and modified in part. The ALJ's order is corrected to award claimant's counsel a $3,000 fee, to be paid by the employer, for obtaining acceptance of the L4-5 disc herniation and the reopening of the claim. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the self-insured employer.

In the Matter of the Compensation of
**ROBERT O. BORDERS, Claimant**
Own Motion No. 97-0283M
OWN MOTION ORDER
Welch, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable torn left anterior horn medial meniscus injury. Claimant's aggravation rights on that claim expired on August 26, 1990. SAIF opposes reopening the claim, contending that claimant was not in the work force at the time of disability. SAIF issued a denial of compensability of an October 22, 1996 claim (7836399A). Claimant appealed the denial. SAIF contends "it would appear [claimant] wants the left knee accepted in the 1996 claim and not the 1972 left knee claim."

A hearing was scheduled regarding SAIF claim 7836399A. (WCB Case No. 97-04336). The Board has received a January 15, 1998 letter from claimant advising that claimant has withdrawn his request for hearing concerning SAIF's denial of October 22, 1996 for claim number 7836399A and requests that we proceed with our review of this "Own Motion" matter. In light of claimant's representations, we proceed with our review.

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

In a March 19, 1997 report, Dr. Eilers, claimant's treating physician, recommended that claimant undergo a left total knee arthroplasty. Thus, we conclude that claimant's compensable injury worsened requiring surgery.

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

SAIF contends that claimant was not in the work force at the time of disability. Claimant contends that he worked until the time of his disability. Claimant submitted copies of his 1995 and 1996 W-2 forms, which establish that he was working during those years. Furthermore, Dr. Eilers' December 27, 1996 chart note indicates that he was treating claimant's left knee in late 1996. On this record, we conclude that claimant has established that he was working until the time of his current disability.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning the date he is hospitalized for surgery. When claimant is medically stationary, 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
**JAMES A. PAZ, Claimant**
WCB Case No. C8-00075
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Cole, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

On January 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 her compensable injury. We approve the proposed disposition.

The first page of the CDA lists two claim numbers: A96103199 and A95159024. Based on the Department of Consumer and Business Services' records, claim number A96103199 is in denied status.

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 claim number of the denied claim, the agreement itself appears only to dispose of the accepted claim, claim number A95159024. Under such circumstances, notwithstanding the reference to the claim number for the denied claim, we interpret the agreement as pertaining only to the accepted claim.

We also note that page 3, line 5 provides "The worker ___ returned to the work force." Notwithstanding the blank space, we interpret this provision to mean that the worker has returned to the work force. See OAR 438-009-0022(4)(d).

The agreement, as interpreted herein, 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 $125, payable to claimant's counsel, is also approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
**TERRY R. TYLER, Claimant**
WCB Case No. 96-07138
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Moller and Bock.

The SAIF Corporation 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 reverse.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

Claimant began working for SAIF's insured on July 6, 1996. On July 8, 1996, claimant and two co-workers were in the process of moving a pole barn for the employer. That evening claimant sought medical attention for low back symptoms and filed a claim. On July 18, 1996, Dr. Stahl declared claimant medically stationary and released him to regular work. (Ex. 27). On July 22, 1996, SAIF denied claimant's claim on the basis that there was insufficient evidence that his low back strain was the result of either a work-related injury or disease. (Ex. 29).

The ALJ concluded that claimant proved a compensable injury claim for a low back strain. In contesting this conclusion, SAIF asserts that we should find claimant not credible. Specifically, SAIF contends that claimant's testimony is unreliable and that the injury did not occur as alleged.

The ALJ's order found claimant to be credible based on his demeanor and the substance of his testimony. Although not statutorily required, the Board generally defers to the ALJ's credibility determination. See Erck v. Brown Oldsmobile, 311 Or 519, 526 (1991). Because the ALJ's credibility finding was based in part upon the observation of claimant's demeanor, we defer to that determination. See International Paper Co. v. McElroy, 101 Or App 61 (1990). However, when the issue of credibility concerns the substance of a witness' testimony, the Board is equally qualified to make its own determination of credibility. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). Based on our review of the record, we conclude that claimant is not credible.

Claimant testified that he was helping to put a ten-gauge steel beam through a building at work on July 8, 1996. Claimant surmised that the beam weighed 600 to 700 pounds. (Tr. 14). A co-worker, Mr. Newton, was on one side pushing the beam, and claimant was on the other side pulling the beam when his back "gave." (Tr. 12). Claimant told Newton that he hurt his back, sat down for 30 to 40 minutes and then went back to work nailing up "2 by 12" boards. (Tr. 16).

Mr. Newton testified that, on the date of the alleged injury, claimant was mostly observing and carrying railroad tie blocks and did not work on the steel cross beams until he (Newton) had two or three of them in place. (Tr. 74). The cross beams weighed about 200 pounds but, at that stage of the work, required a force of only about 20 pounds to pick up and slide. (Tr. 77, 78). Newton reported that claimant tried to pull on the beam, then said his back hurt and he could not do it. Claimant did not move the beam at all. Claimant then went outside and took about a two-hour break, doing nothing. (Tr. 79-81). Claimant later dug concrete rubble away from some poles by hand with a claw hammer, for about an hour and a half. (Tr. 81-82). Claimant did not mention his back again that day, and Mr. Newton later saw claimant "hop" out of the boom truck back at the yard. (Tr. 85, 88).

Mr. Emmert, president of the company, who was back at the yard, testified that claimant asked him where to park the boom truck and told him that his back was a little sore from driving the truck. (Tr. 30, 32). Emmert then watched claimant pull the boom truck onto the staging area and jump out of the truck, a distance of two feet, and then run from the boom truck to his personal vehicle, a distance of about 150 to 200 feet. (Tr. 34-35).

Claimant also testified that he had experienced two injuries to his back at prior employers. (Tr. 21). However, Emmert, who interviewed claimant before hiring him, testified that claimant told him (Emmert) that he had never been injured. (Tr. 30). Claimant subsequently admitted that he did not include the two prior employers with which he had filed workers' compensation claims among his past employers. (Tr. 55, 58).

In addition to the testimony from the employer's witnesses, which fails to corroborate the circumstances of his alleged injury, claimant left off of his employment application the two employments where he had made prior injury claims. (Ex. 41-2). He also reported on his employment application that he left Best Delivery Service in April 1994 because the company relocated, whereas he reported to Dr. Edwards in February, 1994, that he left because of "eyestrain" at least four months earlier. (Compare Exs.#41-2, 5-2).

After our de novo review of the record, we conclude that claimant is neither a reliable historian nor credible in his testimony regarding the circumstances of his alleged injury. Consequently, we do not find Dr. Harris's medical opinion, which relies on claimant's report of the circumstances of his injury, to be persuasive. Somers v. SAIF, 77 Or App 259 (1986). Therefore, claimant has failed to prove that he experienced a compensable low back injury during his employment at SAIF's insured.

ORDER

The ALJ's order dated April 23, 1997 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award is likewise reversed.

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January 30, 1998 Cite as 50 Van Natta 142 (1998)

In the Matter of the Compensation of
**DAVID C. THOMPSON, Claimant**
Own Motion No. 95-0646M
ORDER POSTPONING ACTION ON REVIEW OF CARRIER CLOSURE
Peter Hansen, Claimant Attorney
Hoffman, Hart, et al., Defense Attorneys

Claimant has requested Board review of the insurer's November 7, 1997 Notice of Closure, which closed his claim with an award of temporary disability compensation from September 12, 1996 through October 29, 1997. The insurer declared claimant medically stationary as of October 29, 1997. Claimant contends he is entitled to additional benefits beyond October 29, 1997.

Claimant has requested a hearing with the Hearings Division. (WCB Case No. 98-00217). In a January 5, 1998 letter to the Board, claimant indicated that he had requested that acromioclavicular synovitis and chronic subacromial bursitis with impingement be accepted as a compensable portion of the 1986 claim. The Board is unaware of the specific issues submitted for the hearing; however, "denial" and "compensability" are apparently being litigated. If the litigation concerns claimant's acromioclavicular synovitis and chronic subacromial bursitis with impingement, those conditions have not been accepted by the insurer. Should the Administrative Law Judge (ALJ) find that claimant's current acromioclavicular synovitis and chronic subacromial bursitis with impingement are a compensable portion of claimant's 1986 claim, the finding could have an effect on the Board's review of the carrier's closure of the claim.

It is the Board's policy to postpone action until pending litigation on related issues has been resolved. Therefore, we conclude that it would be in the best interest of the parties to defer action on this request for review of the insurer's November 7, 1997 closure. At the conclusion of the hearing, we request that ALJ Thye, who is scheduled to conduct the hearing in WCB Case No. 98-00217 on March 25, 1998, submit a copy of the hearing order to the Board. In addition, if the matter is resolved by stipulation or disputed claim settlement, the ALJ is requested to submit a copy of the settlement document to the Board. After issuance of the order or settlement document, the parties should advise the Board of their respective positions regarding own motion relief.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**ELAINE M. BORGELT, Claimant**
WCB Case No. 96-05395
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Davis' order that set aside its denial of claimant's current low back condition. On review, the issues are the propriety of the denial and, if proper, compensability. We affirm the ALJ's decision to set aside the denial, but we base our conclusion on different grounds.

## FINDINGS OF FACT

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

Claimant, age 50 at the time of hearing, has sustained various disabling injuries over the years, including compensable cervical and lumbar strains in 1979 and 1982. In 1986, she was involved in a compensable motor vehicle accident, and was treated for left-sided low back pain and left leg symptoms as well as cervical discomfort and numbness along the right ulnar distribution. Then, in 1987, claimant was involved in another compensable motor vehicle accident, in which she experienced an exacerbation of symptoms, particularly in her low back, legs and neck.

In 1988, claimant began treating with Dr. Mason. She complained of chronic low back pain and pain extending into the left buttock and leg. An MRI scan indicated some degenerative changes at L5-S1 on the left, but no nerve root encroachment. Claimant's 1987 automobile accident claim was closed by means of a December 7, 1989 Determination Order that awarded more than two years of temporary disability and 19 percent unscheduled permanent disability. Claimant also brought a third party action arising out of her 1987 automobile accident, which was later settled for $85,000.

Over the years, claimant has also treated with Dr. Valleroy. In July 1989, Dr. Valleroy's impression was chronic low back pain with no essential change in examination or physical status. Claimant returned to Dr. Valleroy in September 1990. At that time, Dr. Valleroy noted tenderness in the left lumbosacral spine and reported that claimant had intermittent tingling of the lateral left foot.

Between 1990 and 1993, claimant attended nursing school. In January 1994, she began working for the employer as a registered nurse. On December 7, 1994, claimant tripped on a hospital step and fell forward onto her left side. She developed pain in her left hip, buttock and leg as well as on the left side of her neck. She sought treatment on December 9, 1994, and was diagnosed with contusion and strain of the left leg and back A few days later, claimant saw Dr. Borman, who diagnosed muscular strain in the hip area and prescribed medication and hot soaks.

On January 13, 1995, the employer accepted a nondisabling low back strain, which was later reclassified as disabling.

Claimant's low back and radiculopathy symptoms continued. An April 1995 MRI showed a herniated disc at L5-S1 with degeneration of the disc without evidence of nerve root compression. In August 1995, Dr. Mason referred claimant for injection therapy, which provided her with temporary relief of her buttock pain but did not relieve her low back pain or sciatica of the left leg.

In April 1996, claimant returned to Dr. Valleroy complaining of chronic low back pain radiating into the left leg. Dr. Valleroy recommended medication and physical therapy. She became claimant's attending physician.

On June 3, 1996, prior to closure of the accepted lumbar strain claim, the employer issued a partial denial, asserting that claimant's accepted strain had resolved and had ceased to be the major cause of her current disability and need for treatment. On that same day, the employer submitted the accepted low back strain claim for closure. Claimant requested a hearing contesting the procedural and substantive validity of the employer's partial denial. A June 20, 1996 Determination Order awarded temporary disability but no permanent disability.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's accepted December 7, 1994 low back strain remains the major contributing cause of her current condition and need for treatment. On review, the employer asserts that claimant has failed to prove the compensability of her current condition. Because we find, for the reasons set forth below, that the employer's "pre-closure" partial denial was procedurally invalid, we do not address the substantive merits of the employer's denial.

Pursuant to ORS 656.262(7)(b), a "pre-closure" denial is appropriate 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). ORS 656.262(7)(b) is not applicable in this case, however, 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). The employer accepted a "low back strain" and not a combined condition involving claimant's preexisting degenerative changes or left sciatica. (Ex. 66A).

Because ORS 656.262(7)(b) is inapplicable, the validity of the employer's "pre-closure" denial is dependent upon whether the denial constitutes an attempt to limit future responsibility on an accepted claim before the extent of disability arising out of the accepted condition has been determined. If so, it is impermissible. See Roller v. Weyerhaeuser Co., 67 Or App 583, 586 (1984). Although there is no prohibition against issuing a pre-closure denial of a condition distinctly separate from the accepted condition,[2] the employer may not issue a pre-closure denial of a condition to which the accepted condition has contributed or combined. Id.; see also Elizabeth B. Berntsen, 48 Van Natta at 1223 (a carrier may not deny further responsibility for any condition arising from the accepted claim while the claim is in open status and before the extent of permanent disability has been determined).

Here, the employer formally denied claimant's current disability and need for treatment asserting that it was no longer compensably related to her accepted low back strain. The denial further asserted that claimant's accepted strain had "resolved" and that her current disability and need for medical treatment are caused in major part by her preexisting low back condition. Therefore, although the employer did not accept a combined condition, it is attempting to deny claimant's current condition on the grounds the accepted strain condition is no longer *contributing to* that condition.

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 implies (and a preponderance of the medical evidence establishes[3]) there was a point in time, while the accepted strain claim was in open status, in which that injury and the preexisting back condition were not completely separate or unrelated. 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).

Furthermore, under similar circumstances, we have 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. See Charles L. Wallace, 49 Van Natta 52, on recon 49 Van Natta 472 (1997); see also Michael C. Leggett, 50 Van Natta 151 (1998) (finding

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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 as a result of a judgment or order).

[2] See, e.g., Johnson v. Spectra Physics, 303 Or 49 (1987); Tattoo v. Barrett Business Services, 118 Or App 348 (1993) (carrier may issue a partial denial of an unrelated condition while an accepted claim is in open status); see also ORS 656.262(7)(a) (carrier may issue a denial of a new medical condition).

[3] Dr. Mason reported in November 1995 that claimant's December 1994 fall was "just another incident in a line of [clinical] problems." (Ex. 106). He further acknowledged that claimant's preexisting spinal changes were an "element of" her symptoms in 1995, even though he believed her December 1994 injury was the major cause. (Ex. 107B). Dr. Valleroy also noted that, although claimant suffered a compensable strain in 1994, her continued symptomatic flare-ups were caused in major part by her preexisting chronic low back condition. (Ex. 133). In light of such circumstances, we cannot conclude that claimant's accepted strain did not contribute to claimant's disability or need for treatment.

pre-closure current condition denial invalid where carrier argued that compensable strain condition had resolved without treatment). Here, as in Wallace and Leggett, insofar as the employer's pre-closure denial attempts to limit its responsibility to a "resolved" strain, it is an impermissible denial of future responsibility with respect to a compensable condition. Accordingly, we find the employer's pre-closure denial procedurally invalid.[4]

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the pre-closure denial 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 December 23, 1996, as reconsidered April 1, 1997, is affirmed. The employer's denial is set aside as procedurally invalid. For services on review, claimant's counsel is awarded $1,000, payable by the employer.

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[4] In making this determination, we express no opinion on the compensability of claimant's current condition, i.e., whether or not her accepted strain remains the major contributing cause of her disability and need for treatment.

**Member Haynes specially concurring.**

I concur with the lead opinion's conclusion that the carrier's "pre-closure" denial is procedurally invalid. I write separately to emphasize what I perceive to be a carrier's claim processing obligations when confronted with situations such as those present in this case.

To begin, in the absence of a carrier's acceptance of a "combined condition" (either voluntarily or by means of litigation order), the provisions of ORS 656.262(7)(b) permitting a pre-closure denial of a "combined condition" have no application. Moreover, unless a claimant has filed a claim for the "combined condition" or preexisting condition, a carrier is under no obligation to issue a denial (pre-closure or otherwise). In fact, such a denial would be premature.

I understand the dilemma faced by a carrier when an accepted condition approaches medically stationary status, but an unclaimed or unaccepted preexisting condition may not be medically stationary or may be permanently disabling. When preparing for the closure of a claim under such circumstances, the carrier may be concerned that these unclaimed or unaccepted condition will be evaluated once the claim is closed. However, rather than issuing a premature pre-closure denial, I believe that the appropriate approach under the statutory scheme is for the carrier to clarify with medical experts the status of the accepted condition (as distinguished from any unaccepted conditions), including any permanent impairment attributable to that condition.

Once the accepted condition is medically distinguished from the other conditions, the claim could be appropriately closed and evaluated in such a way that only disability (temporary and / or permanent) related to the accepted condition would be considered. Ideally, this clarification would occur prior to claim closure. Nonetheless, in those claims where the Evaluation Section has rated conditions that the carrier believers have not been accepted, the carrier is entitled to seek reconsideration (as well as request the appointment of a medical arbiter) and , in doing so, raise its specific concerns.

My conclusions regarding the statutory scheme are further supported by the 1997 legislative amendments to ORS 656.262. Specifically, subsection (7)(c) has been added to the statute, which requires a carrier to issue at claim closure "an update notice of acceptance that specifies which conditions are compensable." These statutory changes provide further confirmation that only those conditions that have been accepted by the carrier are subject to evaluation at the time of claim closure. In light of such circumstances, a denial of an unclaimed and unaccepted condition prior to claim closure is unwarranted.

In the Matter of the Compensation of
**JERALD J. COOPER, Claimant**
WCB Case No. 96-02211
ORDER ON REVIEW
Burt, Swanson, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Hall and Bock.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Myzak's order that declined to authorize an offset for an alleged overpayment against claimant's future disability awards. On review, the issue is offset. We modify.

## FINDINGS OF FACT

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

Claimant has an accepted disabling injury claim for a low back strain he sustained in September 1994. He suffered periods of disability and received temporary disability benefits. The claim was closed by Notice of Closure on October 20, 1995 with an award of temporary disability benefits only. Claimant requested reconsideration. By Order on Reconsideration dated February 16, 1996, the Department modified the closure notice to award 27 percent unscheduled permanent disability. The reconsideration order also assessed a penalty and authorized the insurer to deduct overpaid temporary disability from unpaid permanent disability benefits. (Ex. 43-2).

The insurer filed a hearing request concerning the reconsideration order, raising the issues of unscheduled disability, penalty, and "overpayment of TTD [i.e., temporary disability] of $4,877.01." Claimant filed a response to the hearing request, asserting that the reconsideration order should be affirmed. Instead of a hearing, the parties submitted the matter based on the documentary record and written closing arguments. In its closing argument, the insurer requested that the ALJ's order indicate its entitlement to recover an overpayment against any future awards.

## CONCLUSIONS OF LAW AND OPINION

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

The ALJ reversed the reconsideration order award of permanent disability. In addition, finding no evidence to establish the amount of the alleged overpayment, the ALJ ordered that "[t]he insurer shall not offset any amount as an overpayment against future awards of compensation." The insurer requested reconsideration of the offset issue. The ALJ granted reconsideration, but again denied the offset request. Concluding that the Hearings Division had jurisdiction over the offset issue and that the issue was ripe for adjudication, the ALJ ordered that "[t]he insurer shall not offset $4,877.01, or any amount thereof, as an overpayment against future awards of disability."

On review, the insurer states that its appeal is largely precautionary. Insofar as the ALJ's order contains language that would preclude it from recovering the alleged overpayment from future awards, it requests modification of the order to eliminate that language. The insurer argues that the offset issue should not have been addressed because it was mooted by the ALJ's reversal of the permanent disability award. The insurer further argues that the ALJ should not have disapproved an offset because it was authorized by the Department's reconsideration order and claimant did not contest the reconsideration order.

ORS 656.268(15)(a) provides that "[a]n 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." Consistent with this statute, the Department expressly authorized the insurer to

offset overpaid temporary disability against any unpaid permanent disability.[1] (Ex. 43-2). Claimant did not contest the Department's offset authorization or any other portion of its reconsideration order.

Thus, although the insurer raised the amount of the overpaid compensation as an issue at hearing, its entitlement to an offset for overpaid temporary disability against future disability awards was established by ORS 656.268(15) and the Department's reconsideration order. Under these circumstances, the issue of the insurer's entitlement to an offset for any overpaid temporary disability was not before the ALJ.

Rather, the sole offset issue before the ALJ was whether the insurer had proven the specific amount of its alleged overpayment. On that precise issue, we agree with the ALJ that there was a failure of proof on this record. See Thomas A. Hutcheson, 46 Van Natta 354, 356-57 (1994). In reaching this conclusion, we reject the insurer's contention that the offset issue was mooted by the ALJ's reversal of the permanent disability award. Even without a permanent disability award, the ALJ was authorized to approve an offset of overpaid compensation against any future disability awards. See Travis v. Liberty Mutual Ins., 79 Or App 126 (1986); see also SAIF v. Zorich, 94 Or App 661 (1989) (carrier's request for offset of overpaid compensation against future awards was a "matter concerning a claim"). Because the insurer did not prove the amount of its alleged overpayment, we conclude that the ALJ properly denied authorization for an offset in the amount of $4,877.01. In effect, the amount of the overpayment has been litigated and, based on a failure of proof, stands as zero ($ 0).

At the same time, however, the ALJ's order contains language that could be read to preclude the insurer from asserting an offset against future awards. We decline to address whether the doctrine of "issue preclusion" would bar future litigation regarding the insurer's entitlement to an offset for any alleged overpayment. The preclusive effect of this order on future litigation is not a ripe issue until the insurer again asserts an offset based on the alleged overpayment. Until the insurer takes that action, and claimant contests the action in a later proceeding, it would be premature for us (or the ALJ) to address the preclusive effect of the order in this proceeding. See, e.g., Dwight M. Page, 48 Van Natta 972 (1996); Scott C. Clark, 47 Van Natta 133 (1995) (Board declined to issue advisory opinion). Accordingly, we modify the ALJ's order to delete language that could be read to preclude the insurer from asserting an offset based on its alleged overpayment against future disability awards.

## ORDER

The ALJ's order dated December 23, 1996, as reconsidered on January 16, 1997, is modified in part and affirmed in part. That portion of the order that stated that "[t]he insurer shall not offset $4,877.01, or any amount thereof, as an overpayment against future awards of disability" is modified to read: "The insurer's request for authorization to offset $4,877.01 as an overpayment against future disability awards is denied." The remainder of the ALJ's order is affirmed.

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[1] ORS 656.268(15) was enacted by the 1995 Legislature. Or Laws 1995, ch 332, § 30. Prior to the enactment, there were essentially two avenues available to a carrier for recovering an overpayment of compensation. One avenue was ORS 656.268(13), which provides that a determination order or notice of closure may include necessary adjustments in compensation, including crediting temporary disability payments against current and future disability awards. The other avenue was to request a hearing pursuant to ORS 656.283(1) and obtain authorization from an ALJ or the Board. See Travis v. Liberty Mutual Ins., 79 Or App 126 (1986); Forney v. Western States Plywood, 66 Or App 155 (1983); Steven F. Sutphin, 44 Van Natta 2126 (1992); Steve E. Maywood, 44 Van Natta 1199 (1992). In Travis and Forney, the court held that a carrier may not unilaterally recoup an overpayment without prior authorization.

By enacting ORS 656.268(15), it appears that the legislature has effectively overturned 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. Under current law, it appears that 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). At the same time, however, nothing prevents a carrier from requesting prior authorization for an offset in a specific amount, as the insurer did in this case when it filed the hearing request asserting an overpayment of $4,877.01.

In the Matter of the Compensation of
**FRED E. FERRY, Claimant**
WCB Case No. 96-09186
ORDER ON REVIEW
Michael B. Dye, 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) Galton's order that affirmed a Determination Order awarding 35 percent (52.5 degrees) scheduled permanent disability for the loss of use or function of the right hand and 35 percent (52.5 degrees) scheduled permanent disability for the loss of use or function of the left hand. On review, the issue is extent of scheduled permanent disability. We modify.

## FINDINGS OF FACT

Claimant has an accepted claim for bilateral Raynaud's syndrome. On December 16, 1994, claimant became medically stationary. A March 1996 Order on Reconsideration awarded 3 percent scheduled permanent disability for each hand. Eventually, in December 1996, that award was increased to 5 percent scheduled permanent disability for each hand by the Board.

Meanwhile, in August 1995, claimant began participating in an authorized training program (ATP). In July 1996, the ATP ended. A Determination Order and amended Determination Order awarded 35 percent scheduled permanent disability for each hand. In September 1996, based on Weyerhaeuser v. Purdy, 130 Or App 322 (1994), the Department issued an Order Denying Request for Reconsideration. The insurer requested a hearing, seeking to reduce the permanent disability award.

## CONCLUSIONS OF LAW AND OPINION

The ALJ agreed that claimant was entitled to 35 percent scheduled permanent disability for each hand. The ALJ based this conclusion on his finding that the employer failed to carry its burden of proof that claimant was not entitled to Class 3 impairment under former OAR 436-35-110(6) (WCD Admin. Order 6-1992). The insurer objects to the ALJ's order, asserting that claimant is entitled only to his prior award of 5 percent scheduled permanent disability for each hand.

We initially note that, in appealing the amended Determination Order, it was not necessary for the parties to first request reconsideration by the Department. Former ORS 656.268(8), 656.268(9).[1]

Former OAR 436-35-110(6) provides:

> "Vascular disease of the upper extremity is valued according to the affected body part, using the following classification table:
>
> "(a) Class 1: 3% for the affected body part if the worker experiences only transient edema; and on physical examination, the findings are limited to the following: loss of pulses, minimal loss of subcutaneous tissue of fingertips, calcification of arteries as detected by radiographic examination, asymptomatic dilation of arteries or veins * * *, or Raynaud's phenomenon which occurs with exposure to temperatures below freezing (0° Centigrade) and is readily controlled by medication.
>
> "(b) Class 2: 15% for the affected body part if the worker experiences intermittent pain with repetitive exertional activity; or there is persistent moderate edema incompletely controlled by elastic supports; or there are signs of vascular damage such as a healed

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[1] Under former ORS 656.268(8), after a worker ceased being enrolled in an ATP, the Department was required to redetermine the claim, unless the worker was not medically stationary. Any interested party could then request a hearing from the resulting Determination Order. Former ORS 656.268(9). Both statutes were amended in 1995 so that redeterminations following an ATP are now "appealed in the same manner as are other determination orders or notices of closure[.]" The amended statutes, however, apply only to those claims that become medically stationary on or after June 5, 1995, the effective date of the amendments. Or Laws 1995, ch 332, § 66(4). Because claimant was medically stationary on December 14, 1994, the former statutes apply.

> stump of an amputated digit, with evidence of persistent vascular disease, or a healed ulcer; or Raynaud's phenomenon occurs on exposure to temperatures below 4° Centigrade and is controlled by medication.
>
> "(c) Class 3: 35% for the affected body part if the worker experiences intermittent pain with moderate upper extremity usage; or there is marked edema incompletely controlled by elastic supports; or there are signs of vascular damage such as a healed amputation of two or more digits, with evidence of persistent vascular disease, or superficial ulceration; or Raynaud's phenomenon occurs on exposure to temperatures below 10° Centigrade and is only partially controlled by medication."

The Determination Orders based the award on finding that claimant fell in Class 3 of the rule. The ALJ agreed on the basis that, "[p]ursuant to and in reliance on [claimant's] totally credible and reliable testimony, [he] suffers [sic] Raynaud's phenomenon when exposed to temperatures below 15 degrees Centigrade * * *, which [sic] is only partially controlled by medication."

As the employer contends, when the value is based on a Raynaud's phenomenon, there must be medical evidence concerning at what temperature the condition occurs and the extent the condition is controlled by medication in order to determine the appropriate class. E.g., Ronald W. Myers, 47 Van Natta 1039 (1995). The March 1996 Order on Reconsideration based its award in part on the medical arbiter panel's report that claimant's impairment came under Class 1. (Exs. 34-4, 35-4). On May 2, 1996, claimant saw his treating physician, Dr. Feldstein, who specializes in occupational medicine. Dr. Feldstein in the chartnote stated that claimant "clearly notes that he is triggered by temperatures way above freezing, and in fact, sometimes he has spontaneous onset of the Raynaud's." (Ex. 37). Referring only to this chartnote, the Determination Orders found that claimant was entitled to Class 3 impairment under former OAR 436-35-110(6)(c). (Exs. 39-3, 40-1).

After reviewing the standards, Dr. Feldstein reported to the employer's attorney that claimant "continues to fall into class 1." (Ex. 41-1). Dr. Feldstein explained that claimant had undergone one "objective" test, which "did not confirm the presence of cold-induced digital artery spasm" and that she had "no way to objectively state at what temperature [claimant] gets Raynaud's." (Id. at 1-2). Dr. Feldstein also found it "likely that [claimant] would be readily controlled by medication, if he desired to take it." (Id. at 1).

In response to claimant's counsel's request for information concerning claimant's impairment, Dr. Feldstein indicated that claimant fell in Class 2, adding that "Raynauds triggered by temperatures above freezing but likely still below 4° C[.]" (Ex. 43-2).

Dr. Feldstein was then deposed. She explained that she had based her response to the employer's attorney that claimant fell under Class 1 on looking at the entire rule; when based only on that portion concerning Raynaud's syndrome, Dr. Feldstein thought that claimant came under Class 2. (Ex. 44-11). Dr. Feldstein further explained that claimant had declined to use proposed medication and that, because responses varied, she could not state the effect of that medication on claimant's condition. (Id. at 15-16).

Based on this record, we find that the employer successfully showed that claimant should not be rated under Class 3. According to an earlier report from Dr. Feldstein, claimant's condition likely would be readily controlled by the proposed medication. Although, during the deposition, Dr. Feldstein declined to provide an opinion concerning the issue, her opinion that claimant came under Class 2 is consistent with her earlier report that claimant's condition probably would be controlled with the proposed medication. We find such evidence sufficient to show that claimant's condition would be "controlled by medication" and not merely "partially controlled by medication."[2] Consequently,

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[2] We find meritless claimant's contention that, because Dr. Feldstein confirmed that he takes aspirin and Tylenol, his condition is "only partially controlled by medication." As our previous cases indicate, the rule is based on the effect of prescribed medication and not the effect of a worker's sole decision to use over-the-counter pain relievers. See Ronald W. Myers, 47 Van Natta at 1039; Ryan F. Johnson, 46 Van Natta 844, 846 (1994). Furthermore, even if over-the-counter pain relievers could qualify as "medication" in a general sense, in this case there is no evidence that it has any beneficial effect on Raynaud's syndrome; in other words, there is an absence of evidence that a worker's voluntary use of over-the-counter pain relievers acts as "medication" for Raynaud's syndrome.

whether or not claimant's condition "occurs on exposure to temperatures below 10° Centigrade," we conclude that he does not fall under Class 3.

Based on Dr. Feldstein's opinion, however, we further find that claimant's Raynaud's syndrome "occurs with exposure to temperatures below 4° Centigrade and is controlled by medication." Consequently, we conclude that claimant's condition falls under Class 2 of former OAR 436-35-110(6)(b) and, thus, he is entitled to 15 percent for each hand.

Finally, we note the employer's argument that claimant's prior award should preclude him from obtaining an additional permanent disability award. As stated in footnote 1, the applicable statutes required the Department to redetermine claimant's previous award and provided that any interested party could request a hearing from any resulting Determination Order. We find that such statutes showed a legislative intent that a worker could obtain a greater permanent disability award following an ATP. Consequently, like the ALJ, we find no preclusive effect by the prior award.

ORDER

The ALJ's order dated June 30, 1997, is modified. In lieu of the Determination Order, amended Determination Order and the ALJ's order, claimant is awarded 15 percent (22.5 degrees) scheduled permanent disability for the loss of use or function of each hand. The ALJ's attorney fee award is reversed.

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February 2, 1998 Cite as 50 Van Natta 150 (1998)

In the Matter of the Compensation of
**KIM A. COLE, Claimant**
WCB Case No. 97-02031
ORDER ON REVIEW
Heiling, Dodge & Associates, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Lipton's order that: (1) declined to admit a "post-hearing" exhibit into the record; and (2) upheld the self-insured employer's denial of her claim for a left shoulder, neck and brachial plexus condition. On review, the issue are evidence and compensability.

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

On review, claimant contends that the ALJ erred in excluding Exhibit 153, correspondence in which Dr. Henry "clarifies" an earlier letter to the employer.

To begin, claimant agrees that the ALJ left the record open solely for the purpose of receiving Dr. Johnson's deposition into evidence. Under these circumstances, the ALJ did not abuse his discretion in excluding Exhibit 153. See Clifford L. Conradi, 46 Van Natta 854 (1994); Darrel L. Hunt, 44 Van Natta 2582 (1992)(when an ALJ leaves the record open for a limited purpose, it is within the ALJ's discretion to exclude evidence that does not comport with that purpose). In any event, consideration of Exhibit 153 would not affect the outcome of this case as we agree with the ALJ that Dr. Henry's opinion is inconsistent and based on an inaccurate history.

ORDER

The ALJ's order dated October 6, 1997 is affirmed.

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In the Matter of the Compensation of
**MICHAEL C. LEGGETT, Claimant**
WCB Case No. 96-04719
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that: (1) found that the self-insured employer was not precluded from denying claimant's current cervical condition; and (2) upheld the employer's denial. On review, the issues are res judicata, the propriety of the denial, and compensability. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's Findings of Fact, with the following summary and supplementation:

Claimant, age 40 at the time of hearing, injured his upper back at work on January 25, 1995, handling a heavy bale of paper. He was initially diagnosed with a lumbar and thoracic strain, and prescribed physical therapy. Thereafter, claimant began experiencing cervical symptoms. As a result of an August 15, 1995 Opinion and Order, the claimant's cervical and thoracic conditions were found compensable. On September 22, 1995, the employer accepted claimant's claim for "cervical/thoracic strain." Claimant also had preexisting lower back problems due to a prior, out-of-state, industrial injury.

On October 10, 1995, Dr. Ordonez reported that claimant had a herniated disc at C5-6. A cervical discectomy and fusion at C5-6 was performed by Dr. Ordonez on October 20, 1995.

Following the surgery, claimant continued to experience pain in the back of the neck and numbness of the right arm. Claimant continued to treat with Dr. Ordonez who reported that claimant's symptoms seemed to be legitimate although there was no question that there was psychological overlay.

On April 17, 1996, claimant was examined by the Columbia Medical Consultants on behalf of the employer. The Consultants diagnosed a currently stationary cervical strain and status post C5-6 discectomy. The Consultants reported that claimant's osteophyte formation and disc herniation at C5-6 were preexisting and chronic in nature. The Consultants also found that claimant's cervical and thoracic strains were resolved and there was no permanent impairment due to the strains.

On April 25, 1996, claimant was examined by Dr. Turco, psychiatrist, who diagnosed a preexisting personality disorder.

On April 29, 1996, claimant was examined by Drs. Zivin and Thompson on behalf of the employer. Drs. Zivin and Thompson concluded that claimant's symptoms were due to cervical spondylosis at C5-6 and the results of the surgery, rather than a cervical strain which had become stationary by April 1995.

On May 7, 1996, Dr. Ordonez reported that claimant was improving and, following a work hardening program, a closing exam would be performed.

On May 13, 1996, the employer issued a denial which provided, in part, as follows:

> "Your claim was accepted for a cervical and thoracic strain for which related medical and disability benefits were paid against this claim. Currently, there is a preponderance of medical opinions that indicate that the accepted cervical and thoracic strains are no longer the material and/or major contributing cause for your current disability and need for medical treatment. A cause of your current need for disability and treatment for your cervical condition is your preexisting C5-6 and C6-7 abnormalities and osteophytes. Furthermore, another contributing factor of your current disability and need for medical treatment is your diagnosis of a preexisting personality disorder."

CONCLUSIONS OF LAW AND OPINION

On review, claimant renews his argument that the employer's denial is precluded by the August 1995 Opinion and Order which found that claimant's cervical and thoracic strains were compensable. Claimant also argues that the employer is estopped from denying his current condition, based on the employer's oral authorization of surgery. We disagree with claimant's first two contentions, and we adopt the ALJ's "Conclusions and Opinion" on the preclusion/estoppel issue.

Claimant next argues that, because his accepted cervical/thoracic strain claim had not been closed,[1] the employer's denial constituted an improper pre-closure denial of a previously accepted condition. The employer contends that, pursuant to ORS 656.262(7)(b), it was required to issue a denial prior to claim closure when the accepted injury was no longer the major contributing cause of the worker's combined condition. For the reasons set forth below, we conclude that ORS 656.262(7)(b) is inapplicable. We further find that the denial constitutes, at least in part, an invalid pre-closure denial.

As previously noted, the employer relies on ORS 656.262(7)(b) as authority for its pre-closure denial. In interpreting ORS 656.262(7)(b), we have held that a "pre-closure" denial is valid when the denial is based on the combined condition no longer being compensable under ORS 656.005(7)(a)(B). Marianne L. Sheridan, 48 Van Natta 908 (1996). We have also held that, by its terms, ORS 656.262(7)(b) applies only to situations involving a "combined condition." Elizabeth B. Berntsen, 48 Van Natta 1219 (1996).[2] Further, in Robin M. Spivey, 48 Van Natta 2363 (1996), we held that the requirement for a "pre-closure" denial of a combined condition pursuant to ORS 656.262(7)(b) is applicable only when the carrier has accepted a "combined condition," either voluntarily or by means of a litigation order.

In accepting a cervical/thoracic strain (caused in material part by claimant's work activity on January 26, 1995), the employer did not accept a "combined condition." Because the employer did not accept the combined condition it is now seeking to deny, ORS 656.262(7)(b) does not apply. Robin M. Spivey, 48 Van Natta at 2366.

Having found ORS 656.262(7)(b) inapplicable, we must nevertheless determine whether the pre-closure denial was valid. The denial's validity is dependent upon whether it constitutes an attempt to limit future responsibility on an accepted claim before the extent of disability arising out of the accepted condition has been determined. If so, it is impermissible. See Roller v. Weyerhaeuser Co., 67 Or App 583, 586 (1984). Although there is no prohibition against issuing a pre-closure denial of a condition separate from the accepted condition,[3] the employer may not issue a pre-closure denial of a condition to which the accepted condition has contributed or combined. Id.; see also Elizabeth B. Berntsen, 48 Van Natta at 1223 (a carrier may not deny further responsibility for any condition arising from the accepted claim while the claim is in open status and before the extent of permanent disability has been determined).

Here, the employer's denial does not solely deny conditions that are separate from the accepted condition. The denial references claimant's "current disability and need for medical treatment" for his "cervical condition," which includes the accepted strain conditions. To the extent the pre-closure denial attempts to deny conditions that are not separate or severable from the accepted condition, it is improper. Elizabeth B. Berntsen, 48 Van Natta at 1223; Compare Zora A. Ransom, 46 Van Natta 1287 (1994) (where the medical evidence "unequivocally" indicated that the claimant's current condition was not related to the accepted condition, the pre-closure denial was proper).

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[1] Based on the discussion between the parties at hearing, it appears that the claim was closed by the time of the scheduled hearing. (Tr. 6).

[2] In Berntsen, we noted that the insurer denied the claim for current treatment and disability in connection with the claimant's mid and low back condition, on the ground that insufficient evidence existed that her current back condition was the result of the compensable injury. We concluded that, because the denial was not based on a combined or consequential condition, ORS 656.262(7)(b) did not apply. 48 Van Natta 1219.

[3] See, e.g., Johnson v. Spectra Physics, 303 Or 49 (1987); Tattoo v. Barrett Business Services, 118 Or App 348 (1993) (carrier may issue a partial denial of an unrelated condition while an accepted claim is in open status); see also ORS 656.262(7)(a) (carrier may issue a denial of a new medical condition).

Moreover, at hearing and on review, the employer argued that its denial was appropriate because the compensable strain condition had resolved without impairment. (Tr. 6, Resp. Br. at 6). Contrary to the employer's position, we have previously 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. See Charles L. Wallace, 49 Van Natta 52, on recon 49 Van Natta 472 (1997). Here, as in Wallace, the employer's acceptance was unequivocal. An attempt to limit responsibility to a resolved strain through a pre-closure denial which limits future responsibility for the accepted claim is impermissible. Accordingly, we conclude that the denial constitutes an invalid pre-closure denial and must be set aside.[4]

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 pre-closure denial issue is $3,800, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated September 30, 1996 is reversed. The employer's May 13, 1996 denial is set aside. The claim is remanded to the employer for processing according to law. For services at hearing and on review, claimant's counsel is awarded an assessed attorney fee of $3,800, to be paid by the employer.

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[4] In making this determination, we express no opinion on the compensability of claimant's current cervical condition, i.e., the extent (if any) to which claimant's accepted cervical and thoracic strains contributed to his disability and need for treatment at the time of the employer's May 1996 denial.

**Member Haynes specially concurring.**

I concur with the lead opinion's conclusion that the carrier's "pre-closure" denial is procedurally invalid. I write separately to emphasize what I perceive to be a carrier's claim processing obligations when confronted with situations such as those present in this case.

To begin, in the absence of a carrier's acceptance of a "combined condition" (either voluntarily or by means of litigation order), the provisions of ORS 656.262(7)(b) permitting a pre-closure denial of a "combined condition" have no application. Moreover, unless a claimant has filed a claim for the "combined condition" or preexisting condition, a carrier is under no obligation to issue a denial (pre-closure or otherwise). In fact, such a denial would be premature.

I understand the dilemma faced by a carrier when an accepted condition approaches medically stationary status, but an unclaimed or unaccepted preexisting condition may not be medically stationary or may be permanently disabling. When preparing for the closure of a claim under such circumstances, the carrier may be concerned that these unclaimed or unaccepted conditions will be evaluated once the claim is closed. However, rather than issuing a premature pre-closure denial, I believe that the appropriate approach under the statutory scheme is for the carrier to clarify with medical experts the status of the accepted condition (as distinguished from any unaccepted conditions), including any permanent impairment attributable to that condition.

Once the accepted condition is medically distinguished from the other conditions, the claim could be appropriately closed and evaluated in such a way that only disability (temporary and / or permanent) related to the accepted condition would be considered. Ideally, this clarification would occur prior to claim closure. Nonetheless, in those claims where the Evaluation Section has rated conditions that the carrier believes have not been accepted, the carrier is entitled to seek reconsideration (as well as request the appointment of a medical arbiter) and, in doing so, raise its specific concerns.

My conclusions regarding the statutory scheme are further supported by the 1997 legislative amendments to ORS 656.262. Specifically, subsection (7)(c) has been added to the statute, which requires a carrier to issue at claim closure "an updated notice of acceptance that specifies which conditions are compensable." These statutory changes provide further confirmation that only those conditions that have been accepted by the carrier are subject to evaluation at the time of claim closure. In light of such circumstances, a denial of an unclaimed and unaccepted condition prior to claim closure is unwarranted.

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In the Matter of the Compensation of
**HERBERT L. LOCKETT, Claimant**
WCB Case No. 97-02667
ORDER ON REVIEW
Hollander, et al, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Poland's order that: (1) set aside its denials of claimant's injury claim for a mental disorder and right shoulder and knee conditions; and (2) assessed a 25 percent penalty for the insurer's alleged discovery violation. 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 the ALJ's reasoning and conclusions.

### Discovery Issue

On March 27, 1997, claimant's counsel made his first request for discovery of all documents relevant to the December 16, 1996 injury claim. Claimant's counsel made several subsequent requests in March and April 1997. At the time of the discovery requests, the insurer had in its possession the initial report of its investigator, Mr. Plant, (Exs. Q and R) and documents regarding claimant's May 1992 motor vehicle accident (MVA) and related insurance claim. (Exs. D and 24 A). The insurer eventually provided claimant's attorney with these documents when they were submitted as evidence on May 2, 1997 and May 7, 1997, prior to the May 16, 1997 hearing.

Finding that the insurer's actions constituted a discovery violation, the ALJ assessed a 25 percent penalty. Citing Kenneth D. Legore, 48 Van Natta 1577 (1996), the ALJ reasoned that the insurer did not have a reasonable belief that the documents were only relevant for impeachment.

After the ALJ's order, we decided Marylin L. Hunt, 49 Van Natta 1456 (1997). Upon the claimant's demand, the carrier in Hunt disclosed all investigative materials prior to hearing, with the exception of the claimant's recorded statement which it allegedly withheld for impeachment purposes. At hearing, the carrier attempted to use the recorded statement to impeach the claimant's testimony. The ALJ reviewed the withheld evidence and, after determining that the statement was not relevant solely for impeachment purposes, concluded that the statement should have been disclosed and, therefore, assessed a penalty against the carrier.

We reversed the penalty assessment. In doing so, we reasoned that neither ORS 656.283(7) nor OAR 438-007-0017(2)(b) (eff. 1-1-96) requires that withheld evidence be relevant "only" or "solely" for impeachment purposes. We distinguished SAIF v. Cruz, 120 Or App 65 (1993), which was based on prior discovery rules that limited withheld evidence to evidence "only" or "solely" relevant to

impeachment purposes. Based on the current statute and rule, we held that a party may withhold evidence it reasonably believes to be relevant and material for impeachment purposes, i.e., evidence tending to impair or destroy a witness's or the claimant's credibility in the estimation of the ALJ, even if that evidence may have some other relevance to the claim being litigated.

In reaching our conclusion, we disavowed Sandra E. Post, 48 Van Natta 1741 (1996), and Kenneth D. Legore insofar as those cases indicated that evidence could be withheld if it was relevant "only" or "solely" for impeachment purposes. We clarified that we were not disavowing our determination in Post and Legore that, when there is a dispute concerning the withholding of alleged impeachment evidence, the ALJ should review the evidence in camera to determine whether the evidence constitutes impeachment evidence.

Turning to the merits of the penalty issue, we found in Hunt that, based on a comparison between the claimant's recorded statement and her 801 form, the carrier could reasonably believe that portions of the recorded statement tended to impair or destroy the claimant's credibility. Consequently, we determined that it was not unreasonable for the carrier to withhold the entire statement as impeachment evidence.

In this case, we also find that it was not unreasonable for the insurer to have withheld the documents in question as impeachment evidence. At the time claimant's counsel requested discovery in March and April 1997, the insurer had in its possession information regarding claimant's 1992 MVA and the initial investigative report of Mr. Plant. However, the documents pertaining to the 1992 MVA could be reasonably interpreted as impairing or destroying claimant's credibility because the February 5, 1997 report of examining physicians McKillop, Reimer and Freidman contained statements that claimant had denied any prior history of work injuries or other accidents. (Exs. 48-3, 8; 49-4 ).

Moreover, while the investigative report contained summaries of statements of witnesses that tended to support the compensability of claimant's alleged December 16, 1996 injury, it also contained information from a potential witness (Scott) who doubted the validity of the alleged injury and who surmised that the alleged injury incident was a "set up." (Ex. Q-10, 11). In addition, in a March 13, 1997 summary of a statement given by claimant, claimant was reported to have described his injury to have occurred after he emptied a recycling bin. (Ex. 66-2). Yet, in the initial Plant investigative report, it was reported that claimant's recycling truck was parked in an area where no recycling bins were present, the nearest bin being located 60 feet from the rear of the truck. (Ex. Q-6). Because the Plant investigative report could reasonably be interpreted as impairing or destroying claimant's credibility, we conclude that the insurer had a reasonable belief that it was relevant for impeachment purposes and, thus, could withhold it from discovery, even though it may have had some other relevance to the claim.[1]

In conclusion, we find that, when its obligation to provide discovery arose, the insurer reasonably believed that the documents in question were relevant and material for impeachment purposes, i.e., that the evidence tended to impair or destroy the claimant's credibility.[2] Thus, we

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[1] The Plant investigation report consisted of two parts, the written portion (Ex. Q) and a section consisting of photographs (Ex. R). The written portion referred to photographs included in the "photographs" section of the report. (Ex. Q-6). Under these circumstances, although treated separately as exhibits, we consider both sections of the Plant report as comprising one document.

[2] Claimant asserts that it is "crucial that Hunt not turn into a blank check to insurers to withhold every document for which strained theories of impeachment value can be concocted." With this concern in mind, we emphasize that the determination of whether evidence has impeachment value comes not at the hearing, but rather at the time the duty to provide discovery arises. As our decision in Hunt illustrates, the carrier must have a reasonable belief that evidence to be withheld tends to impair or destroy the claimant's or a witness's credibility based on the evidence available to the carrier at the time it must provide discovery. It, therefore, follows that a carrier may not withhold evidence otherwise properly discoverable on the suspicion that a claimant or another witness may testify in a certain manner at hearing or on speculation that evidence might eventually become impeachment evidence. See Comments in Order of Adoption (WCB Admin. Order 3-1997) of Section 2 of OAR 438-007-0017 (December 10, 1997). In this case, the insurer could reasonably withhold the documents in question not because of the substance of claimant's testimony at hearing, but rather because the documents in question tended to impair or destroy claimant's credibility based on evidence the insurer already possessed when the obligation to provide discovery arose.

conclude that the insurer did not act unreasonably in withholding them from discovery. See Oswald F. Kuznik, 45 Van Natta 1194 (1993) (citing Brown v. Argonaut Insurance Co., 93 Or App 588 (1988)) (in the discovery context, the standard for determining unreasonable delay or refusal is whether the carrier had any legitimate doubt regarding its obligation to disclose the document to the claimant). Because the ALJ concluded otherwise, we reverse.

Attorney Fees 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 compensability issue is $3,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and counsel's statement of services), the complexity of the issue, and the value of the interest involved. We have also considered that claimant is not entitled to a fee for defending the ALJ's decision on the penalty and attorney fee issues. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated August 18, 1997 is reversed in part and affirmed in part. That portion of the ALJ's order that assessed a 25 percent penalty is reversed. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $3,000, to be paid by the insurer.

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February 2, 1998 Cite as 50 Van Natta 156 (1998)

In the Matter of the Compensation of
**DONALD E. PAULSON, Claimant**
WCB Case No. 97-03032
ORDER ON REVIEW
Patrick K. Mackin, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall, Bock, and Moller.

The insurer requests review of Administrative Law Judge (ALJ) Hoguet's order that set aside its denial of claimant's left indirect inguinal hernia condition. In addition, the insurer moves to strike the transcript of the closing arguments, which claimant submitted with his respondent's brief. On review, the issues are motion to strike and compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Claimant submitted a transcript of the closing arguments at hearing along with his respondent's brief. The insurer moved to strike the closing arguments, contending that because they are not evidence, they should not be part of the record. We recognize that the closing arguments are not evidence and would not consider them as such. Were we to review the closing arguments, we would do so only in terms of their value in elucidating the parties' arguments. We view the closing arguments as no more than an elaboration of the arguments the parties present in their briefs on review. Thus, we are not persuaded by the insurer's argument.

However, we find it unnecessary to grant or deny the motion to strike because, whether or not we were to consider the closing arguments, we would reach the same conclusion in this case. Thus, because the closing arguments do not affect our decision in this case, we find it unnecessary to address the insurer's motion to strike.

Compensability

After our review of the record, we agree with the ALJ's evaluation of the medical evidence, reasoning and conclusion. Moreover, we find that the ALJ used the appropriate standard in determining compensability. ORS 656.005(7)(a)(B); see also SAIF v. Nehl, 149 Or App 309, 311-12 (1997). Therefore, we affirm the ALJ's order finding the claim compensable.

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 is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated July 30, 1997 is affirmed. Claimant is awarded an attorney fee of $1,000 for his counsel's services on review, to be paid by the insurer.

**Board Member Moller dissenting.**

Because I disagree with the majority's evaluation of the medical evidence, I respectfully dissent.

This case concerns the compensability of claimant's indirect inguinal hernia condition. On February 3, 1997, claimant tripped while carrying a box at work. He immediately experienced left groin pain and swelling. A left inguinal hernia was diagnosed, and Dr. Gingrich surgically repaired the hernia on March 17, 1997. The medical evidence established that claimant had a preexisting congenital sac which combined with the work incident to cause the hernia.

Drs. Gingrich and Gross provided medical opinions regarding the major contributing cause of claimant's hernia condition, disability and need for treatment.

Dr. Gross, who reviewed the record at the insurer's request, opined that claimant's congenital sac was the major contributing cause of his indirect inguinal hernia. He noted that the medical records established that claimant had an **indirect** inguinal hernia, as distinguished from a direct hernia. (Ex. 14-1). He explained the distinction between direct and indirect hernias and the role of the congenital sac in the development of indirect hernias. He further explained that if the congenital sac were not present, no amount of increased abdominal pressure would create an indirect hernia. (Exs. 10, 14). He believed that, while the work incident was the precipitating cause of the indirect hernia, the presence of the congenital sac was nevertheless the major contributing cause of claimant's hernia. (Ex. 14). Dr. Gross supported his opinion with a medical treatise on the anatomy and surgery of hernias. (Id.).

I find Dr. Gross' opinion to be complete, well-reasoned, and based on complete and accurate information. Somers v. SAIF, 77 Or App 259, 263 (1986). I am particularly persuaded by the well-explained and expertly supported distinction Dr. Gross draws between direct and indirect hernias. Therefore, I would rely on Dr. Gross' opinion and find the hernia condition not compensable.

Alternatively, I would find that the medical evidence is in equipoise. Dr. Gingrich, claimant's treating surgeon, opined that the work incident was the major contributing cause of claimant's hernia, and he also explained the basis for his opinion. (Ex. 13). This is not the type of case, however, where the treating physician has any particular advantage in rendering an opinion. See Allie v. SAIF, 79 Or App 284, 287 (1986). Rather, resolution of this case depends on expert medical analysis, which is ably provided by both Drs. Gingrich and Gross. However, because I am unable to find that Dr. Gingrich's opinion is more persuasive than Dr. Gross' opinion, I would conclude that the medical evidence is in equipoise. Therefore, I would find that claimant has failed to carry his burden of proving compensability by a preponderance of the evidence.

Because I believe that claimant failed to prove the compensability of his claim by a preponderance of the evidence, I dissent.

In the Matter of the Compensation of
**DEVIN W. WARD, Claimant**
WCB Case No. 96-11401
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Biehl and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Neal's order that set aside its denial of claimant's aggravation claim for a left wrist condition. On review, the issue is aggravation.

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

Relying on the opinion of Dr. Barnhouse, the ALJ found that claimant had established a compensable aggravation of his left wrist condition. SAIF argues that Dr. Barnhouse's opinion is insufficient to establish an actual worsening of claimant's condition and only establishes a symptomatic worsening.

Under ORS 656.273(1), "[a] worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings." 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.

Here, Dr. Barnhouse opined that claimant's work activities were the major contributing cause of an "objective worsening (aggravation) of [claimant's] left wrist condition." In his deposition, Dr. Barnhouse agreed that claimant's worsening was an "objective symptomatic worsening," but he also agreed that claimant's condition had "objectively changed." (Ex. 44-11, 12). Based on Dr. Barnhouse's statement that claimant's condition had changed, as well as his earlier opinion that claimant's work activities were the major contributing cause of an objective worsening of his left wrist condition, we find Dr. Barnhouse's opinion sufficient to establish that claimant's symptoms have increased to the point that the condition has worsened. See SAIF v. Walker, 145 Or App at 305.[1] Accordingly, based on this record, we find that claimant has proven an "actual worsening" of his left wrist condition.

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

ORDER

The ALJ's order dated June 18, 1997 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by SAIF.

[1] We note that Dr. Barnhouse's opinion is supported by the opinion of Dr. George, who opined that claimant's condition had pathologically worsened.

In the Matter of the Compensation of
**MARSHALL H. AUDAS, Claimant**
WCB Case No. 97-04424
ORDER ON REVIEW
Pozzi, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Neal's order that set aside its denial of claimant's occupational disease claim for a bilateral elbow condition. On review, the issue is compensability. We reverse in part, modify in part, and affirm in part.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

Finding that claimant's work activities as a roofer were the major contributing cause of bilateral elbow strains, the ALJ set aside SAIF's denial of the occupational disease. The ALJ relied on the opinion of claimant's treating physician, Dr. Baum. On review, SAIF argues that Dr. Baum's opinion was unpersuasive and that the ALJ should have relied on the opinion of the examining physician, Dr. Tesar.

The dispositive issue is whether claimant's work activities were the major contributing cause of his bilateral elbow strain. Because claimant has preexisting degenerative arthritis in both elbows which contributed to his current condition, and there are conflicting medical opinions on the causation issue, we find that the causation 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, 426 (1967); Linda D. Lunow, 46 Van Natta 1120, 1121 (1994).

For the reasons discussed by the ALJ, we also are more persuaded by the opinion of Dr. Baum. As the treating physician, he saw claimant on multiple occasions, whereas Dr. Tesar examined claimant only once. In fact, Dr. Tesar did not see claimant until April 1997, about three months after Dr. Baum began treating claimant for elbow strains in January 1997. By the time of his examination, Dr. Tesar could find no objective evidence of elbow strains. (Ex. 10, pp. 6-7). In light of those circumstances, we conclude that Dr. Baum had a better opportunity to evaluate claimant's elbow condition. See Weiland v. SAIF, 64 Or App 810, 814 (1983). Furthermore, Dr. Baum explained the mechanism of how the preexisting degenerative arthritis combined with use of the elbows to cause the development of elbow strains. (Ex. 13-2). Based on his well-reasoned opinion, we find that claimant's work activities were the major contributing cause of the right elbow strain. (Ex. 13-1).

However, we find no opinion by Dr. Baum to support the ALJ's finding that work activities were the major contributing cause of the left elbow strain as well. To the contrary, Dr. Baum concurred with Dr. Tesar's opinion that the preexisting degenerative arthritis was the "major factor" in the bilateral elbow strains. (Exs. 10-7, 11). Dr. Baum subsequently reversed his opinion with regard to the right elbow, stating that work activities were the major cause of the right elbow strain and explaining how use of the elbows interacted with the arthritis to produce elbow strains. (Ex. 13). Dr. Baum was not asked, however, whether work activities were the major cause of the left elbow strain, nor did he state an opinion that would support that finding. Because there is no expert medical opinion to support the compensability of the left elbow strain, SAIF's denial of that condition is reinstated.

Because claimant ultimately did not prevail over the denial of the left elbow strain, the ALJ's assessed fee award must be reduced accordingly. 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 regarding the right elbow strain is $1,400, 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 claimant's attorney's services may go uncompensated. The ALJ's assessed fee award is modified accordingly.

Claimant's attorney also is entitled to an assessed 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 services on review regarding the right elbow strain is $700, 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.

ORDER

The ALJ's order dated September 9, 1997 is reversed in part, modified in part and affirmed in part. That portion of the order that set aside SAIF's denial of the left elbow strain is reversed. SAIF's denial of the left elbow strain is reinstated and upheld. The ALJ's $2,000 assessed fee award, to be paid by SAIF, is reduced to $1,400. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $700, payable by SAIF.

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In the Matter of the Compensation of
**JULIO C. GARCIA-CARO, Claimant**
WCB Case No. 96-07359
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorneys
Zimmerman, Nielsen, et al, Defense Attorneys

Reviewed by the Board en banc.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that increased claimant's unscheduled permanent disability award for a right shoulder condition from 20 percent (64 degrees), as awarded by an Order on Reconsideration, to 38 percent (121.6 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The parties do not dispute the values for age (0) and education (3). In addition, the parties do not dispute the 5 percent impairment value for loss of range of motion of claimant's right shoulder, as measured by Dr. Neumann, the medical arbiter. The parties' dispute concerns the adaptability factor and whether claimant's loss of range of motion of the cervical spine, as measured by a Physical Capacities Evaluation (PCE), should be included in the impairment factor.

Impairment

The insurer accepted claimant's claim for disabling right shoulder tendonitis. (Ex. 6). As the ALJ found, the sole issue at hearing was the extent of permanent disability (scheduled and unscheduled)[1] relating to that condition. Nevertheless, relying on former OAR 436-035-0005(5),[2] the

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[1] On review, only the ALJ's decision regarding extent of unscheduled permanent disability is challenged. Therefore, the sole issue on review is extent of unscheduled permanent disability.

[2] Former OAR 436-035-0005(5) provides:

"'Direct medical sequelea' [sic] means a condition which originated or stems from the compensable injury or disease and/or any consequential condition, that is clearly established medically. Disability from direct medical sequelae, whether due to the original or consequential compensable condition, is rated in accordance with these rules and ORS 656.268(16). For example: The accepted condition is low back strain with herniated disc at L4-5. The worker develops permanent weakness in the leg and foot due to radiculopathy. The weakness is considered a 'direct medical sequelae' of the herniated disc." WCD Admin. Order 96-051.

We note that, other than spelling corrections, the current version of OAR 436-035-0005(5) is identical to this former version. WCD Admin. Order 96-072.

ALJ concluded that several cervical and thoracic conditions were compensably related to the work injury. As a result of this conclusion, the ALJ rated claimant's loss of cervical range of motion as measured by a PCE.[3] We disagree.

Disability standards adopted by the Director pursuant to ORS 656.726 are used to evaluate disability. ORS 656.283(7), 656.295(5). Claimant was found to be medically stationary as of March 22, 1996, and a Notice of Closure was issued on May 22, 1996. (Ex. 54). Therefore, the disability standards contained in Workers' Compensation Department Administrative Orders 96-051 and 96-068 apply to claimant's claim. 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 656.268(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." (Emphasis added).

We find that former OAR 436-035-0005(5), in effect, expands ORS 656.268(16). In this regard, whereas ORS 656.268(16) directs rating of conditions (unless denied) that are direct medical sequelae to the original accepted condition, former OAR 436-035-0005(5) directs rating of "condition[s] which originate[] or stem[] from the compensable injury or disease and/or any consequential condition." Former OAR 436-035-0005(5) (emphasis added). While we acknowledge that, although the administrative rule references the "compensable" injury, the example provided in the rule more narrowly refers to direct medical sequelae of the "accepted" condition, we do not agree with the dissent's assertion that this establishes that the terms "compensable" and "accepted" are used interchangeably by the administrative rule. The important point is that the administrative rule itself uses the term "compensable" injury, only the example uses the term "accepted" condition.

Furthermore, rules are to be interpreted in the same manner as statutes. That is, we are "simply to ascertain and declare what is, in terms or in substance, contained therein, not to insert what has been omitted, or to omit what has been inserted * * *." ORS 174.010. In interpreting a rule, we assume that the agency's choice of words is purposeful; therefore, we should not disregard that choice. See Martin v. City of Albany, 320 Or 175, 181 (1994) (interpreting a statute, the Court stated that it does "not lightly disregard the legislature's choice of verb tense, because [it assumes] that the legislature's choice is purposeful"). Thus, we assume that the Director's choice of the word "compensable" was purposeful. However, the dissent disregards the Director's choice of words and erroneously interprets former OAR 436-035-0005(5) by assuming that, although the rule explicitly states "compensable," it really means "accepted." In making this interpretation, the dissent is substituting its own language into the rule. Moreover, the words of a rule are to have their common, ordinary meaning unless there is a clear indication that some other meaning was intended. Welliver Welding Works v. Farmen, 133 Or App 203, 208 (1995) (applying this reasoning to the interpretation of a statute). An "accepted" condition is defined by statute. See ORS 656.262(6)(b) (provides the requirements of a notice of acceptance). "Compensable" does not mean "accepted," although a compensable claim may also be an accepted claim, that is not always the case.

The expansive effect of former OAR 436-035-0005(5) is illustrated by the facts of this case, where the compensability of various conditions, which were neither accepted by the insurer nor claimed by claimant, must be determined in order to determine whether those conditions "stemmed from the compensable injury or disease" under the rule. Thus, by focusing on "compensability" rather than "acceptance," as ORS 656.268(16) mandates, the rule may require a compensability determination to be made in an extent setting, a process not provided by the statutory scheme.

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[3] Relevant impairment findings include the findings of the attending physician at the time of claim closure or any findings with which he or she concurred, as well as the findings of the medical arbiter when one is appointed. See ORS 656.245(3)(b)(B); 656.268(7); OAR 436-035-0007(12) and (13); Raymond L. Owen, 45 Van Natta 1528 (1993). On review, the insurer argues that the PCE was not concurred with by claimant's attending physician. Claimant counters that it was, citing a March 22, 1996 chart note from Dr. Gargaro, attending physician. (Ex. 40). In this chart note, Dr. Gargaro stated the PCE "recommend[s] sedentary to light-medium work capacity, and I think I agree with this." Id. Given our interpretation of former OAR 436-035-0005(5), infra, we need not decide whether Dr. Gargaro's agreement regarding work capacity constitutes a concurrence with the PCE in all respects.

In other words, here, the accepted condition is right shoulder tendonitis.[4] ORS 656.262(7)(a)[5] provides the mechanism for a worker to make a claim for new medical conditions after claim acceptance. Claimant did not file a claim for new cervical or thoracic conditions. Furthermore, we have found that the statutory scheme set out in ORS 656.262(7) and 656.283(7) limits compensability litigation in the "extent" rating process. See Robin W. Spivey, 48 Van Natta 2363, 2366 (1996). Our conclusion in Spivey (that ORS 656.262(7)(b) does not apply unless the accepted condition is a "combined" condition) "should be interpreted as precluding litigation regarding whether a non-accepted condition is compensable within the context of a hearing on the extent of permanent disability that is attributable to the accepted injury." Id. at n.6 (emphasis in original); see also Brian D. Shipley, 48 Van Natta 994, 996 (1996) (Where the claimant did not comply with ORS 656.262(7)(a), we declined to address the compensability of a non-accepted condition); Charles S. Grove, 48 Van Natta 829, 830 n.2 (Compensability of a non-accepted condition was not properly before the ALJ, where no formal claim for that condition had been made); Tatyana Zima, 49 Van Natta 760 (1997) (Compensability of a non-accepted condition was not ripe, where no formal claim for that condition had been made). See also ORS 656.262(6)(b) (the notice of acceptance shall "[s]pecify what conditions are compensable").

Moreover, the 1997 legislative amendments provide further support for both our prior conclusion that the statutory scheme in ORS 656.262(7) and 656.283(7) limits compensability litigation in the "extent" rating process and our current conclusion that the accepted condition determines what is included in rating permanent disability of a claim. In this regard, subsequent to the date of the ALJ's order in this case, the 1997 Legislature amended ORS 656.262(7) by adding subsection (c), which provides:

> "When an insurer or self-insured employer determines that the claim qualifies for claim closure, the insurer or self-insured employer shall issue at claim closure an updated notice of acceptance that specifies which conditions are compensable. The procedures specified in subsection (6)(d) of this section apply to this notice. Any objection to the updated notice or appeal of denied conditions shall not delay claim closure pursuant to ORS 656.268. 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. Sess., Sec. 1 (July 25, 1997).

Thus, the 1997 addition of ORS 656.262(7)(c): (1) requires an updated notice of acceptance at claim closure specifying which conditions are compensable; (2) provides that the procedures in ORS 656.262(6)(d) apply to this updated notice, thereby providing a method for the worker to challenge the updated notice, if the worker believes it is deficient; (3) provides that "[a]ny objection to the updated notice or appeal of denied conditions shall not delay claim closure pursuant to ORS 656.268;" and (4)

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[4] At hearing, claimant agreed that the accepted condition was "right shoulder tendonitis." See Hearing Memorandum, page 8, Ex. 6. On review, claimant contends that the insurer also accepted "right shoulder strain" and "right trapezius strain." Because claimant did not raise this scope of acceptance issue at hearing, we are not inclined to address it on review. Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

In any event, even assuming the insurer also accepted "right shoulder strain" and "right trapezius strain," there is no evidence that those conditions included any cervical or thoracic conditions. Claimant cites to Gray's Anatomy in asserting that the anatomical relationship between the trapezius muscle and the lower cervical and upper thoracic spine results in compensability of any cervical and thoracic condition that may be deemed to exist. We are without the medical expertise to make such a broad finding. Therefore, we do not find such reasoning persuasive.

[5] ORS 656.262(7)(a) provides, in part:

> "After claim acceptance, written notice of acceptance or denial of claims for aggravation or new medical conditions shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the insurer or self-insured employer receives written notice of such claims. New medical condition claims must clearly request formal written acceptance of the condition and are not made by the receipt of a medical claim billing for the provision of, or requesting permission to provide, medical treatment for the new condition. The worker must clearly request formal written acceptance of any new medical condition from the insurer or self-insured employer. * * * * Notwithstanding any other provision of this chapter, the worker may initiate a new medical condition claim at any time."

provides that a carrier must reopen a claim for processing of a condition found compensable after claim closure. This added subsection clearly supports our conclusions that the accepted condition determines what is rated in extent determinations and the statutory scheme contemplates that compensability determinations will be made separately from extent determinations.

Accordingly, to the extent that former OAR 436-035-0005(5) impermissibly expands ORS 656.268(16), we give no effect to that rule. See Forney v. Western States Plywood, 66 Or App 155 (1983) (In the event that there is a conflict between the administrative rule and the statute, it is the statute rather than the rule which controls); Lee R. Jones, 46 Van Natta 2179 (1994).

Furthermore, there is no relevant medical evidence that claimant's cervical loss of range of motion is a direct medical sequelae of the accepted right shoulder tendonitis condition. As noted above, relevant impairment findings include the findings of the attending physician at the time of claim closure or any findings with which he or she concurred, as well as the findings of the medical arbiter when one is appointed. See ORS 656.245(3)(b)(B); 656.268(7); OAR 436-035-0007(12) and (13).

Here, Dr. Neumann served as the medical arbiter. The Department informed Dr. Neumann that the accepted condition was "right shoulder tendonitis" and directed him to review enclosed medical reports "for determining impairment due to the accepted condition(s), including any direct medical sequelae." (Ex. 57A-3, emphasis added). Thus, Dr. Neumann was expressly not limited to addressing the right shoulder. Furthermore, Dr. Neumann did not limit his examination to the right shoulder, he also examined the biceps, triceps, and brachioradialis areas, as well as measuring sensation in the hands and muscle strength in biceps, triceps, wrist extensors and flexors, pinch and intrinsics. (Ex. 58-3, -4). Nevertheless, although indicating that there was impairment to the right shoulder itself, Dr. Neumann did not indicate there was any impairment that was a direct medical sequelae of the right shoulder injury. (Ex. 58).

Nor did Dr. Gargaro. Dr. Gargaro's March 22, 1996 chart note served as his closing exam. (Ex. 40). In that chart note, Dr. Gargaro found claimant "medically stationary with impairment" and agreed with the PCE that claimant had a sedentary to light-medium work capacity. However, he did not indicate that claimant had any direct medical sequelae impairment.[6] Therefore, ORS 656.268(16) does not apply to provide for rating of the cervical impairment.[7] Accordingly, on this record, claimant's impairment value is 5 percent, the value of his loss of right shoulder range of motion due to the accepted shoulder condition.

Adaptability

The ALJ determined that claimant has an adaptability factor of 6. We agree.

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[6] We note that Dr. Gargaro concurred with a May 24, 1995 medical report from Dr. Potter, examining orthopedist. (Exs. 38, 39). However, we do not find this persuasive evidence of any direct medical sequelae impairment. First, this concurrence occurred almost a year before claimant became medically stationary. Second, Dr. Potter's opinion is all over the board. In this regard, Dr. Potter diagnosed painful range of motion of the cervical spine and shoulders, "etiology undetermined." (Ex. 38-8). He also stated that he did not know what claimant's condition(s) could be, indicating that it could be fibromyalgia or rheumatoid arthritis. (Ex. 38-9). He also indicated claimant's pain in the extensor muscles of his forearms could relate to an overload type syndrome. Id. He also stated that "claimant probably has a cervical myofascial pain syndrome secondary to the pain that he has in his trapezius muscles as well as in the shoulder girdles." (Ex. 38-9, -10). However, he also opined that it was hard to formulate a specific diagnosis without ruling certain diagnoses out. He recommended a referral to a rheumatologist for evaluation of rheumatoid arthritis versus fibromyalgia and a cervical MRI to rule out a cervical lesion. Both of these referrals were later made, with no findings of rheumatoid arthritis and a normal cervical MRI. (Exs. 37, 43). However, no decision was made regarding fibromyalgia. Given the timing of Dr. Potter's report and the wide range of possibilities Dr. Potter provided, we do not find that Dr. Gargaro's concurrence with that report establishes any medical sequelae impairment from the right shoulder condition at claim closure.

[7] In making this finding, we note that, although claimant has not yet made a new medical condition claim for any cervical/thoracic conditions, that does not mean that he cannot make such a claim in the future. ORS 656.262(7)(a).

The adaptability factor is determined by comparing claimant's "Base Functional Capacity" (BFC), his physical capacity before the injury, to his "Residual Functional Capacity" (RFC), his remaining ability to perform work-related activities. Former OAR 436-035-0310(3). The parties do not dispute that claimant's BFC is heavy, the physical capacity of his at-injury job as a butcher.

Following his medical arbiter examination, Dr. Neumann placed claimant "in a medium category with a 50 pound maximum limit occasionally, and a 20 pound frequent lifting limit." (Ex. 58-5). However, a PCE conducted at the time of claim closure determined that claimant was capable of sedentary to light-medium work capacity. (Ex. 51). Dr. Gargaro concurred with this determination. (Ex. 40). We find that the PCE provided a more thorough evaluation of claimant's physical capacity than Dr. Neumann's examination. Therefore, we find that claimant's RFC is sedentary/light. Former OAR 436-035-0310(3)(e). Comparing claimant's BFC of heavy to his RFC of sedentary/light, results in an adaptability factor of 6. Former OAR 436-035-0310(6).

We assemble the various factors to determine claimant's unscheduled permanent disability. The age (0) and education (3) factors are added for a value of 3, which is multiplied by the adaptability factor (6), for a result of 18. Former OAR 436-035-0280. This result is added to the impairment value (5), for a total of 23. Former OAR 436-035-0280(7). Thus, claimant is entitled to 23 percent unscheduled permanent disability.

## ORDER

The ALJ's order dated December 27, 1996 is modified in part and affirmed in part. In lieu of the ALJ's unscheduled permanent disability award, and in addition to the 20 percent (64 degrees) unscheduled permanent disability awarded by the Order on Reconsideration, claimant is awarded 3 percent (9.6 degrees) unscheduled permanent disability for a right shoulder injury, for a total award to date of 23 percent (73.6 degrees) unscheduled permanent disability. The ALJ's attorney fee award is modified accordingly. The remainder of the ALJ's order is affirmed.

**Board Member Hall dissenting.**

To focus the scope of this dissent, it is best to begin by stating that with which I and the majority agree. After all, it really appears that this is a case of semantics[1] and not substance. Whether claimant obtains the additional permanent partial disability compensation at issue depends not on whether one term is used instead of another. This is so because no party is urging that one term is more expansive or offers more than the other term.

I agree with the majority that statutes control regulations. I also agree that regulations are interpreted by the same principles of construction as statutes (including the principle that illustrations and examples do not control over the actual language of the rule). Furthermore, I agree that compensability determinations are not made in the context of permanent disability determinations.[2] I further agree that it is the direct sequelae of accepted compensable conditions that are to be rated in determining permanent partial disability benefits. Interestingly enough, neither party disagrees with these propositions either.

The majority focuses on the use of the term "compensable" in OAR 436-035-0005(5) and the term "accepted" in ORS 656.268(16) as effecting the permanent disability determination in this case, and goes so far as to find the rule invalid. In fact, the parties (like OAR 436-035-0005(5)) are using the terms

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[1] I fully recognize that in the interpretation of statutes and regulations that "semantics" can be everything, absolutely critical, to the analysis of the ultimate decision. See PGE v. Bureau of Labor and Industries, 317 Or 606, 611 (1993) (if the legislature's intent is clear from the text and context of the statute, further inquiry is unnecessary). Yet in cases, such as the present case, where the interpretation and application of two different terms (here, "accepted" vs. "compensable") is the same and no one urges that one word should result in a different application of law or result than the other word, then the debate becomes one of "semantics" rather than substance.

[2] Yet in every permanent disability determination the scope of what has been accepted as compensable is a prerequisite.

"compensable" and "accepted" interchangeably and are litigating the scope of what was accepted as compensable (given the various diagnoses of tendonitis, strain, etc., for the same condition)[3] and litigating what is a direct sequela of the accepted compensable condition.

Unlike the majority, I would not invalidate OAR 436-035-0005(5). I would determine the scope of the accepted compensable condition (which, like the ALJ, I believe includes the right shoulder in its various diagnoses of strain, tendonitis, etc.) and determine whether the cervical limitations (i.e., objective permanent disability findings in the cervical spine) are a direct sequelae of the accepted compensable condition.

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[3] As the ALJ noted, the diagnoses have been all over the map. To the extent claimant is urging that certain diagnoses and/or conditions are compensable, he does so in the context of litigating the scope of what was accepted. It must be kept in mind that ORS 656.262(7)(a) states, in relevant part: "The insurer or self-insured employer is not required to accept each and every diagnosis or medical condition with particularity, so long as the acceptance tendered reasonably apprises the claimant and medical providers of the nature of the compensable conditions." Thus, what has been accepted is not limited to only the conditions listed in the written notice of acceptance. What has been accepted as compensable is a question of fact determined case by case. SAIF v. Tull, 113 Or App 449, 454 (1992). Furthermore, ORS 656.262(6)(b), which the majority refers to in attempting to distinguish between "accepted" and "compensable," actually provides that the notice of acceptance is to identify what conditions are compensable. OAR 436-035-0005(5) reflects this use of "accepted" and "compensable."

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February 3, 1998 Cite as 50 Van Natta 165 (1998)

In the Matter of the Compensation of
**BRIAN P. HANSBERRY, Claimant**
WCB Case No. 96-08392
ORDER ON RECONSIDERATION
Vick & Conroyd, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

On January 20, 1998, we withdrew our December 19, 1997 order that had affirmed an Administrative Law Judge's (ALJ's) order that had set aside the insurer's denial of his occupational disease/injury claim for an L5-S1 disc herniation, S1 radiculopathy and lumbosacral neuritis. We took this action in response to the insurer's announcement that the parties had resolved their dispute.

The parties have now submitted a proposed "Stipulation and Order of Dismissal" and "Disputed Claim Settlement Agreement," which are designed to resolve all issues raised or raisable between them. Pursuant to the stipulation, the parties agree that our December 19, 1997 order "is affirmed in all respects and will forever remain in force and effect." In accordance with the settlement, the parties further stipulate that the insurer's denial of claimant's current condition and need for treatment, as set forth in the agreement, "shall forever remain in full force and effect" and that claimant's hearing request from that denial "shall be dismissed with prejudice."

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

IT IS SO ORDERED.

In the Matter of the Compensation of
**GINO J. BARBISAN, Claimant**
WCB Case No. 96-11210
ORDER ON REVIEW
Cole, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

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

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

In the first paragraph on page 2, we change the date in the third sentence to "July 10, 1961." In the third paragraph on page 2, we change the second sentence to read: "Claimant indicated on the '801' form that his hearing loss was caused by shooting in an indoor firing range without ear protection."

In the last paragraph on page 2, we replace the section beginning with the fourth sentence ("On cross-examination* * *") with the following:

"Claimant answered the following questions from SAIF's counsel regarding his discussion with Dr. Johnson in 1984:

"Q. Okay. And when you saw Dr. Johnson it sounds to me like at least in your own mind you had already come to the conclusion in 1984 that what was causing your tinnitus and hearing loss problems was shooting the guns as a police officer from '60 to '64-'65.

"A. Pretty much had no doubt in my mind.

"Q. Okay. And you told that to Dr. Johnson in 1984, didn't you?

"A. Uh-huh.

"Q. Is that a yes? I'm sorry, you have to say yes or --

"A. Yes, sir.

"Q. And he agreed with you, didn't he?

"A. No, he didn't agree with me. He just said -- he just wanted to know how I acquired it.

"Q. Okay. So he said, 'How did you acquire your hearing loss?' and you said, 'I acquired it firing guns as a police officer'?

"A. Correct.

"Q. And he didn't say, 'You're wrong', did he?

"A. No, he didn't say I was wrong. He just --

"Q. Okay.

"A. I guess he just sort of wrote down some notes." (Tr. I-31, -32).

At the end of the ALJ's order, we add the following supplementation.

We agree with the ALJ's conclusion that claimant's occupational disease claim was timely filed.

Moreover, even if claimant's occupational disease claim was untimely filed, it would still not be time-barred. Occupational disease claims are to be processed in the same manner as accidental injuries. ORS 656.807(3). As amended, ORS 656.265(4)(a) now provides that "[f]ailure to give notice as required by this section bars a claim under this chapter unless the notice is given within one year after the date of the accident and: (a) The employer had knowledge of the injury or death[.]" As amended, the statute eliminates the prejudice requirement of former ORS 656.265(4)(a). The amended statute, however, applies only to injuries occurring on or after June 7, 1995, the effective date of the Act. Or Laws 1995, ch 332, Secs. 66(2), 69. As to injuries (or diseases) occurring before June 7, 1995, pre-Senate Bill 369 law remains viable in this context. Ann M. Manley, 49 Van Natta 147, 148 (1997); Melvin L. Gordon, 48 Van Natta 1275 (1996).

Because claimant's occupational disease arose before the effective date of Senate Bill 369 (June 7, 1995), the claim would not be time-barred unless SAIF could prove it was prejudiced by the untimely claim filing. Manley, 49 Van Natta at 148; Gordon, 48 Van Natta at 1276. SAIF does not argue that it was prejudiced by claimant's allegedly untimely claim filing. In addition, we find that the record does not establish any prejudice to SAIF. Therefore, even if claimant's occupational disease claim was untimely filed, it would still not be time-barred.

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

ORDER

The ALJ's order dated May 28, 1997 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,200, payable by the SAIF Corporation.

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February 2, 1998 Cite as 50 Van Natta 167 (1998)

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

Claimant requests reconsideration of our January 2, 1998 Own Motion Order on Reconsideration, in which we declined to reopen his claim for the payment of temporary disability compensation because he failed to establish that he was in the work force at the time of disability.

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

IT IS SO ORDERED.

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In the Matter of the Compensation of
**RICHARD L. COBURN, Claimant**
WCB Case No. 97-00969
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) T. Lavere Johnson's order that upheld the insurer's denial of claimant's claim for a bilateral basilar joint synovitis condition, which claimant claimed as an occupational disease claim involving both thumbs or, in the alternative, an aggravation claim for claimant's accepted right thumb tendonitis claim. In its brief, the insurer requests that those portions of claimant's appellant's brief that refer to evidence outside of the record be stricken. On review, the issues are the motion to strike and compensability.

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

Motion to Strike

In his appellant's brief, claimant quoted extensively from a medical treatise that Dr. Plotkin, examining orthopedist, mentioned in his deposition. Claimant argues that the quoted passages, taken as a whole, establish that Dr. Plotkin's medical opinion regarding the cause of claimant's bilateral thumb condition is unpersuasive.

Claimant argues that we should consider excerpts from this medical treatise, even though not admitted at hearing and not part of the hearings record, because he had little time to respond to Dr. Plotkin's deposition. Claimant's attorney participated in that deposition, which took place nine days prior to hearing. However, if claimant did not have time to respond to the deposition, his remedy was to request postponement or continuance of the hearing. OAR 438-006-0081; 438-006-0091. Claimant made no such request.

Our review is limited to the record created at hearing. ORS 656.295(3) and (5). The only exception 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).

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

Consequently, because claimant's quotations from this medical treatise are taken from a source not subject to confrontation and cross-examination, we decline to take administrative notice in this case. See 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). Therefore, we strike those portions of claimant's appellant's brief that refer to the medical treatise.

Compensability

Claimant argues that we should rely on the opinion of Dr. Sohlberg, treating orthopedist, regarding causation. However, for the reasons addressed by the ALJ, we find Dr. Sohlberg's opinion is unpersuasive. Claimant focuses on the ALJ's comment that Dr. Sohlberg's opinions did "not address claimant's off-work activities which require the use of claimant's forearm and hands." Claimant contends that the record does not specify any off-work activities, nor does any physician implicate any off-work activities as causing claimant's problems. While we agree with these contentions, we find that the ALJ's comment addressed a different aspect of the medical opinions.

On June 7, 1993, Dr. Plotkin and Dr. Farris, neurologist, examined claimant on behalf of the insurer. (Ex. 13). During the physical examination, they found that, as claimant flexed and extended his elbows, his ulnar nerve popped out of its anatomic grove and was caught with flexion and extension on the bony ridge of the medial epicondyle. (Ex. 13-3, -5). They opined that this anatomic variation was the major cause of claimant's disability and need for treatment, although the need to flex his elbows to do his work, including using an electronic clipboard (a "DIAD"), contributed in a lesser manner to the continuance of claimant's symptoms in both upper extremities. (Ex. 13-6). They noted that claimant reported that he did very little off-work because his symptoms occurred soon after he started an activity such as using his personal computer or doing housecleaning, such as washing his shower. (Ex. 13-5).

In his deposition, Dr. Plotkin explained that a person's ulnar nerve ordinarily stays in a protected anatomic grove when the elbow is flexed and extended. However, on examination, he found that claimant has a high riding ulnar nerve, or an ulnar nerve variation, which causes his ulnar nerve to pop out of the protected area and be mechanically irritated as it goes over the bony ridge each time claimant flexes and extends his elbow. (Ex. 15A-13-15, -22). Dr. Plotkin opined that this ulnar condition was not caused or worsened by work activities, but was simply part of claimant's "constitutional" make up. (Exs. 15A-26-27, -33, -35). He explained that this ulnar condition, in combination with all activities over a long period of time, starts to hurt. (Ex. 15A-32). Dr. Plotkin also opined that this ulnar nerve variation was the major contributing cause of claimant's bilateral thumb condition, explaining that the muscle that moves the thumb is innervated by the ulnar and medial nerves, and that the mechanical irritation of the ulnar nerve was causing referred pain. (Ex. 15A-15-16, -21-22, -26-27, -35, -48). He noted that any activity causing extension and flexion of the elbow would cause these symptoms, noting that claimant complained of symptoms while attempting to wash his shower, an activity that would require flexion and extension of the elbow. (Ex. 15A-23).

Dr. Plotkin explained that claimant's condition improved when he was not working because he was using his elbows less, which resulted in the nerve settling down. (Ex. 15A-35-37). Dr. Plotkin also explained that claimant's physicians had exhausted care for the area around the thumb and had not looked further for a cause of claimant's condition, which he opined was claimant's unstable ulnar nerve. (Ex. 15A-41-42).

Thus, Dr. Plotkin's discussion of off-work activities was in relationship to the fact that off-work activities also caused symptoms because of claimant's ulnar nerve variation. It is in this regard that the ALJ discounted Dr. Sohlberg's opinion, in part, because he did not address claimant's off-work activities.

Furthermore, although the ALJ found the medical evidence in equipoise, we find Dr. Plotkin's opinion better reasoned. In addition, whereas Dr. Sohlberg's opinion is conclusory, Dr. Plotkin fully explains his opinion. Moreover, Dr. Sohlberg acknowledges that he did not examine claimant for hypermobile ulnar nerves, the condition that Dr. Plotkin finds is the major contributing cause of claimant's condition. (Ex. 16-1). Thus, on this record, we find that claimant has failed to meet his burden of proof.

Finally, claimant argues that, although the ALJ correctly stated at hearing that the issue was compensability of the left thumb condition as a new occupational disease and compensability of the right thumb as either an aggravation of the right thumb tendonitis condition accepted in 1993, or a new occupational disease claim, he did not address the new occupational disease claim theory regarding the right thumb condition.

To establish a compensable occupational disease claim, claimant must prove that the 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). Given the medical record, as evaluated above and by the ALJ, claimant has failed to establish compensability of a new occupational disease claim regarding his right thumb condition. To the extent that the ALJ did not address that issue, we modify his order accordingly.

## ORDER

The ALJ's order dated May 22, 1997 is affirmed. The insurer's denial of claimant's aggravation claim for the accepted right thumb tendonitis condition and its denial of claimant's new occupational disease claim for bilateral thumb conditions is upheld.

In the Matter of the Compensation of
**DARLA J. FEICKERT, Claimant**
Own Motion No. 97-0157M
OWN MOTION ORDER
Welch, Bruun, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys

The insurer has submitted claimant's request for temporary disability compensation for claimant's compensable lumbar disc condition, L5-S1. Claimant's aggravation rights expired on March 31, 1992. The insurer opposes the reopening of the claim on the grounds that: (1) no surgery or hospitalization has been requested; (2) the current condition is not causally related to the accepted condition; (3) the insurer is not responsible for the current condition; and (4) surgery or hospitalization is not reasonable and necessary. In addition, the insurer issued a denial of responsibility of claimant's current lumbar strain and asserted that claimant's subsequent employer, Clackamas County, was responsible for claimant's current condition. Clackamas County issued compensability and responsibility denials of claimant's current condition. Claimant filed a request for hearing on both denials with the Hearings Division. (WCB Case Nos. 97-03157 and 96-09261).

A hearing was held in this matter on May 28 and May 29, 1997. On September 11, 1997 (as amended on October 2, 1997), Administrative Law Judge (ALJ) Peterson issued an Opinion an Order which: (1) affirmed the insurer's responsibility denial; (2) set aside Clackamas County denials; and (3) ordered Clackamas County to accept the claim. Clackamas County has requested Board review of the ALJ's order.

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

It is the Board's policy to postpone action until pending litigation on related issues has been resolved. However, in this instant case, responsibility is not the key issue but, rather, has there been surgery and/or hospitalization for the compensable condition. The record submitted to us fails to demonstrate that claimant requires surgery or hospitalization for treatment now or in the near future.[1] As a result, we are not authorized to grant claimant's request to reopen the claim.

Accordingly, we deny the request for own motion relief. 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 under ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

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[1] Following ALJ Peterson's Opinion and Order, the Board requested from the insurer and claimant, medical documentation which would evidence that surgery and/or hospitalization had been requested or had taken place for treatment of claimant's compensable condition. To date, neither the insurer nor the claimant have submitted any such evidence.

In the event that claimant disagrees with our decision that no surgery and/or hospitalization has been requested or taken place for treatment of her compensable condition, she may request reconsideration. However, we note that our authority to further consider this matter expires within 30 days of this Order.

In the Matter of the Compensation of
**LISA E. GILBERT, Claimant**
WCB Case No. 97-00223
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Hall and Bock.

Claimant requests review of Administrative Law Judge (ALJ) McWilliams' order that: (1) upheld the SAIF Corporation's denial of claimant's occupational disease claim for left shoulder, wrist and thumb conditions; and (2) declined to assess a penalty for the allegedly unreasonable denial. On review, the issues are compensability and penalties. We affirm in part and reverse in part.

## FINDINGS OF FACT

Claimant is a left-handed woman who was 45 years of age at the time of hearing. She sustained a 1988 left wrist injury resulting in pain and sensory changes in the left hand and wrist. Dr. Nagel, orthopedist, diagnosed carpal tunnel syndrome and ulnar neuritis, and claimant's left hand and wrist symptoms resolved with conservative treatment.

Claimant then began working for the employer as an optician in February 1990. In the course of this work, claimant used her hands and arms in a repetitive manner to insert miniature screws in glass frames, adjust glass frames and edge lenses. Claimant also used her hands and arms in a forceful manner to twist and bend glass frames into shape and insert lenses in glass frames. Claimant frequently spoke on the telephone to customers and suppliers while performing these job duties. To do this, claimant tilted her head to the side to cradle the phone.

Claimant initially worked full-time for the employer from February 1990 through early June 1993. Claimant was involved in off-work motor vehicle accidents in June and September 1993. The first motor vehicle accident (MVA) resulted in pain in the right neck, right scapula, right rib and right hand which was attributed to a cervical strain and right hand strain/contusion. Claimant also initially experienced some left hand pain which resolved shortly after the first MVA without treatment. Claimant sustained a herniated L5-S1 disk in the September 1993 MVA, with related low back pain and right lower limb paralysis. Claimant's 1993 MVA's did not result in any symptoms or conditions related to the left neck, left shoulder or left hand/wrist, other than the temporary left hand pain associated with the first MVA.

Claimant returned to part-time work for the employer in January 1994 and thereafter experienced the gradual onset of left wrist and left shoulder pain. She received further treatment from Dr. Nagel and began wearing a short-arm cast. Claimant then left the employer to sell optical supplies during the period of June 1995 through November 1995. Claimant's wrist and shoulder symptoms improved after she began this sales work, which did not involve repetitive, hand-intensive activity.

Claimant left this sales job and returned to work for the employer in November 1995 for at least 31 hours a week. Thereafter, her left wrist and shoulder symptoms returned and gradually worsened. Beginning in January 1996, claimant wore a short-arm cast to control her symptoms. Sometime prior to July 1996, she developed pain in the volar aspect of her left thumb. In July 1996, Dr. Nagel added a thumb spica to claimant's left arm cast to control the left thumb symptoms.

Claimant continued working for the employer until August 5, 1996. Nerve conduction studies performed on August 12, 1996 demonstrated no median or ulnar nerve involvement. On August 13, 1996, claimant was injured in a motor vehicle accident (MVA) when her hands and wrists were jarred as she gripped the steering wheel on impact. Claimant experienced a further exacerbation of her shoulder, wrist and thumb symptoms after the accident, and she was diagnosed with strains of the left arm, left thumb, neck and upper back. Dr. Nagel provided further treatment to claimant after the MVA. Claimant's symptoms had returned to the pre-MVA level by the end of September 1996.

On September 12, 1996, claimant filed an occupational disease claim with the employer for her chronic left shoulder, wrist and thumb symptoms. Dr. Filarski examined claimant for SAIF on December 8, 1996, at which time he diagnosed left scapular bursitis, left wrist tendonitis and left thumb tenosynovitis. SAIF issued a denial of these conditions on December 23, 1996.

Claimant engaged in no repetitive, hand-intensive off-work activity after she returned to work for the employer in January 1994.

## FINDINGS OF ULTIMATE FACT

Claimant's work activity for the employer is the major contributing cause of her current left shoulder, wrist and thumb conditions.

## CONCLUSIONS OF LAW AND OPINION

### Compensability

The parties agree that the causation issues in this case are 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). The record in the present case includes relevant medical opinions from Dr. Nagel, the treating physician, and Dr. Filarski, who examined claimant for SAIF.

In his July 30, 1996 opinion letter, Dr. Nagel explained that claimant's work activity for the employer aggravated her left wrist condition. In his subsequent March 17, 1997 opinion letter, Dr. Nagel opined the following after noting that claimant's symptoms were complicated by the August 13, 1996 MVA:

> "It remains my medical opinion that the major cause of [claimant's] thumb flexor tendon stenosing tenosynovitis as well as the left shoulder medial scapular bursitis and were the cause of actual worsening of pre-existing conditions [sic].
>
> "I have observed [claimant] work on a pair of glasses and there is severe strain on the thumb in the work required of an optical dispenses [sic]."

In his December 9, 1996 report, Dr. Filarski opined that claimant first experienced the onset of thumb tenosynovitis in January 1996, but had previously experienced left scapular bursitis and left wrist tendonitis in 1988. Dr. Filarski further opined that claimant's current scapular bursitis and wrist tendonitis were "new conditions" because claimant had no shoulder and wrist symptoms for the five-year period preceding her return to work for the employer in 1994. Dr. Filarski also opined that claimant's "pre-existing conditions do combine with the work activities," and that, assuming a combination of pre-existing conditions and work activities, the work activity was the major contributing cause of the condition and need for treatment.

Based on this medical record, the ALJ concluded: that claimant's scapular bursitis and wrist tendonitis were preexisting conditions, so that claimant must prove that her work activity for the employer was the major contributing cause of a pathological worsening of those conditions pursuant to ORS 656.802(2)(b); that claimant's left thumb tenosynovitis did not preexist her employment with the employer, so that claimant need only establish that the work activity was the major contributing cause of the onset of this condition pursuant to ORS 656.802(2)(a); and that the opinions of Drs. Nagel and Filarski did not establish that claimant's work activity for the employer was the major contributing cause of her scapular bursitis, wrist tendonitis or thumb tenosynovitis, or that claimant's shoulder and wrist symptoms were indicative of a pathological change.

On review, claimant argues that the ALJ erred in analyzing her shoulder and wrist conditions under ORS 656.802(2)(b). Claimant further contends that the unrebutted opinions of Drs. Nagel and Filarski are sufficient to establish compensability of her shoulder, wrist and thumb conditions.

We agree that claimant's right shoulder and left wrist conditions should not be analyzed under ORS 656.802(2)(b). While Dr. Filarski characterized these conditions as "pre-existing," he also opined that they should be treated as "new conditions" because of the intervening asymptomatic period between the 1988 treatment and claimant's return to work for the employer in 1994. Moreover, the contemporaneous treatment records in 1988 make no reference to any diagnosis of left wrist tendonitis or any reference to shoulder complaints, findings or diagnoses. On this record, claimant need not establish a pathological worsening under ORS 656.802(2)(b).

Rather, claimant can establish compensability of her left shoulder, wrist and thumb conditions by proving that the work activity for the employer is the major contributing cause of the onset of these conditions. ORS 656.802(2)(a). We conclude that the unrebutted opinions of Drs. Filarski and Nagel establish compensability of all three conditions. We recognize that the causation discussion in Dr. Nagel's March 17, 1997 opinion letter is somewhat confusing due to typographical errors. Nevertheless, we read Dr. Nagel's comments in the context of the opinion letter as a whole and conclude that he has opined that claimant's work activity for the employer was the major cause of her scapular bursitis and thumb tenosynovitis. This opinion is consistent with Dr. Filarski's position that claimant's work activity is the major contributing cause of her current shoulder and wrist conditions. In reaching their unrebutted opinions, Drs. Nagel and Filarski considered claimant's entire medical record, including any possible contribution from the August 13, 1996 MVA. We note that Dr. Filarski did not withdraw his opinion after receiving additional information about the MVA. Furthermore, there is no evidence in this record that the MVA resulted in any more than a temporary exacerbation of claimant's symptoms.

Moreover, we disagree with the ALJ's conclusion that Dr. Nagel's opinion is based on an inaccurate history of full-time work for the employer. Dr. Nagel does not state that claimant was working full time in his chart notes or opinion letters. The ALJ is apparently referring to Dr. Nagel's comment in his July 30, 1996 opinion letter that a short arm cast with a thumb spica is necessary for claimant "to continue working full time as an optician." This comment is ambiguous and could merely be a reference to the goal of returning to full-time work. Furthermore, even if Dr. Nagel assumed that claimant was working full time, we would not reject his opinion on that basis. There is no evidence that claimant gave Dr. Nagel an inaccurate description of her work activity for the employer. Furthermore, the employer acknowledged in his testimony that claimant worked at least 31 hours each week. There is nothing in this record to indicate that Dr. Nagel would have changed his opinion merely because claimant worked nine hours less than the standard 40-hour work week.

Nor do we agree with the ALJ's conclusion that Dr. Nagel's inaccurate history regarding the number of hours worked "is compounded by the inconsistencies in claimant's testimony regarding prior injuries and treatment which render her an inaccurate historian." We recognize that claimant's reporting of her August 1996 MVA complicated the processing of her occupational disease claim. Nevertheless, we have concluded above that the opinions of Drs. Nagel and Filarski are based on an accurate history of claimant's symptoms following this event. Furthermore, claimant noted the MVA on the questionnaire she completed for SAIF on October 18, 1996, and we accept her explanation that she did not report further details of the accident to SAIF because the MVA only resulted in a temporary exacerbation of symptoms she had experienced for many months prior to the accident. The employer has offered no evidence that persuasively rebuts this history of significant shoulder and thumb symptoms prior to the August 1996 MVA. Finally, claimant has otherwise reported her symptomatic and work history in a consistent and forthright manner. In particular, we accept claimant's explanation that she did not notify SAIF of her treatment in 1993 for right neck and right hand pain because her current symptoms involve the opposite side of her body.

Accordingly, we conclude that the opinions of Drs. Nagel and Filarski satisfy claimant's burden of establishing compensability of her left shoulder, wrist and thumb conditions. Consequently, claimant is entitled to an assessed attorney fee for prevailing over SAIF's denial of these conditions. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $5,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time expended in establishing compensability of the shoulder, wrist and thumb conditions (as represented by the record and claimant's appellate briefs), the complexity of these issues, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Penalties

We affirm the ALJ's ruling that SAIF's denial was not unreasonable. The circumstances surrounding the August 1996 MVA provided a reasonable basis for rejecting Dr. Filarski's causation opinion and issuing the denial.

ORDER

The ALJ's order dated May 27, 1996, as republished May 28, 1997, is reversed in part and affirmed in part. SAIF's December 23, 1996 denial is set aside, and the claim is remanded to SAIF for processing according to law. The remainder of the ALJ's order is affirmed. For services at hearing and on review, claimant is awarded an assessed fee of $5,500, to be paid by SAIF.

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February 4, 1998 Cite as 50 Van Natta 174 (1998)

In the Matter of the Compensation of
**CASSANDRA J. HANSEN, Claimant**
WCB Case No. 96-07224
ORDER ON REVIEW
Bennett, Hartman, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Bock and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that upheld the SAIF Corporation's denial of her 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. Following completion of the briefing schedule, without submitting further argument, claimant directed the Board's attention to Beverly Enterprises v. Michl, 150 Or App 357 (1997). 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).

Here, the court's decision in Michl was issued after completion of the briefing schedule. Therefore, claimant acted properly in bringing the decision in Michl to our attention with regard to the merits of the issue on review. Nevertheless, we find Michl distinguishable. In Michl, the court affirmed our decision setting aside the carrier's denial of the claimant's knee injury claim. There, although the medical record noted "patellar tracking problems," the only medical evidence regarding causation was a report from the attending physician stating the injury was solely caused by the work incident. Given this medical evidence, the court found that it was reasonable for us to conclude that the claimant's knee dislocations were discrete injuries, and not an ongoing condition predisposing claimant's knee to dislocation. Therefore, the court found that we did not err in refusing to apply the standard in ORS 656.005(7)(a)(B) for injuries combining with preexisting conditions.

In contrast to the record in Michl, the medical record in the present case shows a consensus that claimant has preexisting conditions involving diabetes and obesity, conditions that both Dr. Hebard, claimant's treating physician, and Dr. Rosenbaum, who performed a record review for SAIF, opined were contributing causes to the development of her right carpal tunnel syndrome.[1] (Exs. 26-23, 27). Furthermore, whereas Michl involved an injury claim, the present case involves an occupational disease claim. Pursuant to ORS 656.802(2)(e), preexisting conditions shall be deemed causes in determining the major contributing cause of an occupational disease. Therefore, notwithstanding ORS 656.005(7)(a)(B), consideration of preexisting conditions is appropriate in the present case.

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[1] Dr. Reimer, examining neurologist, opined that the major contributing cause of claimant's right carpal tunnel syndrome was the predisposing factors of diabetes and family history. (Exs. 12, 23A, 28). Although Dr. Reimer disagreed about the influence of obesity on the development of carpal tunnel syndrome, his opinion does not support compensability of claimant's condition.

Dr. Rosenbaum opined that the combination of claimant's preexisting diabetes and obesity are the major contributing cause of her right carpal tunnel syndrome. We agree with the ALJ's reasoning that Dr. Rosenbaum's opinion is most persuasive.

ORDER

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

**Board Chair Bock specially concurring.**

While I concur with the result of the lead opinion, I write separately to dismiss the notion that a finding of a "preexisting condition" automatically creates a talisman that wards off compensability of a claim. To the contrary, in considering the persuasiveness of a medical opinion addressing the contribution of an alleged "preexisting condition," the Board assesses both whether the condition in question meets the definition of a "preexisting condition" in ORS 656.005(24)[1] and whether the opinion persuasively explains why the "preexisting condition" relates to the injury or occupational disease claim in question. 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; Board Member Hall specially concurred and objected to characterization of obesity as a preexisting 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)).

In other words, the fact that a worker has a condition that qualifies as a "preexisting condition" under ORS 656.005(24) is not sufficient to defeat an otherwise compensable claim. Unless a medical opinion persuasively explains why the preexisting condition contributes to the particular worker's claimed condition to the extent that the work injury[2] or exposure is not the major contributing cause of an otherwise compensable claim, that claim remains compensable. Thus, depending on the medical evidence, a condition such as being overweight may or may not be considered to be a "preexisting condition" that contributes to a claimed condition in a particular case. For this reason, I am unable and unwilling to create a "laundry list" of preexisting conditions.

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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 worsening pursuant to ORS 656.273."

[2] Of course, in an injury claim, a condition precedent to application of ORS 656.005(7)(a)(B) is a factual finding that an otherwise compensable injury "combined" with a preexisting condition to cause or prolong disability or a need for treatment. See Clifford T. Upp, Jr., 48 Van Natta 2236 (1996).

In the Matter of the Compensation of
**DAVID C. LACEY, Claimant**
WCB Case Nos. 95-10021 & 95-09434
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Kemper Insurance Company (Kemper), on behalf of Taylor Electric Supply, requests review of those portions of Administrative Law Judge (ALJ) Herman's order that: (1) set aside its partial denial of claimant's low back injury claim for an L3-4 disc condition; and (2) upheld the SAIF Corporation's partial denial, issued on behalf of Brockamp & Jaeger, Inc., of claimant's claim for the same condition. Claimant cross-requests review of that portion of the ALJ's order that declined to award additional temporary disability benefits. On review, the issues are compensability, responsibility and temporary disability.

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

On the responsibility issue, Kemper cites Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996), in support of its contention that SAIF is responsible for the L3-4 disc condition because SAIF had already paid claimant permanent disability benefits for that condition under its 1978 injury claim. However, subsequent to the ALJ's order, the 1997 Legislature amended ORS 656.262(10) to provide in part that an insurer's payment of permanent disability benefits pursuant to a litigation order, or the insurer's failure to appeal such an order, shall not preclude the insurer from subsequently contesting the compensability of the condition rated therein. HB 2971, 69th Leg., Reg. Sess., § 1 (July 25, 1997). The amendments to ORS 656.262(10) are fully retroactive and therefore apply to this claim. See Bay Area Hospital v. Landers, 150 Or App 154 (1997).

We held in Keith Topits, 49 Van Natta 1538 (1997), that amended ORS 656.262(10) overruled Messmer and that an insurer's failure to appeal a permanent disability award does not preclude the insurer from subsequently denying compensability of the condition for which benefits were awarded. Likewise, in this case, we hold that SAIF's payment of a permanent disability award did not preclude it from denying responsibility for the L3-4 disc 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 $1,700, payable by Kemper. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved. Claimant's attorney is not entitled to a fee for services regarding the temporary disability issue.

ORDER

The ALJ's order dated February 24, 1997 is affirmed. Claimant's attorney is awarded an assessed attorney fee of $1,700, to be paid by Kemper.

In the Matter of the Compensation of
**MARGO A. READYE, JR., Claimant**
WCB Case No. 96-01563
ORDER ON REVIEW
Welch, 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: (1) set aside its denial of claimant's right knee injury claim; and (2) awarded 15 percent (22.5 degrees) scheduled permanent disability for loss of use or function of claimant's left knee, whereas an Order on Reconsideration had awarded 11 percent (16.5) degrees. On review, the issues are compensability and extent of scheduled permanent disability. We reverse.

## FINDINGS OF FACT

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

We do not find that claimant's left leg permanent disability exceeds that awarded by the Workers' Compensation Division.

We do not find that claimant's June 21, 1995 work injury was the primary cause of his subsequent need for medical treatment for his right knee.

## CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the relevant facts.

On June 21, 1995, claimant fell at work, landing on both knees and shins. He initially sought medical treatment for the left knee, later for the right knee.

The employer accepted claimant's left knee injury claim, but denied his right knee injury claim.

On November 6, 1995, Dr. Hanley performed an arthroscopic abrasion chondroplasty on claimant's left knee.

A March 21, 1997 Order on Reconsideration affirmed a Notice of Closure which awarded 11 percent scheduled permanent disability for loss of use or function of claimant's left knee. The Order specifically found that the standards address claimant's disability.

Claimant requested a hearing.

The ALJ found claimant entitled to an additional 5 percent scheduled disability for his left knee surgery. The ALJ also determined that claimant established that his need for right knee treatment was injury-related.

### Extent of Disability: Left Knee

The only extent-of-disability issue is whether claimant is entitled to an impairment rating based on the left knee arthroscopic abrasion chondroplasty performed by Dr. Hanley.

The ALJ acknowledged that the applicable standards do not provide a rating for the abrasion chondroplasty procedure. See former OAR 436-035-0230(5). Nonetheless, the ALJ reasoned that claimant's surgery was "roughly comparable" to a partial meniscectomy (see Ex. 50-7), and therefore found it ratable under former OAR 436-035-0230(5)(b) (which provides for meniscectomy ratings). We disagree.

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). Thus, if the rules do not provide for a rating under particular circumstances, no rating is available under those circumstances. See former OAR 436-35-0010(2); 436-35-0007(25). See also Zinnia L. Palmer, 43 Van Natta 481, 484 (1991) (Neither the ALJ nor this Board has the authority to substitute substantial compliance for strict compliance with a precisely defined rule). Accordingly, because the ALJ rated a surgical procedure for which there is no rating under the standards, we conclude that the consequent additional permanent disability award must be reversed.

Compensability: Right Knee Condition

The ALJ found that claimant injured his right knee on June 21, 1995, when he fell at work. The ALJ also found that claimant established that his right knee work injury was the primary cause of his subsequent need for medical treatment (for a right knee "combined condition" involving a preexisting chondral defect). The ALJ reached the latter conclusion based on the opinion of Dr. Hanley, treating surgeon. We disagree.

Dr. Hanley provides the only medical opinion arguably supporting the claim. (Ex. 47). However, because Dr. Hanley subsequently retracted this opinion (by concurring with Dr. Farris' opinion without reservation or explanation,[1] (Ex. 51)), we conclude that claimant has failed to establish medical causation.

Under these circumstances, in the absence of persuasive supporting medical evidence, we conclude that the claim must fail under ORS 656.005(7)(a)(B).

ORDER

The ALJ's order dated July 29, 1997 is reversed. The self-insured employer's denial is reinstated and upheld. The Order on Reconsideration is affirmed. The ALJ's attorney fee awards are reversed.

[1] Dr. Farris examined claimant on September 9, 1996 and opined that claimant's right knee condition was not related to the June 1995 work injury. (Ex. 50-6-7).

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February 4, 1998 Cite as 50 Van Natta 178 (1998)

In the Matter of the Compensation of
**CINDY L. REED-KEEN, Claimant**
WCB Case No. 96-05290
ORDER ON REVIEW
Max Rae, Claimant Attorney
Cummins, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that upheld the insurer's denial of her low back occupational disease claim. On review, the issue is compensability.

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

Claimant began work in the cabinet shop area for the employer in 1981. After being laid off for a year, claimant returned to work permanently in 1983. Her employment involved lifting, bending, and twisting. (Tr. 12).

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

Claimant experienced intermittent pain following the initial closure. Her symptoms increased in January 1995, and she was taken off work. After claimant returned to work, she was transferred to the Formica and countertop area in March 1995. (Tr. 10). In April 1995, claimant was examined by Dr. Hunt at the insurer's request, who diagnosed preexisting degenerative disc disease, recurrent overuse of the back superimposed on the preexisting degenerative changes and possible pathological changes due to work activities. (Ex. 36- 9). Dr. Hunt found that claimant had some permanent impairment (loss of motion) in her low back, half of which he attributed to her work activities and half of which he attributed to her degenerative condition. Id. Claimant's attending physician, Dr. Molloy, concurred with Dr. Hunt's findings. (Ex. 39).

Claimant's claim was closed a second time by a May 24, 1995 Determination Order which awarded 6 percent unscheduled permanent disability. This 6 percent permanent disability award represented the one-half of claimant's impairment that was due to her work injury. (Ex. 40-2).

On November 27, 1995, claimant returned to Dr. Molloy complaining of progressive back pain that suddenly worsened while she was at home the previous Saturday. (Ex. 41-1). She filed an aggravation claim alleging that her current symptoms were an exacerbation of her previous injury. Dr. Molloy reported that claimant had lumbar pain and degenerative disc disease and referred claimant to a neurosurgeon, Dr. Collada. Noting lumbosacral spondylosis and lumbar disc disease, Dr. Collada found claimant neurologically intact and recommended conservative treatment. (Ex. 49). The insurer denied the aggravation claim on February 26, 1996 and claimant requested a hearing

Also in February 1996, Drs. Scheinberg and Zivin examined claimant at the insurer's request. They diagnosed chronic low back strain and lower extremity pain secondary to musculoligamentous strain superimposed on her preexisting degenerative arthritis and degenerative disc disease. (Ex. 54-6). Drs. Scheinberg and Zivin also reported, among other things, that claimant was experiencing a waxing and waning consistent with her prior unscheduled permanent disability award, that she was predisposed to injury because of the degenerative changes in her back, and that the major contributing cause of her current symptoms was her preexisting degenerative condition. Dr. Molloy concurred with these findings. (Ex. 61).

At the May 16, 1996 hearing concerning her aggravation claim, claimant alternatively contended that she had sustained a compensable occupational disease. The issue was preserved for future litigation. Claimant formally filed her occupational disease claim on May 22, 1996. The insurer denied the claim on May 23, 1996. Claimant requested a hearing.

An Opinion and Order issued on February 7, 1997, finding that claimant's compensable 1993 injury was not the major contributing cause of her current condition since November 1995, and that she had failed to prove a compensable aggravation claim. (Ex. 69). The Board affirmed on July 11, 1997. Cindy L. Keen, 49 Van Natta 1055, on recon 49 Van Natta 1460 (1997).

The occupational disease claim proceeded to hearing on May 28, 1997. The ALJ determined that claimant had failed to prove a compensable occupational disease claim for her low back degenerative disease/overuse condition. The ALJ found that the claim did not involve a "preexisting condition" because there was no evidence that, prior to 1983, claimant suffered from any injury, congenital abnormality, personality defect, or similar condition that contributed to or predisposed her to the claimed low back disease. See ORS 656.005(24). In reaching this conclusion, the ALJ reasoned that, under ORS 656.802 and 656.005(24), a condition could only qualify as a "preexisting condition" if it preexisted the onset of the employment exposure which gave rise to the initial claim for occupational disease. Concluding that the appropriate compensability standard was whether claimant's work for the employer was the major contributing cause of the claimed disease, the ALJ held that the medical evidence did not establish that claimant's low back degenerative condition or the alleged "overuse" condition were compensable.

On review, claimant agrees with the ALJ's reasoning that the existence of a "preexisting condition" is to be determined at the beginning of the employment exposure on which the occupational disease claim is based, and that there are no preexisting conditions in this case. Claimant contends that she need only prove that employment conditions were the major contributing cause of traumatic events or occurrences which required medical services or resulted in disability. Relying on the opinions of the examining physicians, Drs. Hunt and Scheinberg, claimant asserts that she has sustained her burden of proof.

The insurer does not concede that the ALJ correctly determined the preexisting condition issue. However, it does not contest the ALJ's analysis, provided we affirm the ALJ's finding that claimant's employment was not the major contributing cause of her claimed occupational disease for the low back degenerative/overuse conditions.

To begin, we tend to agree with the ALJ's conclusion that a "preexisting condition" for the purposes of the occupational disease statute must be in existence prior to the employment exposure which the claimant asserts caused the disease. See Dan A. Sturtevant, 49 Van Natta 1482 (1997) ("preexisting condition" in an occupational disease claim must have preceded the commencement of employment with the employer). However, we need not decide the issue in this case. That is, even if the ALJ properly found no "preexisting condition," we agree with the ALJ that claimant failed to prove a compensable occupational disease claim for either her degenerative condition or her alleged "overuse" condition.[1]

In the absence of a preexisting condition, in order to establish a compensable occupational disease claim, claimant must prove that employment conditions were the major contributing cause of her low back degenerative/overuse conditions. ORS 656.802(2)(a).[2] 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). It is claimant's burden to prove that her alleged occupational disease is compensable. ORS 656.266.

We agree, for the reasons cited by the ALJ, that claimant failed to prove the compensability of the degenerative component of her low back occupational disease claim. With respect to the "overuse" aspect of the occupational disease claim, the ALJ found that medical evidence from Drs. Hunt, Scheinberg, Collada and Malloy was insufficient to establish compensability. In reaching this conclusion, the ALJ determined that the opinion of Dr. Hunt, the only physician to diagnose overuse of the low back, was unpersuasive, in part because of his deposition testimony. The ALJ concluded that Dr. Hunt could not state how much claimant's overuse condition contributed to her need for treatment in comparison to the underlying degenerative condition.

Claimant cites testimony from Dr. Scheinberg and Dr. Hunt which she asserts strongly supports the compensability of the overuse condition. (Ex. 63: pps. 41-43; Ex. 65: pps. 23-25). Even assuming that Dr. Hunt's testimony supports a conclusion that claimant's work activity was the major contributing cause of the overuse condition, we find that Dr. Scheinberg's testimony only establishes that claimant's work was the major contributing cause of the "immediate" need for treatment in November 1995. (Ex. 63-41). Other portions of Dr. Scheinberg's deposition support a conclusion that claimant's noncompensable degenerative condition was the major contributing cause of claimant's low back condition in November 1995. (Ex. 63-42, 45). Viewing Dr. Scheinberg's testimony as a whole, we agree with the ALJ that it does not support the compensability of claimant's occupational disease claim for the overuse condition. Therefore, at most, the evidence from Drs. Hunt and Scheinberg is in equipoise.[3] Inasmuch as it is claimant's burden of proof under ORS 656.266, we agree with the ALJ that claimant's occupational disease claim is not compensable. Accordingly, we affirm.

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[1] ORS 656.802(2)(e) provides that "preexisting conditions shall be deemed causes in determining major contributing cause under this section." Given our disposition of the claim, we need not address claimant's challenges to ORS 656.802(2)(e) under the state and federal constitutions and the Americans with Disabilities Act.

[2] We reject claimant's contention that she need only prove that employment conditions were the major contributing cause of the traumatic events or occurrences which required medical services or disability. See ORS 656.802(1)(a)(C). Claimant's occupational disease claim is for her degenerative disc disease/overuse condition. (Tr. 5). As such, the appropriate standard is whether work conditions are the major contributing cause of the disease or conditions under ORS 656.802(2)(a).

[3] Dr. Malloy testified that he could not determine whether claimant's degenerative condition or her work activity was the major contributing cause of claimant's low back condition. (Ex. 64-10). Dr. Collada offered no opinion on causation in his medical report. Dr. Collada did, however, concur without explanation with the Scheinberg/Zivin report which concluded that claimant's degenerative condition was the major contributing cause of her current low back condition. (Exs. 49, 62). We conclude that the medical evidence from Drs. Malloy and Collada does not support a finding that claimant's "overuse" condition is compensable.

ORDER

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

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In the Matter of the Compensation of
**JAMES C. RISENER, Claimant**
WCB Case No. 97-01720
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Nichols' order that determined that claimant's back injury claim was prematurely closed. In his brief, claimant argues that if the claim was not prematurely closed, the employer's aggravation denial should be set aside and he is entitled to an additional permanent disability award beyond the 9 percent (28.8 degrees) unscheduled permanent disability award granted by an Order on Reconsideration. On review, the issues are premature closure and, alternatively, aggravation and extent of scheduled and unscheduled permanent disability. We reverse in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact except for the last paragraph.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

The employer argues that the ALJ erred by relying on events that occurred subsequent to closure to describe claimant's condition at closure. The employer contends that the claim was not prematurely closed.

Claims shall not be closed until the worker's compensable condition has become medically stationary. ORS 656.268(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). The propriety of the closure turns on whether claimant was medically stationary at the time of the October 11, 1996 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694, 697 (1985); Alvarez v. GAB Business Services, 72 Or App 524, 527 (1985).

The parties dispute which physician was claimant's attending physician. An "attending physician" is the physician who is primarily responsible for the treatment of a worker's compensable injury. ORS 656.005(12)(b). Whether a physician qualifies as an "attending physician" is a question of fact. Debbie I. Jensen, 48 Van Natta 1235, 1236 (1996).

Claimant sustained a compensable low back injury on March 27, 1995. (Exs. 56, 73). An MRI done in April 1995 showed a broad based left sided protrusion of the L4-5 disc causing nerve root compromise. (Ex. 23). Beginning April 1995, claimant was treated by Dr. Ireland. (Exs. 22, 26, 27). In May 1995, he was released for a trial of work, but his symptoms increased and he was again taken off work. (Ex. 28). Dr. Ireland referred claimant to Dr. Johnson for a surgical evaluation. (Id.)

Dr. Johnson first examined claimant on June 13, 1995 and recommended surgery. (Ex. 31). In the meantime, the employer denied the claim. (Ex. 34). On May 8, 1996, Dr. Johnson reported that claimant continued to have pain, but he was not willing to undergo surgery until the employer agreed to pay for it. (Ex. 58). Dr. Johnson felt that claimant needed to be seen by a chronic pain specialist. (Id.)

On June 19, 1996, claimant was examined by Dr. Maloney. (Ex. 63). Her treatment included medication, injections and a TENS unit. On July 8, 1996, Dr. Maloney reported that claimant's condition had improved and she gave him more injections. (Ex. 66). Dr. Maloney provided a work release for four hours of regular work per day. (Id.)

On July 24, 1996, Dr. Johnson examined claimant and reported that he continued to have left leg and thigh pain, with occasional numbness in the foot. (Ex. 69). Dr. Johnson reported that claimant was able to do some light work for friends, but he was not performing any type of significant labor. Claimant indicated he was satisfied with his current functional level and his symptoms. (Id.) Dr. Johnson felt that claimant was able to return to work and could tolerate light to medium work for a few hours a day. He explained:

> "At the present time, I no longer need to be involved with his care as he seems to be doing well with a conservative approach, nonsurgical in nature, and Dr. Maloney can easily follow the patient as she has already been doing. I will see him only on an as needed based, and I am turning his care over to Dr. Maloney if she accepts his care. If not, I will find another physician to continue the conservative management necessary for what I expect to be another year or so with regards to his LS radiculopathy." (Id.)

On August 13, 1996, Dr. Maloney reported that claimant was painting houses and she provided a full time work release. (Ex. 70). On August 23, 1996, Dr. Maloney signed, as claimant's attending physician, an authorization form for a "TENS" unit. (Ex. 71). In September 1996, Dr. Maloney reported that claimant was medically stationary. (Ex. 72). She noted that claimant had described a recent flare, but in between flares he had no significant pain. (Id.) The employer issued a Notice of Closure on October 11, 1996. (Ex. 73).

At the time of closure, we find that Dr. Maloney was the physician who was primarily responsible for the treatment of claimant's compensable injury. See ORS 656.005(12)(b). Although claimant had been referred to Dr. Johnson for surgical treatment, Dr. Johnson reported on July 24, 1996 that claimant was doing well with nonsurgical treatment and he had turned claimant's care over to Dr. Maloney. (Ex. 69). Dr. Maloney released claimant to full time work and authorized a "TENS" unit as his attending physician. Although claimant did not fill out a "change of attending physician" form, the record establishes that Dr. Maloney was claimant's attending physician at the time of closure.

A worker's compensable condition shall be determined to be medically stationary when the attending physician or a preponderance of medical opinion declares the worker either "medically stationary," "medically stable," or uses other comparable language. See OAR 436-030-0035(1) (WCD Admin. Order 96-052). Based on Dr. Maloney's closing report (Ex. 72), we conclude that claimant was medically stationary at the time of closure. Dr. Johnson's July 24, 1996 report is consistent with Dr. Maloney's conclusion. Dr. Johnson reported that claimant was doing well with a conservative, nonsurgical approach and claimant was satisfied with his current functional level and the level of his symptoms. (Ex. 69). Under these circumstances, we conclude that claimant was medically stationary on the date the claim was closed and the employer's closure was proper. Consequently, we reverse that portion of the ALJ's order that found that the claim was prematurely closed.

Aggravation

Claimant argues that, if we conclude that the October 1996 closure was proper, the employer's April 3, 1997 denial of his aggravation claim should be set aside. We agree, based on the following reasoning.

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.

The October 11, 1996 Notice of Closure awarded claimant 10 percent unscheduled permanent disability, which was reduced to 9 percent by the February 20, 1997 Order on Reconsideration. (Exs. 74, 88).

On November 4, 1996, claimant was examined by Dr. Johnson, who reported that claimant was unable to work and had numbness in the lateral aspect of his left thigh that transferred over the front of the knee into the medial foreleg. (Ex. 76). He reported that claimant had active L5 radiculopathy and had failed conservative management. (Id.) Dr. Johnson reported positive straight leg raising on the left side and decreased leg strength. (Id.) In his previous report on July 24, 1996, Dr. Johnson reported that claimant had "improved" strength and "almost normal" straight leg raising. (Ex. 69). Dr. Johnson ordered new MRI scans and concluded that the herniation at L4-5 had "worsened since his last interval MRI." (Exs. 77, 79). Dr. Johnson requested surgery on November 14, 1996 and submitted an aggravation form on December 31, 1996. (Exs. 80, 81). On January 28, 1997, Dr. Johnson opined that claimant was not medically stationary and "his claim should be reopened for more serious surgical consideration at this time." (Ex. 85).

Dr. Johnson's conclusion is supported by reports from Drs. Rosenbaum and Neumann. Dr. Rosenbaum, who examined claimant on behalf of the employer on January 28, 1997, reported that claimant's November 1996 MRI revealed a "pathologically significant" disc herniation. (Ex. 86-4). He noted that the disc protrusion and bulge at L4-5 had minimally increased since April 1995. (Ex. 86-2). He reported that claimant had failed conservative measures and assuming an accurate history, claimant's condition was not medically stationary and he was an appropriate candidate for surgery. (Id.)

Dr. Neumann, the medical arbiter, concluded on February 8, 1997 that claimant's "condition currently is not stationary and stable" and the proposed surgery was reasonable and necessary. (Ex. 87-7).

Based on Dr. Johnson's reports, as supported by the reports from Drs. Rosenbaum and Neumann, we conclude that claimant's compensable condition has pathologically worsened since the October 11, 1996 closure. Therefore, claimant has established a compensable aggravation claim under ORS 656.273(1).

Claimant's attorney is entitled to an assessed fee for services at hearing and on review concerning the aggravation issue. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review concerning the aggravation issue is $4,500, 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.

Extent of Permanent Disability

Claimant contends that if we conclude that the October 1996 closure was proper, his unscheduled permanent disability award should be increased by 17 percent to a total of 26 percent. He also argues that he is entitled to a 12 percent scheduled permanent disability award for loss of hamstring strength and partial loss of sensation over the plantar aspect of his left foot. He relies on the February 8, 1997 medical arbiter report to support the increased awards of permanent disability.

The employer argues that we should rely on the opinion of Dr. Maloney to rate impairment. The employer contends that, because the medical arbiter found claimant was not medically stationary at the time of the examination, his report should not be considered for purposes of evaluating adaptability or rating impairment.

The October 11, 1996 Notice of Closure awarded claimant 10 percent unscheduled permanent disability, which was reduced to 9 percent by the February 20, 1997 Order on Reconsideration. (Exs. 74, 88). The worksheet attached to the Order on Reconsideration indicated that claimant had decreased lumbar range of motion in flexion and extension, totalling 9 percent impairment. (Ex. 88-2). The report from Dr. Neumann, the medical arbiter, was not considered because it indicated that claimant's condition had changed after claim closure and the report did not reflect claimant's impairment at the time of closure. (Id.)

Based on the October 11, 1996 issuance date of the Notice of Closure in this case, we conclude the applicable standards for rating claimant's permanent disability are set forth in WCD Admin. Order 96-051, as amended by WCD Admin. Orders 96-068 and 96-072. See OAR 436-035-0003(2), (3).

To be entitled to permanent disability compensation for his low back condition, claimant must first establish that the disability is permanent. OAR 436-035-0007(1) provides that a worker is entitled to a value under the rules "only for those findings of impairment that are permanent[.]" Although claimant relies on Dr. Neumann's February 8, 1997 impairment findings, Dr. Neumann opined that claimant's "condition currently is not stationary and stable" and he needed surgery. (Ex. 87-7). Because Dr. Neumann did not believe claimant's condition was stationary, it follows that the impairment findings are not permanent and are necessarily subject to change. We agree with the Department that the report from Dr. Neumann should not considered because it indicated that claimant's condition had changed after claim closure.

Moreover, as we discussed earlier, claimant has established a compensable aggravation claim. In this order, we have concluded that claimant has established an actual worsening. OAR 436-035-0007(8)(b) provides that "[w]hen an actual worsening of the worker's compensable condition occurs, the extent of permanent disability shall be redetermined." Thus, the extent of claimant's permanent disability from the aggravation must be redetermined after closure of the aggravation claim. See Ronald D. Smith, Sr., 49 Van Natta 1807 (1997) (pursuant to amended ORS 656.262(7)(c), a carrier was obligated to reopen a claim for the processing of the claimant's "new medical condition," which was accepted after an Order on Reconsideration).

Impairment is established by the attending physician except where a preponderance of the evidence establishes a different level of impairment. OAR 438-035-0007(13). Here, we find no reason not to rely on the closing examination impairment findings of Dr. Maloney. See Weiland v. SAIF, 64 Or App 810 (1983).

After reviewing the record, we conclude that claimant is entitled to 10 percent unscheduled permanent disability for his "pre-aggravation" back condition. We rate claimant's permanent disability on this "closed" claim as of the date of closure. See generally Lindon E. Lewis, 46 Van Natta 237, aff'd mem Morgan Manufacturing v. Lewis, 131 Or App 267 (1994). Dr. Maloney, claimant's attending physician at the time of closure, had released claimant to full time regular work duties on August 13, 1996, and continued the release at the time of the closing examination. (Exs. 70, 72). Therefore, claimant's base functional capacity is equal to his residual functional capacity and the adaptability factor is 1. See OAR 436-035-0310(6).

In the closing examination, Dr. Maloney reported that claimant's lumbar flexion (using an inclinometer) was 36 degrees and extension was 10 degrees. (Ex. 72). Claimant is entitled to 9 percent unscheduled permanent disability for loss of flexion and extension. See OAR 436-035-0360 (19), (20).

In addition, Dr. Maloney reported that, although there was some reduction in sensation along the medial aspect of the left lower leg, it did not appear secondary to a specific dermatome. (Ex. 72). Based on Dr. Maloney's report, claimant is not entitled to an award of scheduled permanent disability. See OAR 436-035-0230(1) (loss of sensation in the leg is not considered disabling except for the plantar surface of the foot).

In sum, claimant has 9 percent impairment due to his compensable low back condition. Claimant's adaptability factor is rated as 1. We recalculate claimant's unscheduled permanent disability under the standards.

Since claimant is under 40 years of age, the appropriate value for his age is 0. OAR 436-035-0290(2). He is not entitled to a value for education. OAR 436-035-0300(2)(a). Claimant's job at injury was DOT # 669.280-010, which has an SVP rating of " 7." Therefore, claimant is entitled to a skills value of 1. OAR 436-035-0300(4).

The total value of claimant's age (0), education (0) and skills (1) is (1). That value is multiplied by the adaptability value of (1) for a total of 1. OAR 436-035-0280(6). When this value is added to the value for impairment (9), the result is 10. OAR 436-035-0280(7). Therefore, claimant's unscheduled permanent disability is 10 percent (32 degrees). Consequently, we modify the ALJ's order to increase claimant's unscheduled permanent disability award from 9 percent to 10 percent.

Because our order has resulted in increased compensation, claimant's attorney is entitled to an attorney fee in the amount of 25 percent of the increased compensation created by this order not to exceed $3,800. See ORS 656.386(2); OAR 438-015-0055(1). In the event that a portion of this substantively increased permanent disability award has already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed in Jane A. Volk, 46 Van Natta 681, on recon 46 Van Natta 1017 (1994), aff'd Volk v. America West Airlines, 135 Or App 565 (1995).

ORDER

The ALJ's order dated June 16, 1997 is reversed in part and modified in part. That portion of the ALJ's order that set aside the Order on Reconsideration as premature is reversed. The ALJ's "out-of-compensation" attorney fee award is reversed. The Order on Reconsideration is reinstated. In lieu of the Order on Reconsideration's 9 percent (28.8 degrees) permanent disability award, the Notice of Closure award of 10 percent (32 degrees) unscheduled permanent disability is reinstated and affirmed. Claimant's attorney is awarded an approved attorney fee equal to 25 percent of the increased compensation awarded by this order (the 1 percent unscheduled permanent disability, between the Order on Reconsideration and this order), not to exceed $3,800, payable directly to claimant's attorney. In the event the increased compensation has already been paid to claimant, claimant's attorney may seek recovery of the fee in accordance with the procedures set forth in Jane A. Volk. The self-insured employer's denial of claimant's aggravation denial is set aside and the claim is remanded to the employer for processing according to law. For services at hearing and on review concerning the aggravation claim, claimant's attorney is awarded $4,500, payable by the employer.

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In the Matter of the Compensation of
**NORMAN L. SELTHON, Claimant**
WCB Case No. 97-02627
ORDER ON REVIEW
Charles Robinowitz, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Mongrain's order that affirmed an Order on Reconsideration which awarded 34 percent (108.8 degrees) unscheduled permanent disability for claimant's lumbosacral strain condition. On review, the issue is extent of unscheduled permanent disability.

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

We agree with the ALJ that Dr. Smith's opinion concerning claimant's residual functional capacity (i.e., his unexplained 100 pound lifting limit) is less persuasive than those of the treating doctors. In reaching this conclusion, we note that claimant experienced ongoing back symptoms upon his return to work (when he lifted up to 50 pounds, occasionally up to 100 pounds). Under these circumstances (as well as those set out by the ALJ), we find that the treating doctors' 30 pound lifting limit is more consistent with claimant's clinical history. (See Exs. 6-6, 8, 9, 9A, 10). Accordingly, we conclude that claimant's residual functional capacity is "medium/light."

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

ORDER

The ALJ's order dated July 21, 1997 is affirmed. For services on review, claimant is awarded a $750 attorney fee, payable by the insurer.

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In the Matter of the Compensation of
**LORETA C. SHERWOOD, Claimant**
WCB Case Nos. 96-01702 & 95-12804
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Nancy J. Meserow, Defense Attorney

Reviewed by Board Memers Moller and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) upheld the self-insured employer's partial denial of her claim for tarsal tunnel syndrome; and (2) declined to award a $2,800 assessed attorney fee for claimant's counsel services concerning the employer's appeal of the November 17, 1995 Order on Reconsideration. The employer cross-requests review of that portion of the ALJ's previous order that affirmed the November 17, 1995 Order on Reconsideration, which set aside a July 19, 1995 Notice of Closure as premature. On review, the issues are compensability, premature closure and attorney fees. We reverse in part and affirm in part.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact from the May 29, 1996 and May 2, 1997[1] orders with the following changes. In finding of fact number 1, after the first paragraph and before the quotation from Exhibit 36-1, we add this phrase: "In a subsequent letter, claimant explained:" In finding of fact number 8, we change the first sentence to read: "Dr. Rosenbaum recorded a history at odds with the aforementioned histories: 'John's foot kicked her right medial foot, causing the foot to externally rotate.'" In finding of fact number 9, we delete the last sentence. In finding of fact number 10, after the first two sentences, we add: "Dr. Fitchett explained:" In finding of fact number 14, we change the third sentence to read: "Dr. Bald explained that a positive response to Tinel's testing was not a valid diagnostic criteria in this case."

## CONCLUSIONS OF LAW AND OPINION

### Compensability

Claimant sustained an injury at work on July 2, 1994. The employer accepted a right foot strain with plantar fasciitis. (Ex. 6). Claimant continued to have symptoms in her right foot. On April 4, 1996, the employer issued a partial denial of the claim for tarsal tunnel syndrome, on the basis that neither claimant's employment nor her accepted claim for right foot strain with plantar fasciitis had caused the tarsal tunnel syndrome. (Ex. 49). Claimant requested a hearing.

On May 29, 1996, the ALJ concluded that claimant had failed to prove that the tarsal tunnel syndrome, if it existed, was related to her compensable injury. On review, claimant requested that the matter be remanded for the admission of further medical evidence. The proffered evidence, all of which was generated "post-hearing," concerned claimant's September 1996 tarsal tunnel release surgery. We concluded that the proffered evidence concerned claimant's disability and the evidence submitted by claimant was not obtainable, with due diligence, at the time of hearing. Loreta C. Sherwood, 49 Van Natta 92 (1997). We also concluded that the proffered evidence was reasonably likely to affect the outcome of the case. Therefore, we remanded the case to the ALJ for further development of the compensability issue. In addition, because the premature closure and attorney fee issues could be affected by the decision concerning the compensability of claimant's foot condition, those matters were also remanded to the ALJ.

On remand, the ALJ admitted additional evidence, including new testimony, and adhered to his earlier conclusion that claimant failed to prove that the tarsal tunnel syndrome was compensable. The ALJ did not address the premature closure and attorney fee issues.

The employer argues that claimant failed to prove the existence of tarsal tunnel syndrome. Alternatively, even if claimant does have tarsal tunnel syndrome, the employer contends that Dr. Weller's theory of causation is not persuasive.

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[1] We note that the ALJ's second order was incorrectly dated "May 2, 1996."

Claimant contends that her accepted July 2, 1994 injury directly caused her tarsal tunnel syndrome. She does not argue that her tarsal tunnel syndrome is a consequential condition of her accepted right foot strain with plantar fasciitis. See ORS 656.005(7)(a)(A). Claimant asserts that the preponderance of medical opinion supports the diagnosis of tarsal tunnel syndrome and she relies on Dr. Weller's opinion to contend that the tarsal tunnel syndrome is compensable.

We need not address whether claimant has proved the existence of tarsal tunnel syndrome because, even if we assume that she did, we are not persuaded that claimant's condition is compensable.

Our first task is to determine which provisions of the Workers' Compensation Law are applicable. Dibrito v. SAIF, 319 Or 244, 248 (1994); Daniel S. Field, 47 Van Natta 1457 (1995). Claimant is correct that, if her tarsal tunnel syndrome arose directly from her July 1994 injury, the tarsal tunnel syndrome condition would not be treated as "consequential" for purposes of ORS 656.005(7)(a)(A). See Wheeler v. Liberty Northwest Ins. Corp., 148 Or App 301, 307 (1997).

Here, the problem with claimant's argument is that Dr. Weller's opinion does not support claimant's argument that the July 2, 1994 injury directly caused the tarsal tunnel syndrome. In Dr. Weller's January 25, 1996 report, she concluded that claimant's work injury was the major contributing cause of the tarsal tunnel syndrome. (Ex. 47). Dr. Weller explained:

> "I have reviewed literature and enclosed a copy of the article that is pretty consistent with others describing trauma as a cause of tarsal tunnel. In these cases, they describe tarsal tunnel developing probably secondary to hemorrhage within the tunnel and subsequent development of adhesions and scar tissue. This does not require such a significant injury that would result in fracture." (Id.)

Based on Dr. Weller's opinion, claimant's tarsal tunnel syndrome is related to hemorrhage within the tunnel and the subsequent development of adhesions and scar tissue. Thus, the tarsal tunnel syndrome developed secondarily as a consequence following hemorrhaging, scar tissue and adhesions. Therefore, based on Dr. Weller's opinion, claimant's tarsal tunnel syndrome is most appropriately analyzed as an indirect consequence of her work injury and its sequelae. There are no other medical opinions that support claimant's argument that the July 2, 1994 injury directly caused the tarsal tunnel syndrome. Accordingly, we analyze the claim as a consequential condition. Claimant must establish that the July 2, 1994 injury is the major contributing cause of the tarsal tunnel syndrome.

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). In this case, we find persuasive reasons to do otherwise.

Dr. Weller first examined claimant on July 21, 1995, more than one year after the work injury. Dr. Weller explained the injury as follows:

> "[Claimant] reports that she had just served an order and was walking with the tray at her side when she collided with somebody else. She reports that this other person caught her right foot in the area of the medial arch. She reports that her whole foot and lower leg twisted, and she started to lose her balance, but was able to catch it without falling." (Ex. 28-1).

Dr. Weller diagnosed "? posterior tarsal tunnel syndrome vs. plantar fasciitis." (Ex. 28-2). She recommended electrodiagnostic studies with nerve conduction studies to evaluate the tarsal tunnel syndrome.

Dr. Weller performed an electrodiagnostic exam on September 20, 1995 and reported there was evidence of tarsal tunnel syndrome with conduction block of the tibial nerve. (Ex. 34).

On January 25, 1996, Dr. Weller reported that, based on claimant's history and electrodiagnostic studies, she diagnosed tarsal tunnel syndrome. (Ex. 47). She concluded that claimant's work injury was the major contributing cause of the tarsal tunnel syndrome. As mentioned earlier, Dr. Weller referred to an article describing trauma as a cause of tarsal tunnel syndrome and she explained that the cases "describe tarsal tunnel developing probably secondary to hemorrhage within the tunnel and subsequent development of adhesions and scar tissue." (Id.)

Dr. Weller later reported that it was more probable than not that claimant's injury "with the co-worker's right foot striking [claimant's] right instep with sufficient force to cause a twisting and subsequent stumbling was sufficient to cause tarsal tunnel syndrome." (Ex. 51).

Dr. Jones performed a right tarsal tunnel release on September 30, 1996. (Ex. 56C). Dr. Jones reported that he did not expose the nerve and "could not appreciate any masses or any evidence of neural abnormality such as a tumor." (Id.) Dr. Jones refused to become involved in the compensability dispute.

Dr. Weller reviewed Dr. Jones' operative report and follow-up chart notes. Her diagnosis continued to be tarsal tunnel syndrome. (Ex. 58). Dr. Weller acknowledged that there was nothing specific in Dr. Jones' report that would confirm the impression of the work injury as a source of claimant's symptoms.

In evaluating medical opinions, we generally rely on the opinion of a worker's treating physician, because of his or her opportunity to observe the claimant over an extended period of time. See Weiland, 64 Or App at 814. Here, however, Dr. Weller did not examine claimant until more than one year after the injury. Moreover, Dr. Weller saw claimant on only two occasions. (Exs. 28, 34). Under these circumstances, we do not grant any particular deference to Dr. Weller's opinion.

We are not persuaded by Dr. Weller's opinion because it is not well-reasoned and lacks adequate explanation. In Dr. Weller's January 25, 1996 report, she explained that trauma had caused claimant's tarsal tunnel syndrome and it had probably developed secondary to hemorrhage within the tunnel and subsequent development of adhesions and scar tissue. (Ex. 47). However, Dr. Jones' operative report did not refer to any adhesions or scar tissue. (Ex. 56C). Although Dr. Jones did not expose the nerve, he said it appeared without overt constriction or enlargement in size. (Id.) Dr. Weller acknowledged that there was nothing specific in Dr. Jones' operative report that would confirm the fact that claimant sustained a work injury as a source of her symptoms. (Ex. 58). Under these circumstances, we are not persuaded by Dr. Weller's theory of the case and we conclude that her opinion is insufficient to establish that claimant's July 1994 work injury was the major contributing cause of the tarsal tunnel syndrome.

There are no other medical opinions that establish compensability of claimant's tarsal tunnel syndrome. Drs. Bald and Rosenbaum were not persuaded that claimant even had tarsal tunnel syndrome. Dr. Bald reported that, even if claimant had tarsal tunnel syndrome, it did not relate to the July 2, 1994 injury that she described. (Exs. 44-5, 45). Dr. Bald said that the tarsal tunnel syndrome "does not come anywhere close to explaining the full gamut of her pain complaints." (Ex. 44-5). Dr. Bald noted that tarsal tunnel syndrome had been associated with other systemic inflammatory disease processes such as rheumatoid arthritis. (Id.)

In sum, we agree with the ALJ that, even if claimant has tarsal tunnel syndrome, she has failed to prove that it is compensable.

Premature Closure

The employer cross-requests review of that portion of the ALJ's previous order that affirmed the November 17, 1995 Order on Reconsideration, which set aside a July 19, 1995 Notice of Closure as premature.

On July 19, 1995, a Notice of Closure issued, awarding claimant temporary disability benefits and finding her medically stationary as of May 22, 1995. (Ex. 27). Claimant requested reconsideration and submitted additional information, including reports from Dr. Weller dated July 31, 1995 and September 20, 1995. (Exs. 37, 40). The employer objected to the additional documents. (Exs. 38, 42). Dr. Donahoo performed a medical arbiter examination. (Ex. 41).

An Order on Reconsideration issued on November 17, 1995, rescinding the July 19, 1995 Notice of Closure, as amended August 5, 1995.[2] (Ex. 43). The worksheet attached to the Order on Reconsideration indicated that the July 31, 1995 and September 20, 1995 reports from Dr. Weller and claimant's October 18, 1995 affidavit were considered in determining whether claimant's accepted right foot strain with plantar fasciitis was medically stationary at the time of claim closure. (Ex. 43-3). The worksheet referred to Dr. Donahoo's opinion that he could not conclude that no further treatment was necessary. (Id.) The Appellate Reviewer concluded that there was not a persuasive preponderance of medical evidence establishing that the accepted condition was medically stationary at the time of the July 19, 1995 claim closure. (Ex. 43-4).

The employer requested a hearing on the November 17, 1995 Order on Reconsideration. On May 29, 1996, the ALJ concluded that the closure was premature. The employer cross-requested review of that portion of the ALJ's order. On review, we remanded the case to the ALJ for consideration of additional evidence regarding the compensability issue. In addition, we remanded the premature closure and attorney fee issues.

In the meantime, a Notice of Closure issued on June 20, 1996, awarding temporary disability benefits and finding claimant medically stationary on March 14, 1996. (Ex. 54). Dr. Fitchett performed a medical arbiter examination. (Ex. 56). On October 18, 1996, an Order on Reconsideration issued, finding that claimant was medically stationary on May 22, 1995[3] and reducing claimant's temporary disability benefits to zero. (Ex. 57).

On remand, the ALJ admitted additional evidence, including the October 18, 1996 Order on Reconsideration, but the ALJ did not address the issue of premature closure in the May 2, 1997 Opinion and Order. At hearing, the employer's attorney said that WCB Case Number 96-10238 was assigned to the October 18, 1996 Order on Reconsideration and she was not prepared to proceed on that particular issue. (Tr. 7). The ALJ stated that the October 18, 1996 Order on Reconsideration was not at issue. (Id.) On review, the employer's attorney asserts that WCB Case Number 96-10238 is not part of the proceeding presently before the Board.

We begin by explaining the scope of our review. Under ORS 656.283(7), evidence not submitted at reconsideration concerning a claimant's medically stationary status at the time of claim closure is inadmissible at a subsequent hearing. Arlie B. Tompkins, 48 Van Natta 1664 (1996). Here, additional documents were admitted at the second hearing for purposes of deciding compensability. However, for purposes of addressing whether the November 17, 1995 Order on Reconsideration properly rescinded the July 19, 1995 Notice of Closure, we examine the evidence concerning claimant's medically stationary status that was submitted at the first reconsideration proceeding.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Whether an employer has prematurely closed a claim depends on whether the claimant was medically stationary on the date of closure, without consideration of subsequent changes in his or her condition. Hewlett-Packard Co. v. Leonard, 151 Or App 307 (1997).

Dr. Dinneen examined claimant on May 22, 1995 and determined that claimant was medically stationary, without objective evidence of permanent impairment or need for further treatment. (Ex. 16-3). Dr. Clawson agreed with Dr. Dinneen, as did Drs. Streitz, Daven and Daskalos. (Exs. 19, 20, 21, 33).

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[2] The record does not include the August 5, 1995 amendment to the July 19, 1995 Notice of Closure.

[3] The October 18, 1996 Order on Reconsideration stated that claimant's condition was found to be "medically stationary on May 22, 1996." (Ex. 57-2). However, the worksheet attached to the Order on Reconsideration stated that the June 20, 1996 Notice of Closure was amended to reflect the medically stationary date of May 22, 1995. (Ex. 57-4). The worksheet referred to the "May 22, 1995" date on three other occasions. Under these circumstances, we interpret the October 18, 1996 Order on Reconsideration to read that claimant's condition was found to be medically stationary on May 22, 1995.

The evidence considered at the first reconsideration included Dr. Weller's July 21, 1995 and September 20, 1995 reports. (Ex. 43-3). On July 21, 1995, Dr. Weller reported that claimant's current symptoms included pain in the right heel, primarily with weight bearing, and her symptoms were worse with normal activity. (Ex. 28). She diagnosed "? posterior tarsal tunnel syndrome vs. plantar fasciitis." (Ex. 28-2). Dr. Weller recommended electrodiagnostic studies with nerve conduction studies to evaluate for tarsal tunnel syndrome. (Id.) If those tests were normal, she suggested a bone scan to evaluate or rule out plantar fasciitis. If the bone scan was negative, Dr. Weller said that she would consider claimant medically stationary. (Id.) Dr. Weller performed an electrodiagnostic exam on September 20, 1995 and found evidence of tarsal tunnel syndrome with conduction block of the tibial nerve. (Ex. 34).

Dr. Donahoo performed a medical arbiter examination on November 9, 1995. (Ex. 41). He said that claimant did not have clinical evidence of a specific tarsal tunnel syndrome, although Dr. Weller's study indicated she had an entrapment neuropathy of the right posterior tibial nerve. (Ex. 41-4). Dr. Donahoo was unable to resolve the tarsal tunnel issue clinically and he recommended a repeat electrodiagnostic study. (Id.) Dr. Donahoo deferred deciding whether claimant was medically stationary or whether surgery was recommended until further tests had been performed. (Id.)

The issue here is whether claimant's accepted condition of right foot strain with plantar fasciitis was medically stationary, i.e., whether no further material improvement could reasonably be expected from medical treatment or the passage of time. Drs. Dinneen, Clawson, Streitz, Daven and Daskalos agreed that claimant's compensable condition was medically stationary. Although Dr. Weller's July 21, 1995 report indicated a bone scan might be necessary to evaluate plantar fasciitis (Ex. 28-2), her September 20, 1995 electrodiagnostic exam referred only to tarsal tunnel syndrome. (Ex. 34). We have previously held that, even if claimant has tarsal tunnel syndrome, the condition is not compensable. Dr. Weller's reports do not establish that further treatment was expected to materially improve claimant's compensable plantar fasciitis condition. Similarly, although Dr. Donahoo was unable to determine clinically whether claimant had tarsal tunnel syndrome and he recommended further tests, he did not indicate that further treatment was necessary to improve claimant's compensable plantar fasciitis condition. Under these circumstances, we conclude that claimant's compensable conditions were medically stationary at the time of the July 19, 1995 claim closure.

Attorney Fees

The ALJ's first order awarded an claimant's attorney a fee of $2,800 for successfully defending the employer's appeal of the November 17, 1995 Order on Reconsideration. On review, the Board remanded the attorney fee issue, although the ALJ did not address that issue.

Claimant contends that she is entitled to an attorney fee of $2,800 for the successful defense of the November 17, 1995 Order on Reconsideration. In light of our conclusion that the November 17, 1995 Order on Reconsideration should be reversed, we need not consider the appropriate amount of the attorney fee award.

ORDER

The ALJ's order dated May 29, 1996, as republished and supplemented on May 2, 1997, is reversed in part and affirmed in part. That portion of the ALJ's order that affirmed the November 17, 1995 Order on Reconsideration is reversed. The July 19, 1995 Notice of Closure is reinstated and affirmed. The ALJ's attorney fee award is reversed. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
**DEVIN D. COLE, Claimant**
WCB Case No. 96-10740
ORDER ON REVIEW
Foss, Whitty, et al, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Baker's order that: (1) set aside its denial of claimant's right knee injury claim; and (2) assessed a penalty for allegedly untimely discovery. On review, the issues are compensability and penalties. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the relevant facts.

In early 1996, claimant sought treatment for his right knee, following a football injury. His knee was sore for at least six weeks after this injury. (Ex. 1).

On September 24, 1996, claimant suffered another right knee injury when he slipped at work. He sought treatment for symptoms that included pain, popping, and laxity.

On October 12, 1996, claimant was pushed into a swimming pool during an off-work altercation. He experienced additional right knee symptoms after this incident. (Tr. 42, see Tr. 112).

On December 2, 1996, Dr. Matteri performed arthroscopic surgery on claimant's right knee. He discovered and repaired a detached posterior horn of the lateral meniscus, noting an old incomplete tear of the anterior cruciate ligament, which he did not repair.

Dr. Matteri provided the only expert evidence supporting the claim.

The ALJ set aside the employer's denial of claimant's injury claim, based on Dr. Matteri's opinion. In reaching this conclusion, the ALJ reasoned that there was no persuasive reason to discount Dr. Matteri's findings and opinions. We disagree.

Considering the number of potential causes identified for claimant's condition and 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). 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); Argonaut Insurance Company v. Mageske, 93 Or App 698 (1988). In this case, we find such reasons.

Claimant initially treated with Dr. Whitney after the work incident. Dr. Whitney believed that claimant had a linear tear of the medial meniscus. (Ex. 7).

Claimant began treating with Dr. Matteri on October 28, 1996. Based on claimant's clinical presentation and the lack of MRI findings indicating otherwise, Dr. Matteri opined that claimant's problem was a torn medial meniscus. (Ex. 16). However, during the December 2, 1996 surgery, Dr. Matteri discovered that the medial meniscus was intact, but the posterior horn of the lateral meniscus was detached, requiring removal.

Based on his operative notes and his recollection of the surgery, Dr. Matteri stressed the importance of the fact that the lateral meniscus tear appeared "fresh" and opined that the tear was not more than two or three months old at the time of surgery. (Exs. 53-28, -42). Considering the probable timing of the tear, Dr. Matteri concluded that the September work incident was the major contributing cause of claimant's subsequent need for treatment for his right knee. (Ex. 53-43).

We find Dr. Matteri's opinion insufficient to establish compensability, for the following reasons. First, although Dr. Matteri's surgical findings establish that the lateral meniscus tear was recent, that does not mean that it was work-related. Second, although Dr. Matteri opined that claimant did not have a preexisting right knee condition, this summary conclusion is at least potentially inconsistent with claimant's history of a late 1995 football injury. (See Exs. 1, 35, 53-46). In addition, we note that claimant did not tell Dr. Whitney about the football injury and Dr. Matteri did not evaluate its potential contribution to claimant's recent need for surgery.[1] (See Ex. 53-18-23).

Third, although Dr. Matteri opined that claimant's October 1996 off-work altercation did not affect claimant's right knee condition (due to the lack of findings of "acute" injury at his next examination), this conclusion is not consistent with claimant's testimony that everything he did hurt his knee, including the October incident. (See Tr. 42; Ex. 53-31; see also Ex. 53-33-34).

Fourth, considering claimant's multiple right knee injuries, we find that Dr. Matteri was not in a particularly good position to evaluate causation because he did not evaluate claimant's right knee immediately after the work injury. See McIntyre v. Standard Utility Contractors, Inc., 135 Or App 298, 302 (1995) ("A treating physician's opinion [ ] is less persuasive when the physician did not examine the claimant immediately following the injury.").

Fifth, because Dr. Matteri apparently based his causation opinion primarily on the timing of the work incident (i.e., the tear probably happened during the same time period as the work injury), we find his reasoning inadequately explained. See Bradshaw v. SAIF, 69 Or App 587, 589 (1984) (Causation not logically inferred from temporal sequence unless all other explanations excluded); Barbara J. James, 44 Van Natta 888, 889 (1992), aff'd mem James v. O'Rourke, 117 Or App 594 (1993) (An opinion based on consistency between the mechanism of injury, symptoms and the current diagnosis, without more, establishes only the possibility of a causal relationship) (citing Gormley v. SAIF, 52 Or App 1055 (1981).

Under these circumstances, we cannot say that Dr. Matteri's opinion is well-reasoned and based on an accurate and complete history. Thus, his conclusions are unpersuasive. See Somers v. SAIF, 77 Or App 259 (1986). Accordingly, in the absence of persuasive medical evidence supporting the claim, we uphold the employer's denial.[2] Finally, in light of our disposition, there are no "amounts then due" on which to base a penalty and no unreasonable resistance to the payment of compensation to support a penalty-related attorney fee. See Randall v. Liberty Northwest Ins. Corp., 107 Or App 599 (1991).

## ORDER

The ALJ's order dated August 8, 1997 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's penalty and attorney fee awards are reversed.

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[1] Dr. Matteri did opine that claimant's "old" anterior cruciate ligament tear did not contribute to his more recent lateral meniscus problems, after stating that he could not say whether the anterior cruciate ligament injury could have included injury to the lateral meniscus. (Exs. 53-27, 53-39-40)

[2] We would reach this conclusion regardless of the standard of proof under ORS 656.005(7)(a) or 656.005(7)(a)(B).

In the Matter of the Compensation of
**LESLIE A. CREWS, Claimant**
WCB Case No. 96-11168
ORDER ON REVIEW
Neil W. Jackson & Associates, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Bock and Moller.

The insurer requests review of Administrative Law Judge (ALJ) Tenenbaum's order that set aside its denial of claimant's injury claim for an L4-5 herniated disc condition. On review, the issue is compensability. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except for the last three paragraphs.

## CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the relevant facts.

Claimant worked for the employer as a building maintenance supervisor beginning in March 1996. Her job duties included inspecting work sites at the fifty banks serviced by the employer.

Claimant used a company car and pager. She was not required to perform her inspections on a set schedule.

On September 13, 1996, while en route to an inspection site, claimant was involved in a motor vehicle accident (MVA). She felt back stiffness within hours of the accident, first in her neck and upper back, later in her low back. She continued working through October 3, 1996, except that she left work early one day and she did not work on September 27, 1996. She experienced worsening back pain during this time.

Claimant vacationed in California from October 4 through October 7, 1997.

A December 10, 1996 MRI revealed a disc herniation at L4-5.

The ALJ found that claimant was in the course and scope of her employment when she was injured in the September 13, 1996 MVA. Based on the medical evidence, the ALJ also concluded that claimant carried her burden of proof by establishing that the MVA was the major (or material) contributing cause of her subsequent disability and need for treatment for her back. We disagree.[1]

The medical evidence indicates that claimant had preexisting degenerative changes in her lumbar spine which combined with the effects of the MVA to cause her subsequent disability and need for treatment. Under these circumstances, claimant must prove that the work injury was the major contributing cause of her combined condition. ORS 656.005(7)(a)(B).[2]

Because claimant's current condition is a combined condition involving preexisting degeneration, 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).

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[1] We need not address whether claimant was in the course and scope of her employment when she was injured because, even if she was, she has not established medical causation, as explained herein.

[2] We find no persuasive evidence indicating that claimant's current need for treatment for her low back is medically separable from her combined low back condition.

The medical evidence concerning causation is provided by Dr. Winans, treating physician, Dr. Mawk, consulting neurosurgeon, and Dr. Farris, independent examiner. All three doctors initially opined that the MVA caused claimant's herniated disc. (Exs. 20, 22, 23).

Later, Dr. Mawk explained that the disc could have herniated before the MVA and the MVA may have merely rendered it symptomatic. (Exs. 29-7, -12). Although the MVA could have caused the herniation, Dr. Mawk noted that claimant certainly had a preexisting degenerative condition which contributed to the herniation. (Ex. 29-7, -12-13). Dr. Mawk further explained that most of claimant's post-injury combined condition anatomically preexisted the MVA. Although the injury probably made the condition "a little bit worse," Dr. Mawk essentially concluded that the injury was not the major contributing cause of the combined condition. (Ex. 29-16-17). We find Dr. Mawk's well-reasoned opinion persuasive.

Dr. Winans acknowledged that a traumatic incident might or might not cause a sudden onset of disc-related pain. (Ex. 28-26). He also opined that claimant is a very stoic person. In our view, Dr. Winans' observations support only a possibility that claimant's herniated disc is primarily injury-related.[3] 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).

Finally, we note that Dr. Farris' ultimate opinion is not persuasive, because it is based in part on an inaccurate history that claimant's work duties included heavy construction work. (Ex. 26). Accordingly, finding no persuasive medical evidence adequate to establish medical causation, we conclude that the claim must fail.

ORDER

The ALJ's order dated June 19, 1997 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

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[3] Dr. Winans' previous and subsequent opinions, (Exs. 22, 30, 31), are not persuasive, because they are inadequately explained.

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In the Matter of the Compensation of
**KARA HOLMSTEN, Claimant**
WCB Case No. 96-07850
ORDER ON REVIEW
G. Joseph Gorciak III, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that dismissed claimant's request for hearing. In her brief, claimant also moves for remand. On review, the issues are remand and the propriety of the ALJ's dismissal.

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

On May 2, 1997, the ALJ convened the scheduled hearing in this case. Neither claimant nor her former counsel appeared. Based on the failure to appear, the ALJ issued an order dismissing claimant's request for hearing. The order also stated that claimant could move for reconsideration by submitting written documentation showing good cause for the failure to appear.

On May 22, 1997, claimant's former attorney moved for postponement. The letter stated that counsel had left for vacation on April 24, 1997, and, "several months" before that date, wrote to the Hearings Division asking that no hearings be set during April 24 through May 6, 1997. The letter further stated that, on April 25, 1997, counsel telephoned his office and spoke with his legal assistant; the assistant told him that he had taken another job and his last day of employment would be the

following Monday, April 27, 1997. According to the letter, counsel "wrongly assumed" that the legal assistant had arranged to postpone the hearing and that the assistant "forgot to postpone this" hearing; nevertheless, the assistant notified claimant that the hearing was postponed. Finally, the letter stated that "the facts in this particular case lends itself to a finding that the circumstances were extraordinary in the sense that my employee suddenly left without warning while I was out of town and essentially left my office unmanned."

The ALJ determined that such facts did not warrant a finding of extraordinary circumstances beyond the control of the party requesting the postponement. See OAR 438-006-0081(2).[1] In particular, the ALJ found that the legal assistant's failure to carry out counsel's instructions to postpone the case was not "excusable neglect." The ALJ also found that there was inadequate evidence to find that the vacation itself constituted "extraordinary circumstances."

Claimant asserts that the ALJ erred by granting the insurer's motion at hearing to dismiss claimant's request for hearing. According to claimant, "that process apparently violated OAR 438-006-0045" because the motion was not in writing and served upon claimant, nor was claimant provided an opportunity to provide a written response.

Under OAR 438-006-0045, unless otherwise agreed by the parties and ALJ, "pre or post hearing motions shall be filed in writing and copies shall be simultaneously served on all parties or their attorneys" and "ten days after filing [the opposing party] shall be allowed for written response to a motion." Here, the ALJ's order states that, at the scheduled hearing, the insurer moved to dismiss and he granted the motion.

The rule applying to dismissal, however, provides:

> "Unjustified failure of a party or the party's representative to attend a scheduled hearing is a waiver of appearance. If the party that waives appearance is the party that requested the hearing, the Administrative Law Judge shall dismiss the request for hearing as having been abandoned unless extraordinary circumstances justify postponement or continuance of the hearing." OAR 438-006-0071(2).

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[1] OAR 438-006-0081 pertains to postponement and provides:

"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' shall not include:

"(1) Failure of the insurer or self-insured employer to refer or delay in referring the case or any pertinent information to its representative;

"(2) Unavailability of a party, witness (other than a medical expert witness) or representative due to nonemergency medical or dental appointment, occupational, personal or professional business or appointments, or unwillingness to appear, provided that a postponement may be granted if the unavailable person is a worker who is temporarily working out of state and is reasonably expected to return to the state within a time certain or is a person who has been duly subpoenaed and has failed to comply with the subpoena;

"(3) An attorney's, party's, representative's or witness' conflict with administrative proceedings scheduled more than three days after mailing of the notice of hearing;

"(4) Incomplete case preparation, unless the Administrative Law Judge finds that completion of the record could not be accomplished with due diligence. A subpoena of a medical expert witness is not required to satisfy due diligence.

"(5) For purposes of this rule, 'due diligence' shall include, but not be limited to, the unavailability of a medical or vocational expert witness for cross-examination by deposition/interrogatories prior to a scheduled hearing, provided that the request for cross-examination was made no later than seven (7) days after the requesting party received from another party a copy of a report from the medical or vocational expert witness accompanied by written notice that the sending party is submitting the report as a proposed exhibit for admission into evidence at a scheduled hearing."

As this rule states, a motion is not a necessary prerequisite for the ALJ to dismiss the request for hearing. Instead, the ALJ is required to dismiss "unless extraordinary circumstances justify postponement or continuance of the hearing." In this case, no extraordinary circumstances were provided at hearing to justify postponement or continuance. Consequently, whether or not the insurer moved to dismiss, the ALJ properly dismissed the request for hearing. See OAR 438-006-0071(2).

On review, claimant also moves to remand the case to the ALJ. In particular, she contends that the record was inadequately developed concerning the following facts: whether claimant received "actual notice" of the hearing; former counsel's efforts to inform the Hearings Division concerning his vacation schedule; and the details surrounding former counsel's vacation, including its necessity and whether it could be delayed.

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 fails to show that any of the additional evidence upon which she bases her motion for remand was not obtainable at the time of hearing. Claimant's motion is based upon obtaining more information from claimant and her former attorney concerning counsel's efforts to inform the Hearings Division concerning his scheduled vacation and the circumstances surrounding his vacation. As discussed above, following the ALJ's first order dismissing claimant's request for hearing, claimant was provided the opportunity to submit documentation concerning the failure to appear at the scheduled hearing, and claimant's former counsel provided such documentation by explaining why he and claimant failed to appear. Thus, there is no basis for finding that the additional evidence claimant seeks to admit was not obtainable at the time of hearing.

Furthermore, we find that the evidence is not reasonably likely to affect the outcome of the hearing. First, although it is not direct evidence, we find that the record shows that claimant did have "actual notice" of the scheduled hearing; the hearing notice was mailed to claimant and her former counsel's legal assistant informed her (erroneously) that the scheduled hearing was postponed.

Additionally, even if claimant could prove definitively that her former attorney had informed the Hearings Division about his vacation schedule and his vacation was necessary and could not be delayed, claimant does not dispute the following facts: her former attorney left on vacation without knowing that the hearing had been postponed and his legal assistant did not seek to postpone the hearing in counsel's absence. Thus, even with proof that claimant's former attorney gave notice of his vacation schedule to the Hearings Division and his vacation was unavoidable, for the reasons expressed by the ALJ, we would continue to conclude that there are no "extraordinary circumstances" for justifying a postponement.[2]

Thus, having found that the additional evidence claimant seeks was obtainable at hearing and is not reasonably likely to affect the outcome, we deny her motion to remand.

ORDER

The ALJ's order dated May 13, 1997, as reconsidered September 2, 1997, is affirmed.

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[2] Claimant does not assert that her former attorney was not authorized to represent her interests at the time of the hearing. 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). In this regard, because we affirm the ALJ's order of dismissal, it appears that claimant's dispute is now with her former attorney rather than this forum.

In the Matter of the Compensation of
**NORMA J. JOHNSON, Claimant**
WCB Case No. 97-00733
ORDER ON REVIEW
John C. Dewenter, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Crumme's order that: (1) reduced its request to apply an alleged overpayment; and (2) awarded claimant's counsel an insurer-paid attorney fee under ORS 656.382(2). On review, the issues are overpayment and attorney fees. We reverse.

## FINDINGS OF FACT

In March 1993, claimant injured his back and left leg while working for the employer. Claimant's injuries were accepted by the insurer. His claim was first closed by a November 12, 1993 Determination Order that awarded 35 percent unscheduled permanent disability and 4 percent scheduled permanent disability for the left leg. The insurer requested reconsideration and a February 3, 1994 Order on Reconsideration modified claimant's award of scheduled permanent disability to award 5 percent for the left foot.

Claimant's claim was subsequently reopened and closed by an August 9, 1994 Determination Order, which granted claimant 14 percent scheduled permanent disability for the left leg in lieu of the prior 5 percent scheduled award for the left foot. A March 9, 1995 Order on Reconsideration modified the Determination Order and reduced claimant's award of scheduled permanent disability to the 5 percent award, for the left foot, that had been previously granted. By stipulation dated June 6, 1995, claimant's award of scheduled permanent disability was increased to 10 percent for the left leg. In addition, the parties agreed that the insurer had incurred an overpayment of permanent disability benefits in the amount of $1,893.78.

In March 1996, claimant's claim was reopened. Thereafter, on August 28, 1996, the insurer issued a Notice of Closure that awarded claimant temporary disability benefits and indicated that claimant was not entitled to additional unscheduled permanent disability beyond the 40 percent previously awarded. The Notice of Closure also indicated that claimant's total scheduled permanent disability award to date was 15 percent of the left leg, and that "[f]or this open period, no additional compensation is due." Claimant requested reconsideration of the Notice of Closure.

By letter dated September 4, 1996, the insurer informed claimant that it still had an overpayment in the amount of $1,893.78 as well as an additional overpayment in the amount of $2,001.01 for a total overpayment of $3,894.79.

On January 9, 1997, an Order on Reconsideration issued that affirmed the August 28, 1996 Notice of Closure. The Order on Reconsideration calculated claimant's award of scheduled permanent disability to be 7 percent of the left leg. However, because claimant had received an award in excess of 7 percent through the parties' June 6, 1995 stipulation, claimant's award of scheduled permanent disability was not reduced.

During the 52-week period prior to her injury, claimant worked for the employer at its public school as a cook during the school year and as a janitor during portions of the summer. Her rate of pay as a cook was $9.14 per hour. She regularly worked 40 hours per week as a cook with irregular overtime. The insurer calculated claimant's average weekly wage as $365. The insurer later recalculated claimant's average weekly wage as $251.70 and adjusted her temporary disability benefits accordingly.

Claimant's total wages from the employer during the 52 weeks prior to her injury were $13,636.69, including $268.14 for summer janitor work and $25.60 for overtime. Her average weekly wage for those 52 weeks, excluding overtime, was $261.75.

Claimant requested a hearing raising the issues of temporary disability, rate of temporary disability and penalties for failure to pay benefits. In addition, claimant appealed the Order on Reconsideration, contesting the awards of temporary disability, scheduled permanent disability, and

unscheduled permanent disability. In his Opinion and Order, the ALJ framed the issue as concerning the insurer's request for an offset. Specifically, the parties litigated the correct amount of scheduled permanent disability awarded by the Order on Reconsideration and the correct rate of claimant's temporary disability benefits.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that the Notice of Closure, which was affirmed by the Order on Reconsideration, had increased claimant's award of scheduled permanent disability. Because the insurer did not request a hearing contesting the award of scheduled permanent disability, the ALJ concluded that the insurer was not entitlement to offset the requested amount of "overpaid" scheduled permanent disability. We disagree.

As a preliminary matter, while claimant's initial hearing request raised substantive issues concerning the Order on Reconsideration, the ultimate issues litigated by the parties do not arise directly from the Order on Reconsideration.[1] In other words, the dispute involves claimant's objections to the insurer's claimed overpayment and is not an appeal of the Order on Reconsideration. Rather, the dispute concerns enforcement of the Order on Reconsideration, *i.e.*, what benefits were awarded by that order's affirmance of the Notice of Closure. Therefore, in order to resolve this issue, we examine the closure orders.

To begin, the Notice of Closure does not indicate that it was awarding claimant any additional scheduled permanent disability benefits. Rather, it merely recited claimant's award to date, albeit incorrectly, and specifically indicated that no "additional compensation is due." (Ex. 53). Thereafter, claimant appealed the Notice of Closure, contending, *inter alia*, that she was entitled to additional scheduled permanent disability.

The Order on Reconsideration evaluated claimant's scheduled permanent disability and determined that claimant was only entitled to an award of 7 percent. (Ex. 58-2). The Order on Reconsideration did not reduce claimant's award, however, because claimant had been previously awarded in excess of 7 percent. (Id.) This is consistent with OAR 436-035-0007(11), which does not allow for a reduction in these circumstances. Moreover, the Order specifically identified claimant's prior award as being granted in the June 6, 1995 stipulation wherein claimant had been awarded 10 percent scheduled permanent disability. (Ex. 34). Based on the above, we conclude that claimant was not awarded an additional 5 percent scheduled permanent disability, for the loss of use or function of the right leg, by the Order on Reconsideration.

Inasmuch as claimant was not awarded an additional 5 percent scheduled permanent disability, it necessarily follows that the insurer's failure to request a hearing contesting the "award" does not preclude it from asserting an offset. Moreover, because neither party contested the merits of the Order on Reconsideration, the prohibition concerning the raising of new issues set forth in ORS 656.283(7) is not applicable here. Rather, as noted earlier, the dispute concerns the "enforcement" of the Order on Reconsideration, which necessarily requires an inquiry into what benefits were awarded by the Order on Reconsideration.

Because we have concluded that claimant was not awarded any additional scheduled permanent disability and because this ground was claimant's only basis for her objection to the insurer's claimed overpayment, it follows that the insurer's overpayment has been established. Therefore, we authorize the insurer's offset in the amount of $1,893.78.

Finally, because we have found that claimant was not awarded additional scheduled permanent disability benefits, claimant's counsel is not entitled to the $600 assessed attorney fee awarded by the ALJ.

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[1] As noted in the "Findings of Fact," claimant's request for hearing did contest the merits of the Order on Reconsideration. However, the issues framed by the ALJ's order concern offset and rate of temporary disability benefits, neither of which was addressed by the Order on Reconsideration. The ALJ's framing of the issues is not contested by either party on review.

ORDER

The ALJ's order dated August 1, 1997 is reversed in part and affirmed in part. That portion of the ALJ's order which reduced the insurer's offset based on an increased award of scheduled permanent disability is reversed. The insurer is authorized an offset in the amount of $1,893.78, to be recovered from claimant's compensation awards in the manner prescribed in ORS 656.268 (14) and (15). The ALJ's award of a $600 assessed attorney fee is reversed. The remainder of the order is affirmed.

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February 6, 1998 Cite as 50 Van Natta 199 (1998)

In the Matter of the Compensation of
**GERRARDO ALCANTAR-BACA, Claimant**
WCB Case No. 97-02281
ORDER ON REVIEW
Emmons, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Bock and Haynes.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Nichols' order that reclassified claimant's claim from nondisabling to disabling. On review, the issue is claim reclassification. We reverse.

FINDINGS OF FACT

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

Claimant injured his right ankle on May 10, 1995. He reported the incident, but did not seek medical treatment or file a claim until April 8, 1996. On June 14, 1996, the insurer accepted a right ankle sprain as a nondisabling claim. On August 22, 1996, claimant requested reclassification from nondisabling to disabling. On April 16, 1997, the Division issued a Proposed and Final Order dismissing claimant's request for reclassification for lack of jurisdiction, as the request for reclassification was made more than one year after the date of injury. Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Relying on DeGrauw v. Columbia Knit, 118 Or App 277 (1993), and Donald R. Dodgin, 45 Van Natta 1642 (1993), the ALJ found that claimant's request for reclassification was properly before the Hearings Division and concluded that, because claimant's claim became disabling within one year of the date of injury, that the claim should be reclassified as disabling. On review, the insurer contends that claimant's request for reclassification is time-barred and should be made as a claim for aggravation. We agree.

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."

Here, claimant compensably injured his ankle on May 10, 1995, but did not file an injury claim until April 8, 1996. On June 14, 1996, the insurer accepted a right ankle sprain as a nondisabling claim. On August 22, 1996, more than one year after the date of injury, claimant requested reclassification from nondisabling to disabling. Therefore, his request is barred under ORS 656.277(1) and, under ORS 656.277(2), claimant must make his claim as a claim for aggravation.

Claimant, relying on DeGrauw v. Columbia Knit and its progeny, contends that he is excused from compliance with the one-year rule. Claimant's reliance on DeGrauw is misplaced. In DeGrauw, the claimant was injured in August 1989. In February 1990, the insurer accepted the claim as "disabling." In September 1990, more than one year after the date of injury, the insurer issued a second acceptance, in which it classified the claim as "nondisabling." Claimant requested a hearing, protesting the insurer's reclassification of the claim.

The court held that, if a carrier wishes to reclassify a claim from disabling to nondisabling, it must do so within sufficient time to permit the claimant to challenge the reclassification within one year from the date of the injury, or it must process the claim to closure, which can then be reconsidered by the Department. The court reasoned that if the insurer were allowed to reclassify a claim more than one year after the date of injury, then claimant would be deprived of his opportunity to seek redress through no fault of his own.

In this case, unlike in DeGrauw, claimant did not file an injury claim until eleven months after his injury. The insurer had 90 days in which to accept the claim as either disabling or nondisabling. ORS 656.262(6)(a). The insurer's timely acceptance of claimant's claim as nondisabling issued more than one year after claimant's injury. Thus, claimant's request for reclassification more than one year after the date of injury was primarily the consequence of his own late filing, and not because he was prevented from timely requesting reclassification from the Department due to inactions of the carrier.[1]

Accordingly, because claimant requested reclassification more than one year after the date of injury, his request is barred under ORS 656.277(1) and he is required to prove a valid aggravation claim under ORS 656.277(2).

ORDER

The ALJ's order dated July 10, 1997 is reversed in part and affirmed in part. Those portions of the order that reclassified claimant's claim from nondisabling to disabling and awarded an approved attorney fee are reversed. The remainder of the order is affirmed.

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[1] Admittedly, had the insurer responded to the claim within approximately 30 days of the filing of the claim, claimant might have had a few days to challenge the nondisabling classification. Nevertheless, because the insurer was within its statutory authority in responding to the claim some 60 days after the filing of the claim, we are not prepared to hold that such conduct permits us to ignore the statutory parameters of ORS 656.277(1) and (2).

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In the Matter of the Compensation of
**REBECCA S. PITTS, Claimant**
WCB Case No. 97-05645
ORDER ON REVIEW
Rasmussen, et al, Claimant Attorneys
Cummins, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order that: (1) found that claimant's left shoulder injury claim was not prematurely closed; and (2) affirmed an Order on Reconsideration awarding claimant no permanent disability. On review, the issues are premature closure and extent of unscheduled permanent disability.

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

Dr. Manuele, upon whose opinion claimant relies to establish that her claim was prematurely closed, suggests that there is "a possibility" and "a chance" that claimant's condition could improve with additional manipulative treatment. In light of the countervailing evidence, Dr. Manuele's report does not persuasively establish a reasonable expectation of further improvement. Therefore, even if Dr. Manuele's opinion were addressed to claimant's accepted condition, it does not establish that claimant's claim was prematurely closed

ORDER

The ALJ's order dated October 27, 1997 is affirmed.

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February 6, 1998 Cite as 50 Van Natta 201 (1998)

In the Matter of the Compensation of
**JAMES L. ANDERSON, Claimant**
WCB Case No. 96-08613
ORDER ON REVIEW
Brothers, 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) Nichols' order that: (1) found that the Hearings Division had jurisdiction over claimant's request for hearing; and (2) set aside the insurer's denial of claimant's current low back condition. On review, the issues are jurisdiction and compensability.

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

On review, the insurer continues to assert that it denied only medical services and, thus, the Hearings Division lacks jurisdiction pursuant to SAIF v. Shipley, 147 Or App 26, rev allowed 326 Or 57 (1997) (Board lacks jurisdiction where the claimant seeks only medical services related to compensable injury).

Subsequent to the ALJ's order, 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). Jacqueline J. Rossi, 49 Van Natta 1844 (1997). We distinguished this situation from the court's decision in Shipley, where the claimant sought only medical services for a compensable condition, reasoning that because the dispute concerned the compensability of a new condition, it necessarily involved the denial of an "underlying" claim. See also Charles Bertucci, on recon 49 Van Natta 1833 (1997) (Hearing Division has jurisdiction over medical services dispute where the claimant was seeking to establish compensability of a new condition under ORS 656.802).

Here, the insurer accepted a "lumbar strain." (Ex. 75). Claimant's treating neurosurgeon, Dr. Newby, then diagnosed a herniated disc at L2-3 and recommended surgery. The insurer issued a denial of claimant's "current condition and need for treatment, as well as the requested discectomy and fusion L3-L2." (Ex. 81-1). The denial also provided that there was no effect on "any treatment due and reasonable [sic] to your accepted lumbar strain." (Id.)

Based on this evidence, we find that this proceeding concerns compensability of a "new" condition. That is, claimant is not merely seeking medical services for his accepted lumbar strain but is attempting to prove the compensability of his herniated disc condition. Furthermore, the insurer denied claimant's "current condition," which necessarily included the herniated disc condition. Thus, we agree with the ALJ that the insurer denied a new condition or an "underlying" claim and we have jurisdiction.

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 insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated June 30, 1997 is affirmed. For services on review, claimant's attorney is awarded an assessed attorney fee of $1,000, to be paid by the insurer.

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In the Matter of the Compensation of
**OLIVER E. PRITCHARD, Claimant**
WCB Case Nos. 96-08632 & 96-04989
ORDER ON REVIEW
W. Daniel Bates, Jr., Claimant Attorney
Zimmerman, et al, Defense Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Liberty Northwest Insurance Corporation, on behalf of the employer, Triple T Studs Company, requests review of those portions of Administrative Law Judge (ALJ) Michael V. Johnson's order that: (1) set aside its responsibility denial of claimant's current low back condition; and (2) upheld the responsibility denial of the same condition issued by EBI Companies on behalf of the same employer. On review, the issue is responsibility.

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

Responsibility

On September 3, 1985, claimant injured his low back while EBI insured the employer. A chiropractor, Dr. Shirk, diagnosed an acute low back strain/sprain. (Ex. 3). EBI accepted the claim as a nondisabling claim. (Ex. 4). On September 30, 1995, while Liberty insured the employer, claimant noticed the onset of back pain which radiated into both legs after working three hours into his shift.

Dr. Dew, claimant's family physician, recommended an MRI that showed a herniated disc at L4-5. Dr. Dew referred claimant to a neurosurgeon, Dr. Goodwin, who eventually performed an L4-5 discectomy on May 24, 1996. Both EBI and Liberty denied responsibility. On September 25, 1996, an order issued pursuant to ORS 656.307 in which EBI was required to pay benefits pending resolution of the responsibility issue.

The ALJ upheld EBI's responsibility denial, but set aside Liberty's responsibility denial. The ALJ first determined that ORS 656.308(1)[1] was inapplicable because claimant's current low back condition was not the "same condition" as that which EBI accepted as a result of the 1985 injury. Concluding that the case should be analyzed as an occupational disease claim, the ALJ then proceeded to apply the last injurious exposure rule (LIER) to assign responsibility. After applying LIER, the ALJ determined that Liberty was responsible for claimant's current low back condition.

On review, Liberty contends that the ALJ should have applied ORS 656.308 and determined that EBI was still responsible for his current low back condition because the herniated disc was a direct consequential condition resulting from the 1985 injury. For the following reasons, we disagree with Liberty's contentions.

ORS 656.308(1) applies if a worker sustains a "new compensable injury" involving the "same condition" as that previously processed as part of an accepted claim. See SAIF v. Yokum, 132 Or App 18 (1994). Responsibility is then assigned to the carrier with the most recent accepted claim for that condition. Smurfit Newsprint v. DeRosset, 118 Or App 368 (1993), on remand Armand J. DeRosset, 45 Van Natta 1058 (1993). Conversely, ORS 656.308(1) does not apply when a claimant's further disability or treatment involves a condition different than that which has already been processed as part of a compensable claim. See Armand J. DeRosset, 45 Van Natta at 1059.

Here, EBI accepted claimant's 1985 claim for "acute lumbosacral sprain/strain." However, claimant's current low back condition involves a herniated disc at L4-5. Because claimant's current low

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[1] 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."

back claim does not involve the same condition that was processed as part of the 1985 accepted claim, we agree with the ALJ that ORS 656.308(1) is not applicable to claimant's claim. Id. When ORS 656.308(1) is not applicable, the last injurious exposure rule applies to assign responsibility. Lyle H. Brensdal, 47 Van Natta 2209, 2211 (1995), aff'd mem 142 Or App 311 (1996). We agree for the reasons cited by the ALJ that Liberty is responsible under LIER.

Liberty, however, argues that claimant's herniated disc is a direct consequential condition arising from the 1985 injury. It cites evidence from the depositions of Drs. Goodwin and Dew which it alleges establishes that the 1985 injury resulted in an annular tear that in turn led to the herniated disc at L4-5. Assuming without deciding that a direct consequential condition satisfies the "same condition" requirement of ORS 656.308(1), we disagree with Liberty's interpretation of the medical evidence.

At one point in his deposition, Dr. Goodwin agreed that claimant's L4-5 disc herniation was a "consequential condition" of an annular tear arising out of the 1985 injury. (Ex. 90-27, 28). However, at several other points in his testimony, Dr. Goodwin was much less certain, testifying that the annular tear "may well have occurred" in 1985. (Ex. 90-12, emphasis added). Dr. Goodwin later testified, however, that the annular tear and the disc herniation were "two separate entities." (Ex. 90-16).

At another point, Dr. Goodwin testified that it was more than likely that the annular tear occurred prior to September 1995. (Ex. 90-23). However, Dr. Goodwin did not specify when the tear occurred. Still later, Dr. Goodwin testified that the 1985 injury "could have been" the precipitating factor for the annular tear. (Ex. 90-24).

Finally, after attributing the annular tear to the 1985 injury, Dr. Goodwin testified that, while there was no question that the annular tear predated the disc herniation, he could not state that it occurred in 1985, and that it could have occurred anywhere between 1985 and 1993. (Ex. 90-32). We conclude that Dr. Goodwin's medical opinion, viewed as a whole, does not establish to a degree of medical probability that claimant's disc herniation was a direct consequence of an annular tear resulting from the 1985 injury. See Lenox v. SAIF, 54 Or App 551, 554 (1981) (To prove medical causation, a medical opinion must be based on medical probability).

Moreover, we also do not find that Dr. Dew's testimony sufficiently supports Liberty's contention. Dr. Dew testified that an annular tear led to claimant's disc herniation. (Ex. 91-12, 36). Further, Dr. Dew testified that he agreed that the annular tear occurred in 1985. (Ex. 91-11). Later in his deposition, however, Dr. Dew testified that he did not feel comfortable in reaching a conclusion that, to a degree of medical probability, the annular tear arose out of the 1985 injury. (Ex. 91-40). Further, Dr. Dew agreed that, while claimant's history was consistent with an annular tear, this would not necessarily indicate that it was medically probable that there had been an annular tear since the 1985 injury. (Ex. 91-41). Finally, Dr. Dew agreed that there was no way to say to a degree of medical probability that claimant had an annular tear in 1985. (Ex. 91-43). Dr. Dew testified that he would defer to Dr. Goodwin's expertise in determining when the annular tear occurred "only in the sense that I don't feel comfortable saying when the annular tear occurred, period." (Ex. 91-47).

Once again, viewing Dr. Dew's testimony as a whole, we do not find that it establishes to a degree of medical probability that the 1985 injury resulted in an annular tear that later produced the L4-5 disc herniation. For this reason, we disagree with Liberty's contention that the L4-5 disc herniation is a direct consequence of the 1985 injury for which EBI was responsible.

Attorney Fee

We now turn to the issue of attorney fees for services on review. We note that claimant is not entitled to an attorney fee award under ORS 656.307 for his counsel's services on review. See Lynda C. Prociw, 46 Van Natta 1875 (1994); Ernest C. Blinkhorn, 42 Van Natta 2597 (1990).

However, claimant's compensation was at risk for a reduction due to Liberty's appeal on the responsibility issue.[2] Therefore, inasmuch as claimant's compensation was not reduced on appeal,

[2] The order designating a paying agent indicates that claimant's temporary disability rate under the 1985 EBI claim was $165.34, while the rate for the Liberty claim would be $431.81. (Ex. 88a). It follows that, had we reversed the ALJ's responsibility finding and determined that EBI was responsible for claimant's current left knee condition, claimant's benefits would have been reduced. Thus, we conclude that claimant's compensation was at risk due to Liberty's appeal.

claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2); Michael I. Joseph, 47 Van Natta 2043, 2050 (1995).

Based on the factors listed in OAR 438-015-0010(4), claimant's counsel is entitled to $1,000 for services on review. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent brief), the complexity of the issue, and the value of the interest involved. As an aside, we note that whether the $1,000 cap in amended ORS 656.308(2)(d) limits assessed fees awardable under ORS 656.382(2) for services rendered on Board review in defense of compensation awarded by the ALJ in a ".307" responsibility proceeding, is a question we need not decide in this case. That is, inasmuch as our attorney fee award is not greater than the $1,000 fee cap in ORS 656.308(2)(d), we need not determine the applicability of that statute. See Gary L. Brenner, 48 Van Natta 361, 362 (1996), aff'd Dean Warren Plumbing v. Brenner, 150 Or App 422 (1997).

ORDER

The ALJ's order dated June 30, 1997 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,000, to be paid by Liberty.

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February 6, 1998 Cite as 50 Van Natta 204 (1998)

In the Matter of the Compensation of
**VALENTINA I. BOGOMAZ, Claimant**
WCB Case No. 97-02240
ORDER ON REVIEW
Douglas D. Hagen, Claimant Attorney
Mannix, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that affirmed an Order on Reconsideration which classified claimant's claim as nondisabling. On review, the issue is claim classification.

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

On review, claimant argues that her modified job was effectively eliminated and, consequently, temporary disability benefits were due. Claimant relies on Noel A. Baier, 49 Van Natta 290 (1997).

We do not find that Baier is on point. In that case, we found that the claimant's modified, permanent part-time position no longer existed when the employer eliminated it by combining two permanent part-time positions, including that of the claimant, into one full-time position. Baier, 49 Van Natta 294. Here, however, claimant's modified position remained available, although the job subsequently began at a different time. As the ALJ found, there is no evidence that claimant's restrictions precluded her from working during a different shift. Consequently, we conclude that claimant's modified job was not eliminated and we therefore agree with the ALJ that claimant left work for reasons unrelated to the injury.

Because claimant has not established that temporary disability benefits are due and payable, we find that the ALJ properly affirmed the Order on Reconsideration which classified the claim as nondisabling.

ORDER

The ALJ's order dated July 3, 1997 is affirmed.

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In the Matter of the Compensation of
**ESTELLA M. ROGAN, Claimant**
WCB Case No. 97-03837
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) McWilliams' order that affirmed the Order on Reconsideration that rescinded the Notice of Closure. On review, the issue is premature claim closure. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of her findings of ultimate fact.

We summarize the facts as follows. Claimant has an accepted claim for bilateral carpal tunnel syndrome. Her attending physician, Dr. Teal, performed carpal tunnel release surgery on each side and released her for regular work in December 1996. Dr. Teal also declared claimant's condition medically stationary without permanent residuals in March 1997.

SAIF closed the claim by Notice of Closure on March 12, 1997 with an award of temporary disability benefits only. Claimant requested reconsideration, raising numerous challenges to the closure notice. She did not allege, however, that her claim had been prematurely closed. A medical arbiter was not appointed by the Director.

By Order on Reconsideration dated April 24, 1997, the Department rescinded the closure notice as premature, based on the finding that there was insufficient information at closure to rate claimant's disability. SAIF requested a hearing.

## CONCLUSIONS OF LAW AND OPINION

The ALJ affirmed the Order on Reconsideration. Finding that there was insufficient information available at claim closure to determine the extent of claimant's disability, the ALJ concluded that the Department was authorized to rescind the closure notice. We disagree and reverse.

The administrative rules that apply to the Department's review of claim closures are set forth in OAR Chapter 436, Division 30. Because the Department received claimant's request for reconsideration after February 17, 1996, the version of the rules which applies to her claim is set forth in WCD Admin. Order 96-052. See OAR 436-030-0003(1).

In rescinding SAIF's closure notice, the Department reasoned that, because a closing examination was not performed, the insurer did not obtain adequate closing information pursuant to OAR 436-030-0020(1) through (4). While we agree that there was insufficient closing information to rate claimant's disability, we conclude that the Department was not authorized to rescind the closure notice on this basis.

OAR 436-030-0020(4)(a) provides that when a carrier closes the claim, it shall issue a Notice of Closure to the worker within 14 days after evidence is received from the attending physician which shows the worker's condition is medically stationary, and "information is sufficient to determine the extent of any disability." Medical information is "sufficient" if it includes the information required in OAR 436-030-0015(2) and (3), among other rules. OAR 436-030-0020(6).[1] OAR 436-030-0015(2)(c)

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[1] OAR 436-030-0020(6) sets forth the medical information required to be sufficient "[f]or the purposes of section (3) of this rule." The quoted reference to "section (3)" appears to be in error, however, because OAR 436-030-0020(3) does not include any requirement of "sufficient" medical information. Rather, the requirement of "sufficient" medical information is in section (4) of the rule. Therefore, we interpret OAR 436-030-0020(6) as setting forth the information required to be "sufficient" for the purposes of section (4) of the rule.

requires "[a] closing medical examination report which describes in detail all permanent residuals attributable to the accepted claim...." Thus, under the rules, a carrier that intends to close the claim itself must issue its closure notice within 14 days after receiving, among other information, a closing examination report detailing the worker's permanent residuals due to the claim.

The absence of a closing examination report does not, however, mean that the closure notice is "premature." Neither the statutes nor the rules provide that a closing examination report is a prerequisite for issuance of a closure notice. ORS 656.268(4)(a), which sets forth the prerequisites for a carrier's claim closure, states that a claim may be closed by the carrier either: (1) when the worker's condition has become medically stationary and he has returned or been released to work; or (2) when the worker's accepted injury is no longer the major contributing cause of the worker's combined or consequential condition. See also OAR 436-030-0020(1) through (3). These events (1) and (2) are the statutory conditions precedent to a carrier's issuance of a closure notice, in lieu of a claim determination by the Department. Because a closing examination report is not a condition precedent to issuance of a closure notice, we conclude that the absence of such a report is not grounds for setting aside a closure notice as "premature."[2] To the extent that OAR 436-030-0020(4)(a) can be read to require a closing examination report prior to issuance of a valid closure notice, it exceeds the terms of ORS 656.268 and shall be given no effect. See Cook v. Workers' Compensation Dept., 306 Or 134, 138 (1988) (administrative agency may not, by its rules, amend, alter, enlarge or limit the terms of a statute).

For these reasons, we conclude that the Department was not authorized to set aside SAIF's closure notice as "premature."[3] The ALJ concluded otherwise, reasoning that OAR 436-030-0020(12) implicitly authorized the Department to rescind the closure notice for lack of information regarding the extent of claimant's disability.[4] We disagree. OAR 436-030-0020(12) provides, in relevant part:

> "These rules do not prohibit an insurer from rescinding or correcting its Notice of Closure or Notice of Refusal to Close prior to the expiration of the appeal period and prior to receipt of a request for reconsideration of the Notice of Closure by the department. A Notice of Closure may be corrected or rescinded when:
>
> "* * * * *
>
> "(d) the department has instructed the insurer to correct a Notice of Closure because it did not contain information pursuant to section (7) of this rule [which requires that the insurer apply the Department's standards for rating disability]." (Emphasis added.)

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[2] Though not a basis for rescinding claim closure as premature, a carrier's failure to comply with the Department's regulatory requirements may be the basis for assessment of civil penalties by the Director pursuant to ORS 656.745(2). See OAR 436-060-0200(2).

[3] OAR 436-030-0135(6) provides that, when the Department finds that a claim was closed prematurely, the Department must issue an order rescinding the claim closure. For the reasons discussed above, we have concluded that the absence of a closing examination report was not a permissible basis for finding that claim closure was premature. Therefore, OAR 436-030-0135(6) does not apply to the facts of this case, and the Department was neither required nor authorized to rescind the closure notice under the rule.

[4] On review, SAIF argued that, because claimant did not raise the premature closure issue at the reconsideration proceeding, the Department erred in addressing the issue sua sponte. However, SAIF does not cite to any statute or rule which restricts the scope of the Department's review of a timely appealed closure notice to only those issues expressly raised by the parties. Moreover, we have previously held that the Department may reduce or increase a permanent disability award even if the reduction or increase was not requested by a party. E.g., Jason O. Olson, 47 Van Natta 2192, 2194 (1995); Russell D. Sarbacher, 45 Van Natta 2230 (1993); Darlene K. Bentley, 45 Van Natta 1719, 1722 (1993). These cases stand for the general proposition that the Department may take whatever authorized action it deems necessary in its reconsideration of a closure notice or determination order. Thus, in this case, the Department was authorized to address the premature closure issue sua sponte, though, for the reasons discussed in this order, the Department did not have authority to set aside the closure notice as premature under the facts of this case.

By its terms, the rule addresses the circumstances that would permit an insurer to rescind or correct its closure notice. One of those circumstances is when the Department has instructed the insurer to correct the closure notice because it does not contain information for rating disability under the standards. Contrary to the ALJ's reading, we do not interpret the rule to permit the Department to rescind the closure notice for lack of disability rating information. That interpretation is contrary to the express language of the rule, which addresses only the insurer's authority to rescind the closure notice. Furthermore, we reject the ALJ's reasoning that the concept of rescission is implicit in the Department's authority (under the rule) to instruct the insurer to correct the closure notice. In our view, the authority to "instruct" the insurer to correct the closure notice does not imply the authority to rescind the closure notice unilaterally; rather, it implies that the discretion to rescind the closure notice for lack of disability rating information rests ultimately with the insurer, not the Department.

Turning to the facts of this case, it is undisputed that claimant's attending physician, Dr. Teal, declared her condition medically stationary and released her for regular work prior to SAIF's issuance of the Notice of Closure. Thus, the statutory conditions precedent to issuance of the closure notice were satisfied in this case. See ORS 656.268(4)(a); see also OAR 436-030-0020(3). Because SAIF's closure notice was authorized by statute, it shall be reinstated.[5] Furthermore, because "premature closure" was the only challenge that claimant raised to SAIF's closure notice at hearing and on Board review, and we have rejected that challenge, the closure notice shall be affirmed in its entirety. The Order on Reconsideration shall be modified accordingly.

## ORDER

The ALJ's order dated July 23, 1997 is reversed in part and affirmed in part. Those portions of the order that affirmed the Order on Reconsideration and awarded claimant's counsel an assessed fee of $2,200 are reversed. The Order on Reconsideration is modified to affirm the Notice of Closure in its entirety. The remainder of the ALJ's order is affirmed.

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[5] We agree with SAIF's position that the Department had alternative mechanisms available for supplementing the record with a closing examination report. It could have requested the closing report and postponed the reconsideration proceeding for 60 additional days to consider the report. See ORS 656.268(6)(a); OAR 436-030-0020(12). The Department also could have appointed a medical arbiter on the basis that there was insufficient medical information to estimate disability. See ORS 656.268(7)(a); OAR 436-030-0165(1)(a). For reasons not apparent from the record, the Department elected not to request a closing report or appoint a medical arbiter.

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In the Matter of the Compensation of
**BILLIE I. RUMPEL, Claimant**
WCB Case No. 97-04981
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that dismissed her request for hearing for lack of jurisdiction. On review, the issues are jurisdiction and, potentially, claim processing, scope of acceptance, penalties and attorney fees. We affirm.

## FINDINGS OF FACT

On March 11, 1982, claimant compensably injured her left ankle. Claimant eventually gained acceptance of left knee, depression and low back conditions through litigation. SAIF voluntarily accepted a chronic pain syndrome in 1989.

On June 9, 1997, SAIF wrote claimant to advise her that it was disapproving a request for prescription medication (Imetrex) prescribed for a migraine headache condition. As the basis for its disapproval, SAIF asserted that the medication was not medically necessary or appropriate. (Ex. 16).

SAIF requested Director review of the medical treatment issue on June 10, 1997. (Ex. 17). SAIF certified that the compensability of the underlying claim had not been formally denied. However, SAIF informed the Department that migraine headaches were not an accepted condition. SAIF also wrote claimant's attorney and advised that migraine headaches were not an accepted condition and that it would not continue to pay for the prescription medication. (Ex. 18).

On June 18, 1997, claimant's attorney wrote the Department, asserting that the Director did not have jurisdiction over the medical services dispute because SAIF was denying compensability of the underlying claim. (Ex. 19). Claimant also requested a hearing, contesting the alleged denial of June 10, 1997 and seeking penalties and attorney fees. Before the hearing, SAIF moved to dismiss the hearing request for lack of jurisdiction.

## CONCLUSIONS OF LAW AND OPINION

The ALJ granted SAIF's motion.[1] Citing ORS 656.283(1), 656.704(3) and 656.245(6), the ALJ reasoned that the parties' dispute was one of entitlement to medical services and, thus, did not involve a "matter concerning a claim."

On review, claimant contends that the ALJ improperly dismissed her hearing request. Claimant asserts that SAIF's acceptance of her chronic pain syndrome in 1989 encompassed her migraine headache condition. Arguing that SAIF's correspondence of June 10, 1997 (Exs. 17, 18) constituted denials of the underlying headache component of the compensable claim, claimant contends that such "denials" constituted unreasonable "back-up" denials, justifying the assessment of penalties and attorney fees. Claimant's contentions notwithstanding, we conclude that the ALJ properly dismissed claimant's hearing request.

In SAIF v. Shipley, 147 Or App 26, 29 (1997), rev allowed 326 Or 57 (1997), the court held that, pursuant to ORS 656.245(6),[2] the Board lacks jurisdiction to consider disputes that concern only the compensability of medical services. There, the claimant received medical treatment for an off-the-job injury to his knee five years after closure of his compensable knee injury claim. The carrier denied that the claimant experienced a worsening of his compensable condition and declined to reopen the claim. The Hearings Division and Board assumed jurisdiction over the matter and determined that the claimant's medical services were compensably related to his accepted injury. On appeal, the carrier argued that the Board lacked jurisdiction because the case involved only a claim for medical benefits on a previously accepted claim. The claimant contended that, because the carrier denied the compensability of his current condition and need for treatment, it also denied the compensability of the "underlying claim" as described in ORS 656.245(6).

The court rejected the claimant's contention and agreed with the carrier that the Board lacked jurisdiction over the dispute. 147 Or App at 29. The court noted that the claimant never sought benefits for an aggravation of his accepted injury, nor did he seek to establish the compensability of a "new consequential condition." Rather, the court reasoned that the claimant sought only treatment of his current condition, contending that the treatment was compensable because it was materially related to his accepted injury. The court concluded that because the dispute concerned only the compensability of medical services under ORS 656.245, the case was subject to the exclusive jurisdiction of the Director under ORS 656.245(6). Id.

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[1] Although the ALJ granted SAIF's motion, a hearing was held in which claimant was afforded the opportunity to present evidence and raise issues such as scope of acceptance, "back-up" denial, penalties and attorney fees. Thus, we do not view this as a case where a remand is necessary for an evidentiary hearing. Cf. Sarah A. Strayer, 49 Van Natta 244 (1997) (case remanded when the ALJ decided the merits of the parties' dispute and dismissed the claimant's hearing request without conducting a hearing and taking any evidence); Richard L. Saunders, 46 Van Natta 1726 (1994) (same).

[2] ORS 656.245(6) provides:

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

In this case, claimant contends that his medical services claim (prescription medication) is due to the headache component of the accepted chronic pain syndrome. Claimant argues that the acceptance of the chronic pain syndrome encompassed the headache condition. Insofar as claimant is asserting that the medical services are the result of the accepted claim, the issue is one of medical services on a previously accepted claim. The ALJ correctly concluded that the Hearings Division lacked jurisdiction over the dispute. Shipley, 147 Or App at 29.

To the extent that claimant is asserting a "new medical condition" claim for a consequential headache condition, the Hearings Division would have jurisdiction over such a dispute. Id; Jacqueline J. Rossi, 49 Van Natta 1844 (1997) (where the claimant asserted compensability of a "combined condition" under ORS 656.005(7)(a)(B), the Director did not have exclusive jurisdiction over the dispute under ORS 656.245(6)). However, in order to establish compensability of the headache condition as a "new medical condition" claim, claimant must "clearly request formal written acceptance of the condition." ORS 656.262(7)(a). Claimant did not do so in this case. Because claimant failed to satisfy the statutory requirements for asserting a new medical condition claim, any hearing request would be premature. See Diane S. Hill, 48 Van Natta 2351, 2352-53 (1996) (a hearing request concerning an unaccepted condition was premature where a "new medical condition" claim had not been filed with the carrier prior to the filing of the hearing request and the carrier had challenged the propriety of the compensability proceeding).[3] Thus, we conclude that the ALJ properly dismissed claimant's hearing request.

ORDER

The ALJ's order dated September 30, 1997 is affirmed.

[3] At hearing (Tr. 5) and on review, SAIF contended that any new medical condition claim for migraine headaches was improperly raised. Had SAIF not objected to the procedural validity of a "new medical condition" claim, we could have addresssed the issue. Hill, 48 Van Natta at 2353 n.1.



In the Matter of the Compensation of
**VIOLET ALLQUIST, Claimant**
Own Motion No. 98-0001M
OWN MOTION ORDER

The insurer has voluntarily reopened claimant's claim pursuant to ORS 656.278 for her compensable fractured left hip injury. Claimant's aggravation rights expired on February 9, 1983. 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.

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).

The insurer contends that claimant was retired at the time of the current disability and therefore not in the work force. The insurer has not responded to the Board's January 6, 1998 correspondence seeking clarification of the work force issue. Furthermore, claimant has not responded to the Board's

inquiry nor to the insurer's contention.[1] Claimant has the burden of proof on this issue and must provide evidence on that issue (e.g., 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).

The information submitted to us to date does not demonstrate claimant's presence in the work force at the relevant time.[2] While payment of medical benefits is not in dispute, claimant's request for temporary disability compensation is nevertheless 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] The January 6, 1998 letter from the Board requested clarification from the insurer regarding its contention that claimant is not entitled to temporary disability because she is retired. The Board requested that such clarification be received within 14 days from the date of the letter. The letter also indicated that "Upon receipt of the requested information, the Board will proceed with its review in this matter." The letter did not indicate what action would be taken if the Board did not receive "the requested information." However, in giving a 14 day time frame in which to respond, the Board expected a response within that time period. Inasmuch as the 14 day period has expired, we have proceeded with our review.

In the event that claimant disagrees with our decision that she has withdrawn from the work force, she may request reconsideration. However, because our authority to further consider this matter expires within 30 days of this order, she should submit her information as soon as possible.

[2] On the operative report dated 2/19/97, claimant's age was noted to be 73 years old.

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In the Matter of the Compensation of
**DENISE A. BAKER, Claimant**
WCB Case No. 97-00536
ORDER ON REVIEW
Rasmussen, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that upheld the insurer's denial of her injury claim for a left foot ganglion cyst condition. On review, the issue is compensability. We reverse.

## FINDINGS OF FACT

On August 26, 1996, claimant injured her left foot during her work as a flight attendant, when the aircraft experienced turbulence. (Exs. 1, 2). Claimant dropped with all her weight about a foot down onto the outside edge of her left foot, which immediately began to hurt. (Tr. 8). Claimant's foot swelled, and she noticed a bump on the dorsum of her foot in the center of the swollen area a few hours later. (Tr. 8, 13).

On August 29, 1996, claimant sought treatment from Dr. Sauvain, who diagnosed an acute traumatic ganglion cyst and took claimant off work for a week. (Ex. 4). Claimant's cyst condition did not improve, and Dr. Sauvain referred claimant to Dr. Smith, an orthopedist, for aspiration of the cyst. (Ex. 5).

CONCLUSIONS OF LAW AND OPINION

The ALJ determined that claimant's left foot ganglion cyst condition was not compensable, relying on Dr. Smith's opinion. Claimant challenges the ALJ's order. Specifically, claimant asserts that she carried her burden of proof[1] with the opinion of her treating physician, Dr. Sauvain. We agree.

Claimant has the burden to prove, by a preponderance of the evidence, that her claim is compensable. ORS 656.266.

Claimant testified[2] that she injured her left foot on August 26, 1996, when the plane suddenly dropped during turbulence and she dropped down about a foot and landed on the left side of her left foot with all her weight. Her foot immediately began to hurt and swell. A few hours later she noticed a lump on the top of her foot. The lump did not resolve with ice, elevation or anti-inflammatories. Claimant continued to work and sought medical attention a few days later. Dr. Sauvain took x-rays, which were normal. After taking claimant off her foot for a week, Dr. Sauvain referred claimant to Dr. Smith, who drained the cyst.

Dr. Sauvain opined that claimant's cyst was due to her injury, explaining that an event such as an acute stretch of a distal tendon or an acute crush injury to a tendon can cause a ganglion cyst. Dr. Sauvain also reported that claimant had no prior lesion in the past, which claimant would have been aware of, given the shoes she was required to wear. (Ex. 7). Based on claimant's history, Dr. Sauvain further opined that it was medically probable that she could develop a ganglion cyst of the left foot, and that the major contributing cause of the cyst resulted from her work as a flight attendant. (Ex. 12).

In contrast, Dr. Smith reported a history of claimant experiencing a twisting or blunt-trauma injury to the left foot when the plane hit some rough air and claimant was thrown off balance, possibly striking the foot or twisting it, noting that claimant was unsure of the mechanism of injury. He also reported that claimant did not see any swelling or bruising in the area, but became aware of a nontender mass on the dorsum of the foot some time thereafter. (Ex. 6). Subsequently, Dr. Smith opined that claimant's cyst was not traumatically caused or related to her work. (Ex. 11).

We find Dr. Sauvain's opinion more persuasive than that of Dr. Smith. Although both doctors were treating doctors, Dr. Sauvain had an accurate history of the circumstances of claimant's injury and considered those circumstances in rendering her causation opinion.[3] Moreover, her opinion is better reasoned. In our view, Dr. Smith's opinion not only lacks a reliable factual basis to judge its validity, but offers no reasoning for his conclusion. Somers v. SAIF, 77 Or App 259 (1986). Accordingly, claimant has sustained her burden of proof.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $2,500, payable by the 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.

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[1] Absent evidence that a preexisting condition combined with her August 26, 1996 work injury, claimant need only establish that her work injury was a material contributing cause of her disability and need for treatment. ORS 656.005(7)(a); Beverly Enterprises v. Michl, 150 Or App 357 (1997); Albany General Hospital v. Gasperino, 113 Or App 411 (1992); see also Ronald L. Ledbetter, 47 Van Natta 1461 (1995) (major contributing cause standard of ORS 656.005(7)(a)(B) applies only if there is evidence that a compensable injury combined with a preexisting condition).

[2] We note that, subsequent to our receipt of the parties' July 23, 1997 stipulated facts letter, the hearing transcript was recovered. Therefore, we have no need to rely on the stipulated facts.

[3] Without explanation, the ALJ concluded that Dr. Sauvain relied on a mechanism of injury unsupported by claimant's testimony. We conclude, to the contrary, that the history relied on by Dr. Sauvain (see Ex. 17) is entirely consistent with claimant's testimony concerning the incident (Tr. 8).

ORDER

The ALJ's order dated May 7, 1997 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. Claimant's attorney is awarded an attorney fee of $2,500 for services at hearing and on review, to be paid by the insurer.

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February 9, 1998 Cite as 50 Van Natta 212 (1998)

In the Matter of the Compensation of
**CORRIE M. HARP, Claimant**
WCB Case No. 97-02234
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Brazeau's order that set aside its denial of claimant's claim for a left knee injury. Claimant moves to strike the employer's appellant's brief as untimely. On review, the issues are motion to strike and compensability. We grant the motion to strike and affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Claimant moves to strike the employer's appellant's brief on the basis that it was not timely filed. We grant claimant's motion based on the following reasoning.

Pursuant to OAR 438-011-0020(2), a party's appellant brief must be filed within 21 days after the date of mailing of the transcript to the parties. For purposes of appellant briefs, "filing" is defined as "the physical delivery of a thing to any permanently staffed office of the Board, or the date of mailing." OAR 438-005-0046(1)(c). An attorney's certificate that a thing was deposited in the mail on a stated date is proof of mailing on that date. Id.

Here, the employer's appellant brief was due on October 13, 1997. The employer mailed its brief on October 14, 1997, as evidenced by its attorney's certificate that the brief was placed in the mail on that date. Thus, the brief was untimely filed. The employer asserts that it was unable to file its brief on October 13, 1997, as that was a federal holiday (Columbus Day) and the U.S. Postal Service was closed.[1] We treat this assertion as a motion for waiver of our rules. See OAR 438-011-0030. Specifically, that extraordinary circumstances beyond the employer's control prevented it from filing its appellant's brief on October 13, 1997. We conclude that a waiver of our rules is not warranted.

OAR 438-005-0046(1)(c) only requires an attorney's certificate that the brief was deposited in the mail on the stated date. Depositing a brief in the mail does not require a party to physically deliver the brief to an employee of the U. S. Postal Service. Rather, as the rule states, a brief need only be placed in the mail which can be accomplished by using any U.S. Postal Service mailbox (whether located at a Post Office or any other place). See Thomas P. Harris, 48 Van Natta 985 (1996) (motion to strike brief denied where attorney's certificate indicated that brief was timely deposited in the mail). In light of this, we find that the employer has not established extraordinary circumstances beyond its control which would excuse the untimely filing of it appellant's brief. See, e.g., Richard J. Rivera, 49 Van Natta 1592

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[1] The employer neither asserts, nor do we find, that the Board's permanently staffed offices were closed on October 13, 1997. In other words, Columbus Day was not a state holiday. Thus, hand-delivered briefs at the Board's offices on October 13, 1997 would have been accepted as "filed."

(1997) (failure to provide sufficient postage when mailing a brief is not extraordinary circumstances for untimely filing of an appellate brief). Accordingly, claimant's motion to strike the employer's appellant's brief is granted and the brief has not been considered on review.

Compensability

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

Claimant's attorney is entitled to an assessed fee for services on review. 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 $200, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's motion to strike the employer's brief)[2], the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated July 8, 1997 is affirmed. For services on review, claimant's counsel is awarded a reasonable assessed attorney fee of $200, payable by the self-insured employer.

[2] We note that claimant did submit a respondent's brief. However, the respondent's brief was only to be considered in the event that the Board did not grant claimant's motion to strike employer's brief. Inasmuch as we have granted claimant's motion to strike the employer's brief, we do not consider claimant's brief in determining the amount of attorney fees for services on review.

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February 9, 1998 Cite as 50 Van Natta 213 (1998)

In the Matter of the Compensation of
**SANDY L. CALVERT, Claimant**
WCB Case No. C800194
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Rasmussen, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

On January 27, 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 CDA provides that the total consideration due claimant is $9,375 and the total due claimant's attorney is $3,125. This would equal a total consideration of $12,500. However, the total recited on the first page of the document is "$15,000" instead of $12,500. In the body of the CDA, the total consideration is consistently given as $12,500, with $3,125 payable as an attorney fee. (Page 2, number 12, and page 3 number 13). Thus, the lone reference on the first page of the document to a total consideration of $15,000 appears to be an error. Accordingly, we interpret the agreement as providing for a total consideration of $12,500, minus a $3,125 attorney fee.

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. See ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved. An attorney fee of $3,125, payable to claimant's counsel, is also approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
**BETH E. ASMANN, Claimant**
WCB Case No. 96-08476
ORDER ON REVIEW
G. Joseph Gorciak III, Claimant Attorney
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) upheld the self-insured employer's partial denials of her right elbow overuse/right ulnar nerve condition; (2) declined to set aside the employer's alleged "de facto" denial of right elbow overuse and right shoulder tendonitis conditions; (3) declined to award an attorney fee for obtaining compensation of the right shoulder and forearm overuse syndrome without a hearing; and (4) declined to assess penalties for the employer's allegedly unreasonable processing of the right elbow and shoulder claims. On review, the issues are compensability, attorney fees and penalties. We affirm.

## FINDINGS OF FACT

On April 25, 1990, Dr. Platt conducted nerve conduction studies and diagnosed claimant with bilateral carpal tunnel syndrome (CTS). (Ex. 1). He concluded that claimant's condition was indolent and relatively mild electrically. (Id.) Claimant did not file a claim in 1990.

On February 9, 1995, claimant sought treatment from Dr. Busby for numbness and tingling in her fingers. (Ex. 1A). Dr. Busby diagnosed CTS and claimant filed a claim for CTS on February 27, 1995. (Ex. 4). Dr. Busby performed a right carpal tunnel release on August 14, 1995 and a left carpal tunnel release on November 9, 1995. (Exs. 7, 8). Claimant was released to modified work on December 19, 1995. (Ex. 11).

By Stipulation and Order dated December 13, 1995, the employer agreed to accept claimant's bilateral CTS. (Ex. 9).

On January 5, 1996, Dr. Busby reported that claimant had right elbow and arm pain. (Ex. 11). On January 24, 1996, he reported that claimant continued to have problems with her right upper extremity, with pain in the forearm going up into the shoulder. (Ex. 10). He felt that her problems were most likely secondary to a repetitive use tendonitis-type problem and not to CTS. (Id.) Claimant was released for full duty on February 13, 1996. (Ex. 14).

Claimant described her ongoing symptoms in a March 8, 1996 letter to Dr. Busby. (Ex. 15A). On April 3, 1996, Dr. Busby reported that claimant was experiencing pain in her right upper extremity and he referred her for nerve conduction studies. (Ex. 13). Dr. Busby felt that claimant's symptoms could be residual from a long-term carpal tunnel problem, rather than problems with her ulnar nerve. (Ex. 16).

Dr. Gambee performed electrical diagnostic studies on April 15, 1996. (Ex. 17). He found no evidence of residual or recurrent CTS in the right hand, and the ulnar nerve findings appeared normal. (Ex. 17-1, -3). He diagnosed postoperative bilateral carpal tunnel releases with good results, and overuse-type complaints of the right upper extremity. (Ex. 17-1).

On May 2, 1996, Dr. Busby concluded that claimant's nerve conduction studies were normal and she was medically stationary. (Ex. 18). The claim was closed by a Determination Order issued June 3, 1996. (Ex. 19). An Order on Reconsideration issued on August 7, 1996. (Ex. 27).

Claimant terminated her employment with the employer on May 31, 1996. (Ex. 24).

On June 12, 1996, claimant formally requested acceptance of "right side ulnar nerve condition/problems as part of the above captioned [1995 bilateral CTS] claim. In the alternative, claimant requests that you process the ulnar nerve problems as a new claim arising as an occupational disease out of her work activities with [the employer]." (Ex. 21).

On June 25, 1996, the employer requested information from Dr. Busby regarding claimant's alleged right ulnar nerve condition. (Ex. 21B). On July 18, 1996, Dr. Busby replied that there were "no objective findings supporting a right elbow ulnar nerve entrapment condition," but he agreed with Dr. Gambee that claimant suffered from overuse-type complaints of the right upper extremity. (Ex. 25).

On August 19, 1996, claimant was examined by Dr. Puziss for complaints of deep aching in the right shoulder without specific tenderness, and right elbow pain. (Ex. 28-2). He diagnosed overuse syndrome right elbow, forearm and shoulder, with no evidence of internal derangement of the right shoulder or elbow. (Ex. 28-3). He did not recommend any specific treatment and advised claimant to return as needed. (Ex. 28-4).

On September 11, 1996, the employer advised claimant that it was unable to accept responsibility for any treatment and/or disability for her right side ulnar nerve condition. (Ex. 30). The employer explained that there was insufficient medical evidence that claimant suffered a diagnosable condition regarding the right ulnar nerve as a result of her occupational exposure at the employer. (Id.) On the same date, the employer advised claimant that there was insufficient evidence that she suffered a diagnosable condition regarding her right side ulnar nerve as a result of her February 9, 1995 occupational disease claim for CTS. (Ex. 31).

On January 22, 1997, Dr. McKillop examined claimant and diagnosed her current condition as "[m]uscular and aches and pains involving the right scapular area, right upper arm area and lateral elbow and upper forearm areas, probably representing a muscular strain brought on by repetitive use." (Ex. 36-7). Dr. McKillop felt that the designation of "overuse syndrome" was probably correct. (Id.)

On February 5, 1997, the employer accepted claimant's condition as muscular overuse syndrome of the right shoulder girdle and right upper forearm. (Ex. 37).

## CONCLUSIONS OF LAW AND OPINION

### Compensability

At hearing, claimant argued that she had a work-related right elbow condition, in addition to the accepted conditions. The ALJ concluded that the record did not support a separate award of compensation restricted to the elbow alone as a separate and different injury from what had already been accepted.

Claimant contends that she has a compensable ulnar nerve condition. She asserts that the right ulnar nerve condition has been described by some physicians as part of a right elbow overuse syndrome, while other physicians have described right ulnar nerve problems. Claimant relies on Dr. Puziss' opinion to establish that she has an ulnar nerve condition that was inappropriately denied. She contends that, according to Dr. Puziss, the overuse syndrome is an ulnar nerve condition.

We construe claimant's argument to mean that she has suffered a compensable right ulnar nerve condition, or alternatively, a compensable right elbow overuse syndrome, separate from the "muscular overuse syndrome of the right shoulder girdle and right upper forearm" that was accepted by the employer. We disagree with claimant's contentions.

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

Dr. Busby was claimant's attending physician from February 9, 1995 through May 2, 1996. (Exs. 2, 18). Here, we find no persuasive reasons not to defer to Dr. Busby's opinion. Dr. Busby concluded that there were "no objective findings supporting a right elbow ulnar nerve entrapment condition." (Ex. 25). He agreed with Dr. Gambee that claimant had "over-use type complaints of the right upper extremity," but Dr. Busby did not identify a separate right elbow overuse condition. (Id.)

Medical reports from Dr. Gambee and Dr. McKillop support Dr. Busby's conclusion. Dr. Gambee performed electrical diagnostic studies on April 15, 1996 and concluded that claimant suffered from "[o]veruse-type complaints right upper extremity." (Ex. 17-1). Dr. Gambee found no electrical evidence of medial or ulnar neuropathy in the right upper extremity. (Ex. 17-3). He did not identify a separate and independent overuse type condition of the right elbow.

On January 22, 1997, Dr. McKillop examined claimant on behalf of the employer and diagnosed her current condition as "[m]uscular and aches and pains involving the right scapular area, right upper arm area and lateral elbow and upper forearm areas, probably representing a muscular strain brought on by repetitive use." (Ex. 36-7). Dr. McKillop felt that the designation of "overuse syndrome" was probably correct. (Id.) He did not diagnose a right ulnar condition or a separate overuse condition of the right elbow.

Claimant contends that we should defer to the opinion of her treating physician, Dr. Puziss. We generally rely on the opinion of a claimant's treating physician, because of his or her opportunity to observe the claimant over an extended period of time. Weiland v. SAIF, 64 Or App at 814. Here, even if we assume that Dr. Puziss was claimant's "attending physician," his opinion is not entitled to any deference because he examined claimant on only one occasion and did not recommend any specific treatment. Furthermore, we are not persuaded by Dr. Puziss' conclusory opinion. On August 19, 1996, Dr. Puziss diagnosed claimant's condition as overuse syndrome of the right elbow, forearm and shoulder. (Ex. 28-3). He noted, however, that "no definitive diagnosis is made today." (Id.) In a later "check-the-box" report from claimant's attorney, Dr. Puziss advised that claimant's right elbow, forearm and shoulder overuse syndrome was caused in major part by work activities at the employer. (Ex. 32-2).

In sum, based on the persuasive reports from Drs. Busby, Gambee and McKillop, we conclude that claimant has failed to establish that she has a compensable right ulnar nerve condition or a compensable right elbow overuse syndrome that is separate from the "muscular overuse syndrome of the right shoulder girdle and right upper forearm" that was accepted by the employer.

"De Facto" Denial

Claimant contends that the employer "de facto denied" a right elbow and right shoulder tendonitis condition. She argues that she has established the compensability of right elbow overuse and right shoulder tendonitis conditions. We disagree.

We have previously concluded that claimant has failed to establish that she has a compensable right elbow overuse syndrome that is separate from the overuse syndrome accepted by the employer. Therefore, we need not determine whether the employer "de facto" denied claimant's right elbow overuse syndrome.

Regarding her right shoulder tendonitis condition, claimant relies on the July 13, 1996 "801" form that referred to "[on-going] pain in neck, right shoulder, right elbow which was not relieved following carpal tunnel surgery." (Ex. 24). On November 7, 1996, claimant's attorney requested a hearing on a "de facto" denial. In a letter accompanying the request for hearing, claimant's attorney explained that claimant had submitted an "801" form on July 13, 1996 and the employer failed to accept or deny the claim within 90 days of knowledge of the claim for neck, shoulder and elbow conditions. (Ex. 33).

Claimant relies on medical reports from Dr. Busby regarding her right shoulder tendonitis condition. After reviewing the record, we conclude that, even if we assume, without deciding, that the employer "de facto" denied a right shoulder tendonitis condition, claimant has not established that the tendonitis condition is compensable.

On February 9, 1995, claimant saw Dr. Busby for complaints of numbness and tingling in her fingers. (Ex. 1A). Claimant had aching in her hand and wrist area, up her arm and into her shoulder. (Id.) Dr. Busby diagnosed CTS. He performed a right carpal tunnel release on August 14, 1995 and a left carpal tunnel release on November 9, 1995. (Exs. 7, 8).

On January 24, 1996, Dr. Busby reported that claimant continued to have problems with her right upper extremity, with pain in the forearm going up into the shoulder. (Ex. 10). He felt that her problems were most likely "secondary to a repetitive use tendonitis-type problem" and not to CTS. (Id.) On April 3, 1996, Dr. Busby reported that claimant was having symptoms in her right hand and right elbow, with aching and burning in the shoulder. (Ex. 13). At that time, he felt that claimant's symptoms could be residual from a long-term carpal tunnel problem, rather than problems with her ulnar nerve. (Ex. 16). He recommended nerve conduction studies.

Dr. Gambee performed electrical diagnostic studies on April 15, 1996. (Ex. 17). He found no evidence of residual or recurrent CTS in the right hand, and the ulnar nerve findings appeared normal. (Ex. 17-1, -3). He diagnosed postoperative bilateral carpal tunnel releases with good results, and

overuse-type complaints of the right upper extremity. (Ex. 17-1). Dr. Busby agreed that the nerve conduction studies were normal. (Ex. 18). On July 18, 1996, Dr. Busby reported that there were "no objective findings supporting a right elbow ulnar nerve entrapment condition," but he agreed with Dr. Gambee that claimant suffered from overuse-type complaints of the right upper extremity. (Ex. 25).

Although Dr. Busby indicated in a January 24, 1996 chart note that he thought claimant's right upper extremity symptoms, with pain in the forearm going up into the shoulder, were most likely "secondary to a repetitive use tendonitis-type problem" (Ex. 10), none of his later reports referred to a separate right shoulder tendonitis condition. Rather, Dr. Busby's subsequent reports indicated that he agreed with Dr. Gambee that claimant suffered from overuse-type complaints of the right upper extremity. (Ex. 25). There are no other medical reports that diagnose claimant with a right shoulder tendonitis condition. Moreover, even if Dr. Busby diagnosed a right shoulder tendonitis condition, there are no medical reports that establish that claimant's work activities were the major contributing cause of that condition. See ORS 656.802(2). We conclude that claimant has not established compensability of a right shoulder tendonitis condition.

Attorney Fees

Claimant contends that she is entitled to an attorney fee under ORS 656.386(1) for obtaining compensation of the right shoulder and right forearm overuse syndrome. She argues that the employer "de facto" denied her claim for a right shoulder and right forearm overuse syndrome. She relies on the July 13, 1996 "801" form, which referred to her neck, right shoulder and right elbow conditions. (Ex. 24). On November 7, 1996, claimant's attorney requested a hearing on a "de facto" denial. In a letter accompanying the request for hearing, claimant's attorney explained that claimant had submitted an "801" form on July 13, 1996 and the employer failed to accept or deny the claim within 90 days of knowledge of a claim for neck, shoulder and elbow conditions. (Ex. 33).

On February 5, 1997, the employer accepted claimant's condition as a muscular overuse syndrome of the right shoulder girdle and right upper forearm. (Ex. 37). The employer argues that claimant first communicated her contention that she suffered from a compensable right upper extremity overuse syndrome on November 7, 1996. (Ex. 33). The employer asserts that it had 90 days to process the claim and the acceptance was issued within that period.

We first determine whether the employer "de facto" denied a claim for right shoulder and right forearm overuse syndrome.

By Stipulation and Order dated December 13, 1995, the employer agreed to accept claimant's bilateral CTS. (Ex. 9). On June 12, 1996, claimant formally requested acceptance of "right side ulnar nerve condition/problems as part of the above captioned [1995 bilateral CTS] claim. In the alternative, claimant requests that you process the ulnar nerve problems as a new claim arising as an occupational disease out of her work activities with [the employer]." (Ex. 21).

On June 25, 1996, the employer advised claimant that, pursuant to ORS 656.262(7)(a), it would issue a formal written acceptance or denial of the right ulnar condition within 90 days. (Ex. 21A). On the same date, the employer requested information from Dr. Busby regarding claimant's alleged right ulnar nerve condition. (Ex. 21B).

On July 11, 1996, the employer wrote to claimant and asked her to fill out various forms, including an "801" form. (Ex. 23A). On July 13, 1996, claimant signed an "801" form that referred to "[o]n-going pain in neck, right shoulder, right elbow which was not relieved following carpal tunnel surgery." (Ex. 24). On September 11, 1996, the employer issued partial denials of claimant's right ulnar nerve condition. (Exs. 30, 31).

Although claimant relies on the July 13, 1996 "801" form to establish that she filed a claim for right shoulder and right elbow overuse syndrome, we conclude that, under the circumstances of this case, the "801" claim form did not constitute a "new medical condition claim" pursuant to ORS 656.262(7)(a). That statute requires that "[n]ew medical condition claims must clearly request formal written acceptance of the condition." Here, claimant's "801" form was submitted at the employer's request, after claimant's attorney had formally requested acceptance of a right ulnar nerve condition. Although the July 13, 1996 "801" form referred to pain in claimant's neck, right shoulder, right elbow, it did not refer to an overuse syndrome. Furthermore, the "801" form did not indicate claimant was asserting a claim separate from the right ulnar nerve claim.

Under these circumstances, we are not persuaded that the "801" form clearly requested formal written acceptance of the overuse condition, as required by ORS 656.262(7)(a). Despite claimant's reliance on medical reports referring to an overuse syndrome, ORS 656.262(7)(a) specifically provides that new medical condition claims "are not made by the receipt of a medical claim billing for the provision of, or requesting permission to provide, medical treatment for the new condition."

We agree with the employer that it first received a formal written request for an acceptance of the right shoulder and right elbow overuse condition on November 7, 1996, when claimant's attorney contended that claimant "suffers from a compensable right upper extremity overuse syndrome involving the elbow, forearm and shoulder." (Ex. 33). The employer used its full 90 days to process the claim and, on February 5, 1997, it accepted claimant's condition as "muscular overuse syndrome of the right shoulder girdle and right upper forearm." (Ex. 37). Under these circumstances, we conclude that the employer did not "de facto deny" claimant's right elbow and right shoulder overuse condition.

Under former ORS 656.386(1), claimant's attorney is entitled to an attorney fee "in such cases involving denied claims" where the attorney is instrumental in obtaining a rescission of the denial prior to a decision by the ALJ. Under the law in effect at the time claimant made a claim for right shoulder and right forearm overuse syndrome,[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."

Here, no benefits for claimant's right shoulder and right forearm overuse syndrome have gone unpaid. As we explained above, the employer accepted the right shoulder and right forearm overuse syndrome within 90 days of claimant's first written communication concerning those conditions. Consequently, there was no "de facto" denial. Moreover, the record does not establish that the employer refused to pay compensation on the express ground that claimant's right shoulder and right forearm overuse syndrome were not compensable or did not give rise to an entitlement to compensation. Therefore, under these circumstances, no "denied claim" has been established and no attorney fee is warranted under ORS 656.386(1). See Michael Galbraith, 48 Van Natta 351 (1996) (no "denied claim" where carrier paid all benefits for the compensable condition and did not expressly contend the condition was not compensable).

Penalties

Claimant argues that she is entitled to a penalty for the employer's allegedly unreasonable processing of the right elbow and shoulder claims. She contends that the employer ignored the "801" claim form submitted on July 13, 1996. As we discussed above, we do not agree with claimant's contention that the employer "ignored" the "801" claim form. 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 22, 1997 is affirmed.

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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).

In the Matter of the Compensation of
**PAMELA G. FRANK, Claimant**
WCB Case No. 96-06575
ORDER ON REVIEW
Foss, Whitty, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Black's order that: (1) set aside its denial of claimant's aggravation claim for a bilateral wrist condition; (2) remanded the claim for acceptance of the claim as "disabling"; and (3) awarded a $5,000 assessed attorney fee pursuant to ORS 656.386(1). In her respondent's brief, claimant contends that: (1) her attorney fee award should be increased; and (2) the employer's denial was unreasonable, thus justifying an award of penalties and attorney fees. On review, the issues are aggravation, compensability, claim processing, temporary disability, penalties and attorney fees.

We adopt and affirm the ALJ's order with the following supplementation with regard to the penalty and attorney fee issues.[1]

Noting that the ALJ failed to address the reasonableness of the employer's denial, claimant contends that we should address the issue and find that the employer's denial of aggravation was unreasonable.[2] For the following reasons, we find that the employer's denial was not unreasonably issued.

A penalty may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(11)(a). The standard for determining unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt about its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991) (citing Castle & Cook, Inc. v. Porras, 103 Or App 65 (1990)). Thus, if the carrier had a legitimate doubt about its liability, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in light of all the information available to the carrier at the time of the denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988); Price v. SAIF, 73 Or App 123, 126 n.3 (1985).

Here, prior to the employer's July 10, 1996 denial of claimant's current condition/aggravation claim, an examining physician, Dr. Strum, had concluded that claimant's upper extremity symptoms were not related to work activities. (Ex. 45). Moreover, another examining physician, Dr. Rosenbaum, had also concluded prior to issuance of the employer's denial that claimant had no objective abnormality in the left arm and that her symptoms in the right arm were unlikely to have been caused by an organic injury related to claimant's employment. (Ex. 48). Based on this medical evidence, we conclude that the employer had a legitimate doubt regarding its liability for claimant's current bilateral wrist condition. Accordingly, we find that the employer's denial was reasonably issued. It follows that claimant is not entitled to an award of penalties and attorney fees.

The ALJ awarded an assessed fee of $5,000 for claimant's counsel's services in prevailing against the employer's aggravation denial. The ALJ stated that the case was of a little more than ordinary difficulty, and that this accounted for $3,500 to $4,000 of the attorney fee. Noting that the issues of reclassification, aggravation and payment of benefits added to the complexity of the case, the ALJ settled on the $5,000 award after rejecting claimant's request for a $9,390 attorney fee award.

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[1] After setting aside the employer's denial, the ALJ remanded the claim to the employer for acceptance of a "disabling" claim. The employer requests that, should we affirm the ALJ's determination of the compensability/aggravation issues, the ALJ's order be "corrected" to state that the aggravation (not the original) claim is reclassified to "disabling." Inasmuch as this is a claim processing issue separate from the issues litigated at hearing, we decline to address this matter on review. The employer should process the claim in accordance with the ALJ's order. If claimant becomes dissatisfied with that processing, she can request a hearing to resolve any dispute that may arise. See Stephen M. Snyder, 47 Van Natta 1956, 1959 n. 5 (1995).

[2] Claimant raised the penalty and attorney fee issue at hearing. (Tr. 3). However, the employer argues that claimant waived the penalty issue by not cross-requesting review. We disagree. See Catherine E. Wood, 47 Van Natta 2272, 2274 n. 1 (1995) (a party may contest any portion of an ALJ's order in the absence of a cross-appeal, provided the party requesting review does not withdraw it request for review).

The employer argues that the attorney fee award should be reduced in part because claimant did not prevail on the temporary disability and reclassification issues. Moreover, the employer argues that, even if claimant did prevail on those issues, any attorney fee based on those issues would come from increased compensation. See ORS 656.386(2). In response, claimant asserts that, because the ALJ ordered reclassification of the claim to "disabling" and awarded temporary disability, she did prevail on those issues and is entitled to an increase in the attorney fee award.

Claimant is correct that she prevailed (at least in part) on the reclassification and temporary disability issues because the ALJ ordered reclassification of the claim to "disabling" and awarded temporary disability from September 25, 1996 to November 25, 1996.[3] On the other hand, the employer is correct that an assessed fee is not available for services regarding such issues. Joseph M. Lewis, 47 Van Natta 381, on recon 47 Van Natta 616 (1995). In light of such circumstances, we do not find that claimant is entitled to an increase in her assessed fee. On the other hand, we do not find that a decrease in her attorney fee award is appropriate, either.

We determine the amount of claimant's counsel's attorney fee for services at the hearings level by applying the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that any attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses. See Schoch v. Leupold & Stevens, 325 Or 112 (1997) (the Board must explain the basis for setting a reasonable attorney fee so as to permit appellate court review of its exercise of discretion).

Our review of the record reveals the following information. The issue in dispute was the compensability of claimant's bilateral upper extremity conditions Approximately 96 exhibits were received into evidence. The hearing lasted approximately two and one-half hours and the transcript consists of approximately 54 pages. There was one deposition of an examining physician (Dr. Strum) lasting approximately one and one-half hours (56 pages of transcript). Two witnesses, including claimant, testified. The compensability/aggravation issues presented factual and medical questions of a complexity somewhat greater than those generally submitted for Board consideration. The claim's value and the benefits secured are significant, because substantial medical services, including surgery, are involved. The parties' respective counsels presented their positions in a thorough, well-reasoned and skillful manner, identifying the relevant factual and legal issues for the ALJ's resolution. Finally, there was a risk that claimant's counsel's efforts might have gone uncompensated.

Based upon the application of each of the previously enumerated factors, and considering the parties' arguments, we conclude that a $5,000 attorney fee is reasonable and appropriate in this case. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the record 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 go uncompensated.

Claimant's attorney is also entitled to an assessed fee for services on review regarding the aggravation/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 $1,200, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief and counsel's statement of services), the complexity of the issues, and the value of the interest involved. In determining claimant's counsel's fee, we have not considered time devoted to the attorney fee issue. Dotson v. Bohemia, 80 Or App 233, 236, rev den 302 Or 35 (1986).

## ORDER

The ALJ's order dated July 8, 1997 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,200, to be paid by the employer.

[3] Claimant, however, sought temporary disability from May 1996.

In the Matter of the Compensation of
**MARK V. MOSER, Claimant**
WCB Case No. 97-02845
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Mongrain's order that: (1) directed it to pay claimant temporary disability benefits beginning February 27, 1997 and continuing until properly terminated according to law; and (2) assessed a penalty for SAIF's allegedly unreasonable failure to pay temporary disability benefits. On review, the issues are temporary disability benefits and penalties. We reverse.

## FINDINGS OF FACT

Claimant has worked for the employer as a maintenance person since 1991. In September 1993, he sustained a work-related low back injury which was accepted by Liberty Northwest Insurance Corporation, the employer's insurer at the time of claimant's injury. On March 12, 1996, he injured his low back at work when he slipped and fell while installing a washer. He filed a claim for this injury with the employer. At that time, SAIF provided the employer's workers' compensation insurance. Both Liberty Northwest and SAIF denied compensability and responsibility for claimant's March 1996 injury.

Following the March 1996 injury, claimant was treated by Dr. Clark, M.D. On November 12, 1996, Dr. Clark indicated that claimant was off work for 30 days due to continued back pain. On December 12, 1996, Dr. Clark released claimant from work for the time period from December 12, 1996 through December 19, 1996. Dr. Clark indicated that any further work releases would come from Dr. Saviers.

By Opinion and Order dated January 9, 1997, ALJ Brown set aside SAIF's denial and remanded claimant's claim to SAIF for acceptance and payment of compensation. Thereafter, SAIF requested Board review of ALJ Brown's order.[1]

On February 28, 1997, claimant's counsel forwarded to SAIF a February 27, 1997 note from Dr. Clark and requested SAIF to pay temporary disability benefits. Dr. Clark's note stated:

> "[Claimant] is a patient of mine who has been bothered by severe lumbosacral pain since 1995. [Claimant's] current occupation in construction has proved impossible for [claimant] to pursue due to recurrent injury of [claimant's] lumbar spine. Job retraining is required in order to allow [claimant] to pursue an occupation not involving heavy lifting."

SAIF did not pay temporary disability benefits following receipt of Dr. Clark's February 27, 1997 note.

## CONCLUSIONS OF LAW AND OPINION

Relying on OAR 436-060-0020(6), the ALJ concluded that Dr. Clark's February 27, 1997 note provided authorization for temporary disability benefits and directed SAIF to pay such benefits from that date until terminated according to law. We disagree.

At the outset, we do not find OAR 436-060-0020(6) helpful in resolving this issue. OAR 436-060-0020(6) provides, in relevant part:

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[1] SAIF requests that we take administrative notice of our decision in Mark V. Moser, 49 Van Natta 1180 (1997), in which we reversed ALJ Brown's order. Because our order is a capable of accurate and ready determination whose accuracy cannot be readily questioned, we grant SAIF's request and take administrative notice of our decision. See Phyllis Swartling, 46 Van Natta 481 (1994).

> "The insurer or self-insured employer shall verify and document temporary disability authorization from the attending physician within five days of the insurer's notice or knowledge of the worker's disability or claim. Authorization from the attending physician may be oral or written. The insurer, or the Department at the time of claim closure or reconsideration **may infer authorization** from such medical records as surgery report or hospitalization record that reasonably reflects an inability to work because of the compensable claim or from a medical report or chart note generated the time of, and indicating the worker's inability to work . . . ." (Emphasis supplied).

The emphasized language is discretionary, not mandatory; therefore, we do not agree that the rule places an affirmative duty on a carrier to infer authorization of temporary disability benefits from a medical report that does not clearly authorize such benefits.[2] Moreover, we have previously held that this rule does not require a carrier to affirmatively obtain verification of a worker's temporary disability status. See Jim R. Reed, 49 Van Natta 753 (1997); Roberta F. Beiber, 49 Van Natta 1543 (1997). Based on the above, we conclude that OAR 436-050-0020(6) did not obligate SAIF to begin paying temporary disability benefits upon receipt of Dr. Clark's February 27, 1997 note. Rather, the resolution of this issue turns on whether Dr. Clark's note, by itself, was sufficient to obligate SAIF to pay temporary disability benefits. Based on the reasoning below, we conclude that it was not sufficient.

"Procedural" temporary disability benefits are those benefits payable under ORS 656.268 while an accepted claim is in open status.[3] See SAIF v. Taylor, 126 Or App 658 (1994). Entitlement to procedural temporary disability benefits is contingent upon authorization of temporary disability benefits by the attending physician. ORS 656.262(4)(f); Gerald A. Zeller, 48 Van Natta 501, on recon 48 Van Natta 735 (1996).

On November 12, 1996, Dr. Clark specifically authorized claimant to be off work for 30 days due to back pain. (Ex. 1C). On December 12, 1996, Dr. Clark specifically indicated that claimant was released from work from December 12, 1996 to December 19, 1996 due to back pain. (Ex. 2A). Dr. Clark also indicated that any further release would come from Dr. Saviers. (Id.).

In contrast to these specific work releases, Dr. Clark's February 27, 1997 note does not indicate that claimant is released from work, nor does it provide any specific time periods. (Ex. 5). Moreover, Dr. Clark's reference to "job retraining" appears to relate to claimant's future vocational limitations and not to claimant's current ability to perform his job at-injury. Inasmuch as Dr. Clark had previously specifically authorized claimant's release from work, and given his statement that all further such releases would come from Dr. Saivers, we are unwilling to conclude that the statements made in the February 27, 1997 note constitute an authorization for temporary disability benefits. Because we have concluded that the February 27, 1997 note from Dr. Clark is not an authorization of temporary disability benefits, claimant has not established that he was entitled to procedural temporary disability benefits, payable by SAIF. Accordingly, we reverse the ALJ's award of temporary disability benefits.

Because we have found that the February 27, 1997 note from Dr. Clark was not sufficient to authorize temporary disability benefits, it follows that SAIF's failure to pay such benefits was not unreasonable. In any event, we have reversed the ALJ's award of temporary disability benefits, so there are no amounts "then due" on which to base a penalty. See Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991). For these reasons, we also reverse the ALJ's assessment of a penalty.

## ORDER

The ALJ's order dated August 5, 1997 is reversed. The ALJ's awards of temporary disability benefits, penalties, and an out-of-compensation attorney fee are reversed.

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[2] Inasmuch as ORS 656.018(5) allows a carrier to pay compensation not required by ORS Chapter 656, is it not clear why it was necessary to allow a carrier discretion to infer authorization for temporary disability benefits.

[3] We note that as of February 28, 1997 SAIF had not accepted claimant's claim. However, pursuant to ALJ Brown's January 9, 1997 order, SAIF was obligated to process claimant's claim, including the payment of any temporary disability benefits accruing from the date of ALJ Brown's order. ORS 656.313(1)(a)(A). The fact that ALJ Brown's order was subsequently reversed does not relieve SAIF of its processing duties during the time period between ALJ Brown's January 9, 1997 order and our July 25, 1997 order. See Victor Robles, 48 Van Natta 1174 (1996).

In the Matter of the Compensation of
**JAMES K. WASHINGTON, Claimant**
WCB Case Nos. 97-02742, 97-02203 & 97-01952
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

The insurer requests review of Administrative Law Judge (ALJ) Menashe's order that set aside its alleged "back up" denials of claimant's current low back condition. On review, the issues are propriety of the insurer's denials and compensability. We reverse.

## FINDINGS OF FACT

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

On May 8, 1995, claimant compensably injured his low back and groin lifting a tarp. The insurer accepted a nondisabling right groin strain and mild lumbosacral strain, which was later reclassified as disabling. A July 19, 1995 MRI of the lumbar spine showed degenerative changes at L4-5 with mild to moderate foraminal stenosis at both levels.

Claimant returned to his regular work as a warehouseman in early September 1995. He was declared medically stationary as of September 1, 1995. The claim was closed by a January 12, 1996 Determination Order which awarded periods of temporary partial and temporary total disability, but no permanent disability.

On October 24, 1996, claimant saw Dr. Yarusso for an unrelated hand injury. He mentioned that he had experienced the onset of low back and left leg pain in the preceding two days. Dr. Yarusso noted a positive straight leg raising test and positive Lasegue's on the left, greater than right. Claimant was placed on modified duty.

Three days later, claimant had another MRI of the lumbar spine, which again showed degenerative disc disease changes at L4-5 and L5-S1, more marked at L5-S1. Dr. Hirsch noted that the changes appeared stable since the prior (July 1995) MRI and had not progressed significantly.

On November 4, 1996, claimant filed a notice of injury with an injury date of October 24, 1996. In mid-November 1996, Dr. Yarusso advised the insurer that "it appears [claimant] is experiencing symptoms very similar to his prior episodes of back pain, with the exception of some radiation of occasional sharp, tingling pain that radiates down the left posterior thigh and calf." Dr. Yarusso recommended continued physical therapy.

On December 3, 1996, the insurer wrote to claimant advising that it had received a claim for a low back condition that arose on or about October 24, 1996. The insurer further advised that "it appears that your current low back condition is an aggravation of your previous injury on 5/8/95 and not the result of a new injury on 10/24/96." The letter continued: "Therefore, without waiving any other issues of compensability, we formally deny your claim for benefits. We will be processing your current low back condition as an aggravation of your 5/8/95 [injury] under claim number 780C971335-2." (Ex. 41).

On January 23, 1997, claimant was examined by Dr. Rosenbaum on referral from Dr. Yarusso. Dr. Rosenbaum diagnosed left S1 nerve root entrapment and recommended surgery.

On January 30, 1997, the insurer submitted a Form 1502 to the Workers' Compensation Division indicating claimant's aggravation claim was "deferred" and that it was filing the form as a first report of claim for aggravation. The insurer further noted that it first received medical verification of claimant's worsened condition on January 24, 1997. (Ex. 45A).

On February 6, 1997, claimant was examined by Dr. Brooks at the insurer's request. Dr. Brooks diagnosed degenerative disc disease at L4-5 and L5-S1, greater at L5-S1; facet hypertrophy and foraminal stenosis at L5-S1, greater on the left; and left S1 radiculopathy. Dr. Brooks opined that claimant's May 8, 1995 industrial injury was not the major cause of his current disability and need for treatment.

In late February 1997, the insurer wrote to Dr. Rosenbaum concerning claimant's condition in October 1996. In that letter, the insurer explained that although claimant had filed a new injury claim with an October 24, 1996 date of injury, there was no indication that claimant had sustained such an injury on that date. The letter further noted that the claim had been denied on December 3, 1996 "on the basis that his condition was an aggravation of his 5/8/95 injury." Dr. Rosenbaum responded that it did not appear that claimant had sustained an injury or any specific symptoms relative to work on October 24, 1996. Dr. Rosenbaum also noted that claimant's symptoms may have been idiopathic or spontaneous in origination.

On March 6, 1997, the insurer wrote to claimant stating that it had been "processing an aggravation claim relating to your 5/8/95 industrial injury." The letter further stated: "Medical information indicates that your 5/8/95 injury is not the major contributing cause of your current low back condition requiring surgery. Therefore, we are denying your claim for aggravation and current need for medical treatment."

On March 14, 1997, claimant was seen by Dr. Ushman and diagnosed with a herniated nucleus pulposus, left L4-5. Claimant completed a form 827 asserting that his condition resulted from "day-in-day-out lifting and bending." On March 28, 1997, the insurer wrote to claimant advising that it had received an occupational disease claim for his low back condition. The letter further provided that the insurer was denying the claim for benefits on the grounds that claimant's work activities were not the major contributing cause of his low back condition.

In May 1997, Dr. Ushman opined that claimant's current low back problems were probably related to preexisting degenerative changes in the lumbar spine.

## CONCLUSIONS OF LAW AND OPINION

The ALJ found that the insurer had accepted claimant's current low back condition by virtue of its December 3, 1996 denial of the new injury claim, and therefore its subsequent denials were impermissible "back up" denials of a previously accepted condition under ORS 656.262(6)(a).[1] On review, the insurer argues that its December 3, 1996 denial did not constitute an acceptance of claimant's current condition and that claimant has failed to prove the compensability of his current condition under a new injury, aggravation or occupational disease theory. We agree with the insurer.

Whether an acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App at 454. Acceptance is an act through which the insurer acknowledges responsibility for the claim and obligates itself to provide the benefits due under the law. See Richard L. Markum, 48 Van Natta 2204 (1996); Gene C. Dalton, 43 Van Natta 1191 (1991).

In August 1995, the insurer formally accepted two conditions related to claimant's May 8, 1995 disabling injury: a right groin strain and a mild lumbosacral strain. These conditions were found medically stationary on September 1, 1995. The claim was closed without an award of permanent disability on January 12, 1996. Nine months later, claimant completed an 801 form for low back and left leg symptoms identifying an October 24, 1996 injury, although he did not describe any work related incident or injury.[2] At that time, claimant was diagnosed with radiating low back pain, degenerative

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[1] The ALJ found that this case was guided by Elsa S. Wong, 48 Van Natta 444 (1996). In that case, the claimant had an accepted claim for right arm tendinitis. Shortly thereafter, she made a claim for left upper extremity symptoms. The employer acknowledged receipt of a claim for left hand symptoms, but denied that the claimant had experienced a new injury. The employer's letter referred to the claimant's condition as a "continuation" of her accepted right biceps tendinitis claim and advised that all benefits relating to the claim would be processed off her prior accepted claim. Noting that the meaning of the employer's letter was not free from doubt, we adopted and affirmed the ALJ's factual determination that the employer had accepted the claimant's left upper extremity condition as a "continuation" of her prior accepted claim. We do not read Elsa S. Wong as a "rule of law" that a carrier's acknowledgment that a new claim is being "processed" off a prior claim number constitutes an acceptance of the claimed condition. As discussed in the text above, whether an acceptance occurs is a question of fact to be determined on the record in any given case. See SAIF v. Tull, 113 Or App 449 (1992).

[2] Indeed, in the 801 form and again in an October 31, 1996 letter to the insurer, claimant asserted that this October 24, 1996 injury was not a workers' compensation injury and that he did not know when or how the injury occurred. (Exs. 28, 34).

disc disease and degenerative joint disease to the facets. Dr. Yarusso opined that claimant was experiencing symptoms very similar to his prior episodes of back pain, except now with radiating pain down the left leg.

Based on the absence of any evidence of a new injury occurring on October 24, 1996, the insurer issued a denial of claimant's "new injury" claim (claim No. 780C133513-6). Noting that claimant's current condition "appeared" to be an aggravation of his previous injury, the insurer also advised that it would be "processing" claimant's current low back condition as an aggravation of his 5/8/95 injury, under claim number 780C971335-2.[3] Consistent with its "processing" of claimant's aggravation claim, the insurer completed a form 1502 (which notified the Department that the aggravation claim was in "deferred" status) and scheduled an insurer-arranged medical examination of claimant.

On this evidentiary record, we do not find that the insurer's December 3, 1996 denial of claimant's "new injury" claim constitutes an acceptance of claimant's current condition as an aggravation of his accepted lumbosacral and right groin strain. Rather, we construe the insurer's letter as notice to claimant that, in the absence of any evidence of a specific work-related incident or injury in October 1996, his claim was being "processed" as an aggravation of his original injury.[4] An acknowledgment that the claim is being "processed" under a prior claim number is not necessarily notice that the claimed condition has been accepted.[5]

Having determined that the insurer did not accept claimant's current condition by virtue of its December 3, 1996 denial letter, we do not consider the insurer's March 6, 1997 aggravation denial or its March 28, 1997 denial of claimant's occupational disease claim to be "back up" denials of a previously accepted claim or condition. Therefore, claimant retains the burden of proving the compensability of his current condition.[6]

With regard to the aggravation claim, claimant must prove that he has a worsened condition resulting from his original injury. Pursuant to ORS 656.273(1)(a), such a condition "is established by medical evidence of an actual worsening of the compensable condition supported by objective findings." The statute requires direct medical evidence that the condition has worsened. See SAIF v. Walker, 145 Or App 294, 305 (1996).

In this case, the record fails to establish that claimant's worsened condition results from his original injury. Claimant's May 8, 1995 accepted injury was a mild lumbosacral strain and a right groin strain. None of the medical experts relate claimant's current disability or current need for treatment to this compensable injury. In fact, both Dr. Ushman and Dr. Brooks specifically relate claimant's current condition to his preexisting degenerative disease of the lumbar spine (see, e.g. Exs. 46-8, 63), a condition which the insurer has not accepted. Neither doctor even suggested that claimant's accepted conditions had combined with his preexisting degenerative disease to cause or prolong his current disability or need for treatment. Dr. Rosenbaum also declined to link claimant's current condition to his May 8, 1995 injury. (Exs. 51, 67). Consequently, claimant has failed to prove an actual worsening of his compensable condition under ORS 656.273(1).

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[3] In a November 13, 1996 report to the insurer discussing claimant's then-current symptoms and treatment, Dr. Yarusso also offered to complete a request for palliative care and/or an aggravation claim form on claimant's behalf. (Ex. 38). The insurer apparently construed claimant's November 4, 1996 801 form and Dr. Yarusso's November 13, 1996 report as a claim for aggravation even though no Notice of Aggravation Claim form (form 2837) had been submitted.

[4] Indeed, ORS 656.273(6) requires that an aggravation claim "shall be *processed* by the insurer or self-insured employer in accordance with the provisions ORS 656.262, * * * ." (Emphasis added.)

[5] See ORS 656.262, which sets forth the procedure for an insurer's "processing of claims" and requires, as part of that processing, that the insurer furnish the claimant with written notice of acceptance or denial of the claim within 90 days after the insurer has notice of the claim.

[6] Because claimant did not timely request a hearing on the insurer's December 3, 1996 denial (i.e., within 60 days of the mailing of that denial), we are not inclined to address the merits of his "new injury" claim. We note, however, that claimant essentially conceded that he did not experience any specific on-the-job injury on or about October 24, 1996. (See Exs. 28, 34; Tr. 46). In any event, there is no medical evidence relating claimant's low back and left leg symptoms to any work-related incident or accident around that time.

The medical evidence also fails to establish the compensability of claimant's S1 radiculopathy as an occupational disease under ORS 656.802(2)(a). Dr. Brooks specifically opined that claimant's work activities were not the major contributing cause of his current condition. (Ex. 66). Dr. Ushman opined that claimant's current condition resulted from degenerative changes in the lumbar spine which preexisted his employment with the employer. (Ex. 63). Although Dr. Rosenbaum reported that claimant's work activity could involve maneuvers which would cause a lumbar disc herniation, he did not opine that claimant's current condition was caused in major part by his work activity. On the contrary, Dr. Rosenbaum did not consider claimant's lumbar disc herniation and S1 radiculopathy to be an occupational disease. (Ex. 67). Accordingly, claimant has not proven the compensability of his current condition by a preponderance of the evidence.

## ORDER

The ALJ's order dated June 11, 1997 is reversed. The insurer's December 3, 1996, March 6, 1997 and March 28, 1997 denials are reinstated and upheld. The ALJ's attorney fee award is also reversed.

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In the Matter of the Compensation of
**MICHAEL C. LEGGETT, Claimant**
WCB Case No. 96-07715
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) found claimant medically stationary on April 25, 1996; (2) declined to award additional temporary disability benefits; and (3) affirmed an Order on Reconsideration that did not award permanent disability. On review, the issues are medically stationary date, temporary disability and extent of unscheduled permanent disability. We affirm.

## FINDINGS OF FACT

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

On August 14, 1995, a prior ALJ's Opinion and Order set aside the self-insured employer's denial of claimant's "cervical and thoracic spine." On September 22, 1995, the employer accepted claimant's claim for "cervical/thoracic strain."

In October 1995, Dr. Ordonez reported that claimant had a central herniated disc at C5-6, for which he performed anterior cervical discectomy and fusion surgery. (Ex. 32).

On April 17, 1996, Drs. Kirschner and Duff examined claimant for the employer. They diagnosed a currently stationary cervical strain and status post C5-6 discectomy. They opined that claimant's osteophyte formation and disc herniation at C5-6 preexisted claimant's January 1995 injury. They also found that claimant's cervical and thoracic strains had resolved and that claimant experienced no permanent impairment due to the strains. (Ex. 70).

On April 29, 1996, claimant was examined by Drs. Zivin and Thompson for the employer. Drs. Zivin and Thompson concluded that claimant's symptoms were due to cervical spondylosis at C5-6 and the results of surgery, rather than a cervical strain that had become stationary by April 1995. (Ex. 73).

On May 13, 1996, the insurer denied claimant's current need for treatment and disability for his cervical and thoracic strain condition on the basis that the January 1995 injury was no longer the major contributing cause of that condition, that the cause was his preexisting degenerative condition, and that another contributing factor to his current need for treatment was a preexisting personality disorder. (Ex. 78).

On May 16, 1996, the insurer issued a Notice of Closure (NOC) that established claimant's medically stationary date as April 25, 1996; awarded temporary disability for the periods January 30, 1995 through March 29, 1995; September 12, 1995 through January 21, 1996; and January 22, 1996 through April 25, 1996; and awarded no permanent disability. (Ex. 82). Claimant requested reconsideration, raising the issues of premature closure, temporary disability, and extent of unscheduled disability.

On June 4, 1996, Dr. Ordonez declared claimant medically stationary and performed a closing examination. (Ex. 86).

Claimant was examined by Dr. Neumann, medical arbiter, on August 7, 1996. (Ex. 94). An August 15, 1996 Order on Reconsideration affirmed the Notice of Closure in all respects. (Ex. 95).

## CONCLUSIONS OF LAW AND OPINION

### Medically Stationary Date

On review, claimant contends that the medically stationary date should be amended from April 25, 1996 to June 4, 1996, the date that his attending physician, Dr. Ordonez, declared him medically stationary. We disagree.

"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 at the time of claim 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 based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981).

Claimant's accepted condition is "cervical/thoracic" strain. The April 25, 1996 medically stationary date is based upon the medical report of Drs. Zivin and Thompson. Drs. Zivin and Thompson concluded that claimant's neck strain symptoms had resolved by April 1995. The doctors found that claimant's increased symptoms of neck pain with radiation into the right shoulder developed some time later, and, based on their review of the diagnostic studies, they attributed these symptoms to a degenerative condition in claimant's neck that preexisted his January 1995 injury. During their examination, Drs. Zivin and Thompson did not find any objective evidence of a thoracic strain and opined that claimant's current symptoms were due in major part to his degenerative cervical condition and subsequent surgery, and not his cervical strain. (Ex. 73).

Drs. Thompson and Zivin's report is consistent with the medical record. On March 29, 1995, Dr. Campbell indicated that claimant's cervical strain had resolved, and, on July 31, 1995, he indicated that claimant's minor thoracic strain was no longer significant. (Exs. 17, 23).

In an April 17, 1996 report, Drs. Kirschner and Duff found that claimant's cervical and thoracic strains had resolved and that claimant experienced no permanent impairment due to the strains. They diagnosed claimant with a currently stationary cervical strain and status post C5-6 discectomy. The doctors also opined that claimant's degenerative osteophyte formation was related to the extruded disc at C5-6 and preexisted his January 1995 injury. (Ex. 70).

In his closing examination report, Dr. Ordonez declared claimant medically stationary as to his cervical disc condition. He did not mention that he was treating a cervical/thoracic strain, nor did he determine that the accepted strain conditions were stationary. (Ex. 86).

In sum, the only evidence that addresses the medically stationary status of claimant's accepted strain conditions indicate that both strains were stationary as early as July 1995, and as late as April 25, 1996. (Exs. 17, 23, 73). There is no medical opinion which establishes that claimant's accepted cervical and thoracic strains were not medically stationary as of April 25, 1996. Consequently, claimant has failed to prove that he was not medically stationary at the time of the May 16, 1996 claim closure.

### Temporary Disability Benefits

The ALJ concluded that claimant was not entitled to temporary disability benefits from July 11, 1995 until September 11, 1995 because he was employed and there was no contemporaneous authorization of temporary disability benefits by Dr .Ordonez during that period. The ALJ also concluded that claimant was not entitled to temporary disability benefits from April 25, 1996 to June 4, 1996 because claimant's condition during that period was not related to the accepted injury.

On review, claimant asserts that he is entitled to benefits during both of the aforementioned periods. We disagree, but for the following reasons.

It is claimant's burden to prove that any disability is related to the accepted conditions. ORS 656.266. Inasmuch as claimant's claim has been closed, the issue is claimant's substantive right to temporary disability benefits. While a worker's procedural entitlement to temporary disability is contingent on the attending physician's authorization, there is no such requirement for determining substantive entitlement to temporary disability. Rather, a worker's substantive entitlement to temporary disability benefits is determined on claim closure and is proven by a preponderance of the evidence in the entire record showing that the claimant was at least partially disabled due to the compensable injury before being declared medically stationary. ORS 656.210, 656.212; Kenneth P. Bundy, 48 Van Natta 2501 (1996); see also SAIF v. Taylor, 126 Or App 658 (1994); Esther C. Albertson, 44 Van Natta 521, aff'd Albertson v. Astoria Seafood Corporation, 116 Or App 241 (1992). Consequently, any alleged failure by claimant's attending physician to authorize temporary disability, in and of itself, is not determinative in establishing disability.

Claimant concedes that temporary disability benefits had been appropriately terminated as of March 29, 1995, when Dr. Campbell released him to regular work. As discussed above, claimant's compensable condition is a "cervical/thoracic strain." On July 11, 1995, claimant's condition was diagnosed as cervical radiculopathy. Although claimant's radicular condition was initially attributed to the January 1995 injury by history, the subsequent persuasive medical evidence established that claimant's radicular symptoms were attributable to his preexisting, degenerative condition. Accordingly, based on the entire documentary record, a preponderance of the evidence establishes that any disability suffered by claimant during the periods in question was not due to his accepted strain injury. Moreover, claimant is not in any case entitled to temporary disability benefits beyond the April 25, 1996 medically stationary date.

Extent of Permanent Disability

The ALJ concluded that claimant was not entitled to an award of permanent disability because his impairment was not related in major part to his accepted cervical and thoracic strains. On review, claimant requests an award of 43 percent unscheduled permanent disability, based on Dr. Ordonez' closing examination.

Based on the medical record discussed above, there is no persuasive evidence that claimant has any permanent impairment due to his accepted strain conditions. Consequently, claimant has failed to prove entitlement to unscheduled permanent disability. OAR 436-035-0270(2).[1]

ORDER

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

[1] OAR 436-035-0270(2) provides that, if there is no measurable impairment, no award of unscheduled permanent partial disability shall be allowed.

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In the Matter of the Compensation of
**DEWAYNE A. MERIDITH, Claimant**
WCB Case No. 96-07387
ORDER ON RECONSIDERATION
Rasmussen, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Claimant requests reconsideration of our January 16, 1998 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order upholding the SAIF Corporation's denial of claimant's injury claim for the right knee and right shoulder. Claimant contends that we erred in affirming the ALJ's conclusion that claimant has not carried his burden of proving legal and medical causation. Specifically, claimant contends that his unrebutted testimony satisfies his burden of establishing legal causation, his right shoulder and right knee conditions should be analyzed under a material contributing cause standard, and the unrebutted medical opinions establish compensability under that standard.

After further considering the record, we continue to reach the same conclusions we reached in our original order. In other words, we continue to conclude that claimant has not established a compensable claim under either a material or the major contributing cause standard because the supporting medical opinions are based on claimant's inaccurate and unreliable account of his injury and subsequent symptoms. In this regard, we continue to adopt the ALJ's rationale that claimant has not proven legal causation given the absence of corroborating documentary and testimonial evidence, claimant's inconsistent testimony on related matters, and his past documented history of symptom embellishment.

Accordingly, we withdraw our January 16, 1998 order. On reconsideration, as supplemented herein, we adhere to and republish our January 16, 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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In the Matter of the Compensation of
**LEON F. STOWERS, Claimant**
WCB Case No. 96-09958
ORDER ON REVIEW
Thomas J. Dzieman, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl, Bock and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Michael Johnson's order that upheld the SAIF Corporation's denial of his claim for a right eye injury. On review, the issue is compensability. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

We begin by summarizing the ALJ's findings of fact.

Claimant began work in mid-1995 as an "enforcement officer" with the motor carrier transportation branch of the Oregon Department of Transportation (ODOT). As a motor carrier enforcement officer, claimant is authorized to issue citations to motor carriers, and is considered a "uniformed officer." Approximately half of his time is spent working at the port of entry near Ashland, Oregon, and approximately half of his time is spent at outlying scales.

When claimant works at the Ashland port of entry, his primary duty is to observe commercial motor vehicles and determine whether they are in compliance with regulatory requirements, including weight limitations, licenses, and safety devices. The port of entry is located on a turn-off east of the northbound lane of I-5 at mile marker 18. The assigned ODOT employees work in a complex of structures situated on an island which divides truck traffic leaving I-5 so that half goes by the island to the left and the other half passes on the right. There is an administrative building located on the island, but most of the employees' work is done inside the "scale house," because there are large windows on each side allowing the employees to inspect the vehicles as they drive past. The scale house is approximately twelve feet across, and inside there are computers, a ceiling-mounted heating and air conditioner duct, which is unfiltered, and indoor/outdoor carpet. Frequently, 1,400 trucks pass by the scale house in one 24-hour period, and on a busy day, almost 3,000 trucks may pass through the facility. When employees are required to go outside to deal with a truck or operator, they frequently encounter dust and other debris swirling in the air. The airborne particles are transported into the area on the truck tires and undercarriages, and then fall off on ODOT premises. The blowing particles are caused by winds in the area, but also by the driving of the large trucks through the area and from the operation of "spitter valves" on certain truck brakes. The drive lanes are swept periodically in order to clear accumulating road debris.

On the morning of July 18, 1996, claimant arrived at work early. He logged on his computer in the scale house and began work at approximately 6:00 a.m. The interior of the building is also very dusty, which requires claimant to spend the first 10-15 minutes of each shift cleaning his computer screen, the counter tops and blinds. (Tr. 44). After working for approximately 15 to 20 minutes, he felt a painful particle in his eye, although he had not seen anything blowing towards his eye immediately before. The pain was bothersome, but not excrutiating. Claimant went to the restroom and attempted to wash the particle out of his eye. Afterwards, he still felt that there was something cutting the surface of his eye. He then drove himself to the hospital in Ashland.

Claimant was examined in the hospital emergency room by a nurse and Dr. Showerman, who observed nothing abnormal in the eye. Claimant was sent to Dr. Imperia at the Medical Eye Center in Medford. Dr. Imperia found nothing on examination, but rinsed the eye and provided a lubricant. Claimant felt sufficiently improved to return to work. Claimant finished his shift at work.

After his shift, claimant drove home and took a nap. He awoke with severe pain in his eye. Claimant's wife drove him the emergency room, where he was examined by Dr. Trowbridge who found a "strand" or "fiber" in claimant's eye which he removed. Claimant's wife observed a small stiff bristle, which was clear in color. Dr. Trowbridge diagnosed a "diffuse corneal abrasion." Dr. Trowbridge believed that the object he removed from claimant's eye "could have been mucous and or a small hair."

Claimant filed a claim for the right eye injury which SAIF denied on October 18, 1996.

The ALJ found that claimant had not carried his burden of proving the requisite causal relationship between his injury and a risk connected to his employment. Although there was evidence that claimant's workplace exposed him to swirling dust, as well as carpet and unfiltered air conditioning, the ALJ found no direct evidence linking claimant's eye injury to a work-related risk. On this basis, the ALJ found that claimant had not established that his injury arose out of the course and scope of claimant's employment.

For an injury to be compensable under the Oregon workers' compensation law, it must "aris[e] out of and in the course of employment." ORS 656.005(7)(a). The phrases "arise out of" and "in the course of" are two elements of a single inquiry into whether an injury is work-related. Fred Meyer, Inc. v. Hayes, 325 Or 592, 596 (1997). This is called the "work-connection" test. Id. Under that test, both elements must be satisfied to some degree. Id. However, the two elements need not be met to the same degree. When the factors supporting one element are many, the factors supporting the other may be minimal. Redman Industries, Inc. v. Lang, 326 Or 32, 35 (1997).

An injury arises out of employment where there exists "a causal link between the occurrence of the injury and a risk associated with [the] employment." Norpac Foods Inc. v. Gilmore, 318 Or 363, 366 (1994). A causal connection requires more than a mere showing that the injury occurred at the workplace and during working hours. Id. at 368; Phil A. Livesley Co. v. Russ, 296 Or 25, 29 (1983). However, where the claimant's injury results from either an employment-related risk or a neutral risk that the employment put the claimant in a position to be injured, the injury is compensable under ORS 656.005(7)(a). See, e.g., Henderson v. S.D. Deacon Corp., 127 Or App 333 (1994) (worker's injury when she stepped out of an elevator while attempting to leave the building for a lunch break was in the course and scope of employment); see also Helen L. Good, 49 Van Natta 1295 (1997) (the claimant's employment put her in a position to be injured where she was rushing to complete a task during the employer's busiest time of year).

In discussing "risks," the Supreme Court in Redman Industries and Livesley quoted with approval the following from 1 Larson's Workers' Compensation Law § 7.00 at 3-14 (rebound ed. 1997):

> "All risks causing injury to a claimant can be brought within three categories: risks distinctly associated with the employment, risks personal to the claimant, and 'neutral' risks--i.e., risks having no particular employment or personal character. Harms from the first are universally compensable. Those from the second are universally noncompensable. It is within the third category that most controversy in modern compensation law occurs. The view that the injury should be deemed to arise out of employment if the conditions of employment put claimant in a position to be injured by the neutral risk is gaining increased acceptance." Livesley, 296 Or at 29-30.

In Livesley, the Court determined that unexplained injuries are a classic example of neutral risks.

Because this case involves an unexplained injury, we find that it is best characterized as a "neutral risk." Neutral risks are those having no particular employment or personal character. Redman Industries, 326 Or at 36.

Here, there is no contention that the "course of employment" prong of the work connection test has not been met. Rather, SAIF argues only that claimant's injury did not "arise out of" employment. We disagree.

The evidence establishes that claimant's workplace was very dirty with dust and other debris swirling in the air. The small interior space collected sufficient quantities of dust to necessitate cleaning it from the computer screen, blinds and counter at the start of claimant's shifts.[1] We find that claimant's employment exposed him to a risk of getting dust and debris in his eyes. Under these circumstances, we find a causal connection between claimant's work and his injury. We find that the course of employment element is strong and compensates for the weakness in the "arising out of" prong. See Krushwitz v. McDonald's Restaurants, 323 Or 520, 531 (1996).

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated June 10, 1997 is reversed. SAIF's denial is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's attorney is awarded $3,500, payable by SAIF.

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[1] The dissent would find that the "arising out of" element is "nonexistent," despite the acknowledgement that claimant's work environment often exposed claimant to airborne particles. This record permits no other inference but that this increased exposure led to claimant's injury.

**Board Member Haynes dissenting.**

The evidence in this case establishes that there were often airborne particles in claimant's work environment. What is missing from this record is any evidence that the airborne dust or debris at work is what got into claimant's eye and caused his injury.

Assuming that the majority is correct that the risk of getting an object in one's eye is a neutral risk, claimant's injury would be compensable only if his work conditions caused him to be in a position to be injured by the neutral risk. SAIF v. Marin, 139 Or App 518, 524-525 (1996). Based on the evidence in this case, this standard has not been met. The object in claimant's eye was unidentified. The physician who removed the object believed that it could have been mucous or a small hair. Thus, it is not established what the object in claimant's eye was or how it got there. The object could have been dust or some other substance from work or it could have been an eyelash or hair or a fiber from claimant's home or car. As I read the record, the only connection between claimant's injury and work that has been established is that work is where claimant first noticed the object in his eye soon after beginning his shift. It should be noted that claimant noticed the object in his eye while working inside the building. He was not outside inspecting trucks and had not yet worked outside on the date of his injury.

Had claimant been inspecting a truck when dust blew into his eye, or had there been medical evidence connecting the substance or object in claimant's eye to something in the workplace, there would be some causal connection between the injury and a risk associated with work and the injury could be said to arise out of employment. However, those are not the facts of this case. There is no evidence establishing that claimant was put in a position to be injured by his work.

The majority notes that deficiencies in the strength of one factor in the unitary work connection may be compensated for by the strength of the other. While this is a correct statement of the law, in order for the "course of employment" factor to make up for a weak "arising out of" factor, there must be

In the Matter of the Compensation of
**SUZAN K. HANSEN, Claimant**
WCB Case No. 97-03509
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Bock and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the insurer's denial of claimant's aggravation claim for a left thumb condition. On review, the issue is aggravation. We affirm.

## FINDINGS OF FACT

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

Claimant compensably injured her left thumb in August 1993. Fusion surgery at the metacarpophalangeal (MCP) joint took place in December 1993 and included circlage and crosswiring of the joint. The crosswire was removed in March 1994.

In October 1996, claimant sought treatment for pain in her thumb that radiated into the MCP joint. Dr. Jewell filed an aggravation claim, requesting the reopening of claimant's claim to remove the circlage wire. (Exs. 65, 66). Claimant was subsequently seen by Dr. Mayhall. (Ex. 67). On April 16, 1997, the insurer denied claimant's aggravation claim.

## CONCLUSIONS OF LAW AND OPINION

The ALJ upheld the insurer's aggravation denial, reasoning that, although the surgical procedure was curative, claimant was not entitled to time loss. On review, claimant contends that the time loss issue was not relevant to the establishment of an aggravation, and that she had proved an "actual worsening," as required by the ORS 656.273. We agree that the time loss issue was not relevant in this case; nevertheless, we uphold the insurer's denial based on the following reasons.

ORS 656.273(1) entitles an injured worker to additional compensation for worsened conditions resulting from the original injury. The statute provides that a worsened condition is established by medical evidence of an "actual worsening" of the compensable condition supported by objective findings. An "actual worsening" is established by direct medical evidence that a condition has pathologically worsened. SAIF v. Walker, 145 Or App 294, 305 (1996).[1]

Here, Dr. Mayhall stated: "In regard to objective worsening, the thumb remains stable and there is no objective evidence of worsening." (Ex. 67-6). Dr. Jewell concurred with Dr. Mayhall's report. (Ex. 68). There is no contrary medical evidence.

Because there is no medical evidence that claimant's condition has pathologically worsened, we conclude that claimant has failed to prove an "actual worsening." Thus, claimant has not established a compensable aggravation.

## ORDER

The ALJ's order dated August 27, 1997 is affirmed.

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[1] In Walker, after considering the text and context of amended ORS 656.273, together with the legislative history, the court concluded that, under the amended statute, in order for a symptomatic worsening to constitute an "actual worsening," a medical expert must conclude that the symptoms have increased to the point that it can be said that the condition has worsened. The court held that proof of a pathological worsening is required to establish a compensable aggravation claim under amended ORS 656.273.

In the Matter of the Compensation of
**MARILYN A. HODGES, Claimant**
WCB Case No. 96-05670
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Hornecker, Cowling, 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) Mongrain's order that set aside its denial of claimant's left lateral meniscus tear. Claimant cross-requests review of that portion of the ALJ's order that declined to assess a penalty for the employer's allegedly unreasonable denial and unreasonable resistance to the payment of compensation. On review, the issues are compensability and penalties.

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

Compensability

We adopt and affirm the ALJ's analysis and conclusion that claimant's left lateral meniscus tear is compensable.

Penalties

The ALJ reasoned that, in light of the 1990 injury records and the case law regarding the inadequacy of purely deductive medical opinions, the employer's denial was reasonable.

Claimant cross-requests review, arguing that she is entitled to a penalty for the employer's unreasonable denial and its ongoing resistance to paying the claim.

Claimant is entitled to a penalty if the carrier "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." ORS 656.262(11)(a). The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. International Paper Co. v. Huntley, 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).

On May 17, 1996, the employer denied claimant's left knee condition on the following basis:

> "In reviewing initial medical information in 1990 we note the complaints of the left knee were to the medial side of your knee. The current medical information received indicates a degenerative tear of the lateral meniscus. Based on information received we do not believe your current condition and need for treatment is related to the incident of 2-6-90, therefore, on behalf of [the employer] we must respectfully deny your aggravation claim." (Ex. 22).

Claimant compensably injured her left knee on February 6, 1990 after a fall at work. On February 14, 1990, claimant was examined by Nurse Practitioner Frigaard, who diagnosed a left ankle and left knee sprain. (Ex. 3-1). The employer accepted a low back strain and left ankle/knee strain. (Ex. 6). On March 7, 1990, Frigaard reported that claimant still had left knee pain on the medial side. (Ex. 5-1; Tr. 26). Claimant was examined by Dr. Morgan on March 14, 1990 and he reported that claimant's left knee was no better for the past month. He reported that her knee was "clicking, popping, catching in medial side." (Ex. 7-1). Dr. Morgan diagnosed a medial meniscus tear, left knee. (Ex. 7-1). On April 13, 1990, Frigaard reported that claimant's left knee still popped and she recorded left medial knee pain. (Id.) Following claimant's treatment for the 1990 left knee injury in April 1990, she did not seek medical attention for her left knee until February 1996.

On February 14, 1996, claimant sought treatment from Dr. James for left knee pain. He diagnosed a degenerative tear, lateral meniscus, left knee. (Ex. 14). On April 3, 1996, Dr. James opined that it was quite possible that claimant's February 1990 injury resulted in progressive degeneration of

her meniscus, which now required surgery. (Ex. 17). Dr. James performed surgery on April 11, 1996 and his postoperative diagnosis was severe degenerative tear of the lateral meniscus of the left knee. (Ex. 18-4). Claimant filed an aggravation claim.

Claimant's 1996 left knee condition was a lateral meniscus tear. However, the 1990 medical reports indicated that claimant had a medial meniscus tear as a result of the February 1990 injury. Based on the 1990 medical reports, we conclude that the employer had a legitimate doubt as to its liability at the time it issued the denial on May 17, 1996.

The employer, however, has a continuing obligation to reassess the propriety of its denial in light of "post-denial" medical evidence. Brown v. Argonaut Insurance Company, 93 Or App at 592.

On August 10, 1996, Dr. Cronin examined claimant on behalf of the employer. Dr. Cronin reviewed claimant's history, her operative report and medical records and concluded that there was a direct relationship between her 1990 injury and her current left knee condition. (Ex. 25-4). He based his conclusion on no history of knee problems before 1990 and ongoing knee problems since the 1990 injury, including abandonment of recreational activities. He did not feel that claimant's current knee condition was just degenerative in nature or related to her age and weight, because her right knee was asymptomatic and normal. (Id.) He found the only factor that explained her current left knee condition was the 1990 fall. Dr. Cronin noted discrepancies in previous medical reports between medial and lateral, but he reasoned that the 1990 examinations were not made by an orthopedic surgeon and his experience had been that the sensation of popping within the knee is very hard to localize. (Id.) He concluded that, to a medical probability, claimant had a lateral meniscus injury in 1990 and the 1990 injury was the major contributing cause of her current knee condition and need for surgery. (Ex. 25-4, -5).

In a concurrence letter signed on August 28, 1996, Dr. James agreed that claimant's current knee condition was caused in major part by the February 1990 injury. (Ex. 26). His opinion was based on the absence of left knee symptoms before February 1990, symptoms beginning with the February 1990 injury, symptoms consistent with the nature of the injury, and the findings at surgery that were consistent with an old injury. (Id.) Dr. James also agreed that complaints of medial pain were not inconsistent with a lateral injury because knee pain is often referred to the medial side. (Id.)

Claimant contends that, by the end of August 1996, the medical evidence consisted of two physician's opinions, both of which established her burden of proof under a "major contributing cause" standard. She argues she is entitled to a penalty for the employer's unreasonable persistence with its denial after August 1996. She asserts that, at that point, the employer did not have a legitimate doubt, but rather had mere suspicions and speculation. We disagree.

We find that the reports from Drs. Cronin and James are persuasive and the reliability of the 1990 medical reports referring to medial knee pain should be discounted. Nevertheless, in light of the 1990 medical reports referring to claimant's left medial knee symptoms, we conclude that it was not unreasonable for the employer to maintain its denial while awaiting the ALJ's determination of the reliability and persuasive weight of the opinions of Drs. Cronin and James. The fact remains that the 1990 reports from Nurse Practitioner Frigaard and Dr. Morgan both referred to claimant's medial knee pain. Because claimant's current condition is a lateral meniscus tear, the employer continued to have a legitimate doubt as to its responsibility for claimant's knee condition, even after receiving reports from Drs. Cronin and James.

It is well-settled that even the uncontradicted medical opinion of a physician is not binding on the trier of fact. Randy L. Carter, 48 Van Natta 1271, 1272 (1996); William K. Young, 47 Van Natta 740, 744 (1995) (uncontradicted medical opinion found unpersuasive). Moreover, we are not persuaded that the reports from Drs. Cronin and James destroyed all legitimate doubt the employer may have had about its liability for claimant's current knee condition. See Tommy V. Arms, 43 Van Natta 1509 (1991) (on remand) (corrected physician's report did not destroy all legitimate doubt from previous medical reports from other physicians); compare Delores Loving, 47 Van Natta 2079, on recon 47 Van Natta 2256 (1995) (the only foundation for the issuance of the "back-up" denial was a physician's initial chart note; once that foundation was destroyed by virtue of the physician's subsequent reports, the carrier's continuation of the denial was unreasonable).

Although Dr. Cronin concluded that claimant had sustained a lateral meniscus tear in 1990, rather than a medial meniscus tear, he noted in his August 10, 1996 report that, based on his own experience, many times the sensation of popping within the knee is very hard to localize. (Ex. 25-4). In a prehearing deposition, he reiterated that the popping and pain from a meniscus is many times poorly described and poorly localized. (Ex. 27-15). He explained:

> "I would have tended to want to look medially certainly from the descriptions that I've seen in the records, but I have many times in my own surgical practice found the pathology on the side opposite of the side where I thought it was. So that is not an unusual occurrence.
>
> "Q. Okay. Let me kind of ask you this then. As a general proposition, if you had a patient come in with medial side complaints and medial clinical findings of clicking or popping, would it be your conclusion, you know, short of going in there and actually seeing the inside of the knee, that this was a medial side problem?
>
> "A. Oh yes, yes." (Ex. 27-17).

Dr. Cronin testified that "sometimes it's very difficult to decide where the clicking or popping is coming from, even in experienced hands." (Ex. 27-19). Dr. Cronin also acknowledged that it was entirely possible that claimant had sustained a minor ligamentous strain or sprain in 1990. (Ex. 27-20). He said that, under that circumstance, it would not be significant that there were not any medial findings in 1996. (Ex. 27-21).

We do not find it unreasonable under the circumstances of this case for the insurer to have awaited the ALJ's ultimate decision regarding compensability when that determination necessarily involved an assessment of the persuasiveness of the opinions of Drs. Cronin and James. See Randy L. Carter, 48 Van Natta at 1272 & n.3 (it was not unreasonable for the carrier to await the ALJ's review of the record and decision on compensability; no penalty allowed). The fact remains that the 1990 reports from Nurse Practitioner Frigaard and Dr. Morgan both referred to claimant's medial knee pain. Furthermore, the opinions from Drs. James and Cronin that questioned the 1990 findings regarding medial pain were not based on a medical certainty. Their opinions did not destroy all legitimate doubt as to the employer's responsibility for claimant's condition. See Tommy V. Arms, 43 Van Natta at 1510. Because claimant's current condition is a lateral meniscus tear, the employer continued to have a legitimate doubt as to its responsibility for claimant's knee condition, even after receiving reports from Drs. Cronin and James. Even Dr. Cronin acknowledged the difficulty in determining the location of popping and pain from a meniscus.

Therefore, while we find that claimant has established a compensable knee claim, we conclude that the employer's continuing denial of the claim was not unreasonable. Accordingly, we agree with the ALJ that claimant is not entitled to a penalty.

## ORDER

The ALJ's order dated February 6, 1997 is affirmed.

**Board Chair Bock specially concurring.**

Although I agree that claimant's left knee condition is compensable and she is not entitled to a penalty, I write separately to express my concern about the employer's continued denial after receipt of the August 1996 medical opinions. I agree with the lead opinion that, based on the 1990 medical reports referring to claimant's medial knee pain and the fact that the post-denial opinions of Drs. Cronin and James were not stated in terms of medical certainty, the employer continued to have a legitimate doubt as to its liability for claimant's current knee condition. Nevertheless, I believe the employer's rationale for continuing its denial was weak, although legitimate, after it had received the August 1996 reports from Drs. Cronin and James explaining why the 1990 medical reports referring to a medial meniscus tear were not reliable.

In the Matter of the Compensation of
**ROY HAKANSON, Claimant**
Own Motion No. 97-00069M
OWN MOTION ORDER ON RECONSIDERATION REVIEWING CARRIER CLOSURE
Cole Cary & Wing, Claimant Attorneys

Claimant requests reconsideration of our December 22, 1997 Own Motion Order Reviewing Carrier Closure, in which we affirmed the self-insured employer's August 29, 1997 Notice of Closure. With his request for reconsideration, claimant submitted a copy of the employer's January 7, 1998 Modified Notice of Acceptance, which accepted several consequential conditions relating to claimant's accepted L5-S1 disc herniation condition. On reconsideration, claimant requests that his claim be reopened to address these newly accepted conditions.

In order to consider claimant's motion, we abated our December 22, 1997 order and granted the employer 14 days within which to respond to claimant's motion. The time for response having passed without receipt of any response from the employer, we proceed with our reconsideration. After further consideration, we issue the following order in place of our December 22, 1997 order.

FINDINGS OF FACT

On May 14, 1990, claimant sustained a compensable disabling low back strain injury. Claimant's aggravation rights on that claim expired on November 26, 1995. Subsequently, claimant treated with Dr. Kitchel for ongoing low back pain related to the compensable injury. On September 23, 1996, after about a week of increasing back and leg pain, claimant went to the Emergency Room with complaints of urinary incontinence and scrotal numbness. That same day, claimant was admitted to the hospital and underwent bilateral L5-S1 hemilaminotomies and microdiskectomies to treat a disc herniation with cauda equina syndrome. The surgery was performed by Dr. Kitchel. (September 23, 1996 Sacred Heart Medical Center intake records and operative report). As a result of his September 23, 1996 surgery, claimant's claim was reopened by our March 17, 1997 Own Motion Order.

Following his surgery, claimant continued to have urinary retention and treated with Dr. McDuffie, urologist, who noted that patients sometimes recover rapidly from that problem and sometimes they take a while to recover. (September 25, 1996 consultation report by Dr. McDuffie, September 26, 1996 Discharge Summary, October 8, 1996 chart note from Dr. McDuffie). Dr. McDuffie first saw claimant in September 1996, at which time claimant had a neurogenic bladder, urinary retention, cauda equina syndrome following surgery, and loss of erections. (August 13, 1997 letter from Dr. McDuffie). The cauda equina syndrome also resulted in a neurogenic bowel, a condition for which claimant also required ongoing treatment following his disc surgery. Claimant was treated with a "classic bowel program" and Foley catheter. (October 10, 1996, and October 29, 1996 reports from Dr. MacRitchie, M.D; October 8, 1996, and December 20, 1996 chart notes from Dr. McDuffie).

Claimant was hospitalized twice in October 1996 due to problems caused by his deep vein thrombophlebitis, including a pulmonary embolism. (October 10, 1996 and October 18, 1996 hospital records).

On August 7, 1997, Dr. Kitchel examined claimant regarding his lumbar laminectomy and disc excision L5-S1 surgery, and found claimant had "reached maximum medical improvement as of 8/7/97." (August 7, 1997 chart note). Dr. Kitchel did not address the status of claimant's other conditions, including his neurogenic bowel and bladder conditions.

On August 13, 1997, Dr. McDuffie provided the employer with a status report regarding claimant's urologic conditions. (August 13, 1997 letter from Dr. McDuffie to the employer's claims processing agent). Dr. McDuffie stated that over the last nine months, he had been able to get claimant to urinate and "he is slowly improving." Dr. McDuffie also requested authorization to proceed with tests regarding claimant's impotence condition. Id.

On August 25, 1997 and August 29, 1997, the employer issued claimant a "Modified Notice of Acceptance" and an "Updated Notice of Acceptance at Closure," respectively. Both of those documents listed claimant's accepted conditions as a "disabling low back strain" and "disabling L5-S1 herniation."

On August 29, 1997, the employer issued a Notice of Closure, closing claimant's claim with an award of temporary disability compensation from September 29, 1996 through August 7, 1997. The Notice of Closure declared claimant medically stationary as of August 7, 1997.

On October 23, 1997, claimant requested review of that closure, contending that he was entitled to additional benefits because he was not medically stationary regarding additional consequential conditions when his claim was closed.

On December 3, 1997, claimant filed a claim with the employer for additional consequential conditions. On January 9, 1998, the employer accepted the following consequential conditions regarding claimant's accepted L5-S1 disc herniation condition: cauda equina syndrome, neurogenic bowel and bladder, right leg deep vein thromboplebitis, and impotence.

## CONCLUSIONS OF LAW AND OPINION

A claim may not be closed unless the claimant's condition is medically stationary. See OAR 438-012-0055(1). Furthermore, in order for claimant's condition to be medically stationary, all compensable conditions must be medically stationary. See Nordstrom, Inc. v. Gaul, 108 Or App 237 (1991); Rogers v. Tri-Met, 75 Or App 470 (1985); Paul E. Voellar, on recon 42 Van Natta 1962 (1990). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the August 29, 1997 Notice of Closure, considering claimant's condition at the time of closure, without considering 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 employer apparently closed claimant's claim in reliance on Dr. Kitchel's August 7, 1997 chart note, which declared that claimant had "reached maximum medical improvement as of 8/7/97." However, it is apparent from that chart note that Dr. Kitchel considered only the status of claimant's low back surgery, without considering, or even mentioning, claimant's other conditions, including his neurogenic bowel and bladder conditions.

Furthermore, prior to surgery, claimant had bladder and bowel symptoms related to L5-S1 disc herniation. In addition, following the September 23, 1996 L5-S1 disc surgery, claimant developed problems relating to cauda equina syndrome, neurogenic bowel and bladder, right leg deep vein thromboplebitis, and impotence. From the date of that surgery until claim closure, claimant was treated by various physicians for these conditions. Thus, although not accepted until after closure, these conditions were in existence and required treatment before claim closure.

During his treatment of claimant's neurogenic bladder condition, Dr. McDuffie indicated that such a condition often took time to resolve. (September 25, 1996 consultation report by Dr. McDuffie, October 8, 1996 chart note from Dr. McDuffie). On August 13, 1997, Dr. McDuffie stated that claimant's neurogenic bladder condition had improved over the last nine months and claimant "is slowly improving." We find that this statement establishes that there is a reasonable expectation that claimant's compensable neurogenic bladder condition will materially improve with medical treatment or the passage of time. ORS 656.005(17). Thus, the neurogenic bladder condition was not medically stationary at claim closure.[1] Because not all of claimant's compensable conditions were medically stationary at closure, claimant's claim was prematurely closed.

Accordingly, we set aside the August 29, 1997 Notice of Closure as premature. The employer is ordered to recommence the payment of temporary disability compensation in this claim, beginning the date the employer previously terminated these benefits. When appropriate, the claim shall be closed by the employer pursuant to OAR 438-012-0055.

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[1] Because we find claimant's neurogenic bladder condition not medically stationary, we need not address the medically stationary status of claimant's remaining compensable conditions.

We note that, on reconsideration, claimant requested that we reopen his claim "to address the newly accepted conditions." Because we have set aside the employer's closure as prematurely issued, claimant's claim remains open. Therefore, claimant's request that his claim be reopened "to address the newly accepted conditions" is moot.

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.

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February 13, 1998 Cite as 50 Van Natta 239 (1998)

In the Matter of the Compensation of
**ISAIAS E. ALBA, Claimant**
WCB Case No. 96-06469
ORDER ON REVIEW
Anita Smith, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Myzak's order that: (1) found that claimant was medically stationary on January 10, 1995; and (2) affirmed an Order on Reconsideration which awarded 17 percent (32.64 degrees) scheduled permanent disability for loss of use or function of claimant's right arm. The insurer cross-requests review of that portion of the order which addressed its request for authorization to offset an alleged overpayment and moves to vacate that portion of the order. On review, the issues are whether claimant was medically stationary on January 10, 1995, extent of scheduled permanent disability, and motion to vacate.

We adopt and affirm the ALJ's order.

In addition, we offer the following supplementation concerning the motion to vacate.

The insurer moves to vacate that portion of the ALJ's order which addressed its request for authorization to offset an alleged overpayment. Specifically, the insurer argues that the ALJ erred in addressing the offset issue because, in the absence of an additional permanent or temporary disability award, the issue was "moot." We deny the motion, for the following reasons.

The insurer raised the overpayment/offset issue before hearing and argued it in written closing arguments. Under these circumstances, we find that the offset issue was actually litigated and the ALJ properly had jurisdiction over the issue. The overpayment/offset issue was not mooted by the absence of a permanent disability or temporary disability award. Even without a disability award, the ALJ could have authorized an offset of overpaid compensation against any future disability awards. See Travis v. Liberty Mutual Ins., 79 Or App 126 (1986); see also SAIF v. Zorich, 94 Or App 661 (1989) (carrier's request for an offset of overpaid compensation against future awards was a "matter concerning a claim").

ORDER

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

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In the Matter of the Compensation of
**JERRY FERGUSON, Claimant**
WCB Case No. C8-0265
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Glenn M. Feest, Claimant Attorney
Zimmerman, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

On February 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 approve the proposed disposition.

The first page of the CDA lists the total due claimant's attorney as $300 and the total due claimant as $600, which would equal a total consideration of $900.[1] However, typed on the same line as the total amount due claimant, is the phrase "*See No. 19." Paragraph 19 of the CDA provides:

> "An Administrative Order to withhold Workers' Compensation Benefits has been filed with the employer/insurer. Pursuant to this Order, twenty-five percent (25.0%) of this settlement, $300.00, shall be withheld and paid to the State of Oregon Support Enforcement Division. This means claimant will receive $600.00 out of this settlement."

Paragraph 13 of the CDA provides, in part: " * * * in consideration of the payment of $1,200.00 * * * claimant releases his right to the following workers' compensation benefits * * *."

Based on paragraphs 13 and 19 and the notation on the first page of the agreement, we interpret the CDA as follows: The total consideration for the CDA is $1,200, less a $300 attorney fee. In accordance with ORS 656.234(3)(b), one-fourth of the agreement proceeds ($300), is subject to child support obligations. The remainder of the $1,200 ($600) will be paid to claimant.

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. See ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved.

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

IT IS SO ORDERED.

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[1] We note that if the consideration for the CDA was $900 as indicated on the first page of the agreement, the $300 attorney fee would exceed the maximum allowed by OAR 438-015-0052, in the absence of extraordinary circumstances.

In the Matter of the Compensation of
**SHERRY L. MUMFORD, Claimant**
WCB Case No. 97-03878
ORDER ON REVIEW
J.R. Perkins III, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that dismissed her hearing request as having been withdrawn. On review, the issue is the propriety of the ALJ's dismissal. We affirm.

## FINDINGS OF FACT

On May 12, 1997, claimant, through her then-attorney, filed a hearing request concerning the insurer's May 1, 1997 denial. The hearing request was accompanied by a copy of claimant's attorney's retainer agreement that authorized claimant's then-attorney "to sign [claimant's] name and in all other respects to act for [claimant] in relation to any and all Workers' Compensation matters." The agreement was signed by claimant on March 6, 1997.

On May 19, 1997, the Board notified the parties that a hearing in this matter was scheduled for July 30, 1997. By letter dated July 29, 1997, claimant's attorney wrote the Board's Hearings Division and requested, on claimant's behalf, that the hearing request "be withdrawn and the hearing removed from the docket." On August 5, 1997, the ALJ issued an order dismissing claimant's hearing request as having been withdrawn.

Claimant, pro se, filed a request for Board review of the ALJ's dismissal order on August 27, 1997. By letter dated September 23, 1997, claimant's then-attorney notified the Board that he resigned as claimant's attorney. By letter dated October 24, 1997, claimant's current attorney advised the Board that he had been retained as claimant's attorney in this matter. His letter was accompanied by a copy of the current attorney's retainer agreement that was signed by claimant on October 3, 1997.

## CONCLUSIONS OF LAW AND OPINION

The issue before us is whether claimant's hearing request should have been dismissed. Based on the following reasoning, we find the ALJ's dismissal order was appropriate.

By letter dated July 29, 1997, claimant's then-attorney informed the Board that, on claimant's behalf, he was requesting withdrawal of the pending hearing request and removal of the scheduled hearing from the docket. Like the ALJ, we interpret that letter as a withdrawal of claimant's hearing request.

On review, claimant contends that the withdrawal was "without the knowledge, authorization or consent of Claimant and against her express desire." However, the hearings file contains both claimant's executed agreement retaining her then-attorney on March 6, 1997, and her then-attorney's letter of resignation effective September 23, 1997. Because claimant's then-attorney wrote and mailed the July 29, 1997 withdrawal letter to the Board after he was retained but before he resigned as claimant's attorney, we conclude that he had the authority to act on claimant's behalf when he withdrew claimant's hearing request.[1] Furthermore, claimant does not dispute that the ALJ dismissed her hearing request in response to her then-attorney's withdrawal of the hearing request. See Robert S. Ceballos, 49 Van Natta 617 (1997); William A. Martin, 46 Van Natta 1704 (1994); Verita A. Ware, 44 Van Natta 464 (1992). Under these circumstances, we find no reason to alter the dismissal order.

## ORDER

The ALJ's dismissal order dated August 5, 1997 is affirmed.

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[1] Although claimant contends in her brief that her then-attorney's withdrawal of the hearing request was "without the * * * authorization * * * of claimant," the only evidence in the file is the retainer agreement which establishes such authorization.

In the Matter of the Compensation of
**GENE A. SEVEY, Claimant**
Own Motion No. 97-0591M
OWN MOTION ORDER ON RECONSIDERATION

The insurer requests reconsideration of our December 19, 1997 Own Motion Order in which we authorized the reopening of claimant's claim to provide temporary total disability compensation beginning October 6, 1997, the date claimant was hospitalized for surgery. Specifically, the insurer contends claimant is not entitled to temporary disability benefits because he was retired and receiving "full Social Security benefits" at the time of his current disability.

On January 20, 1998, we abated our December 19, 1997 order, and allowed claimant 14 days in which to file a response to the motion.

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 insurer contends that claimant was not in the work force at the time of the current worsening or the time of surgery as he was retired and receiving full Social Security benefits at that time.[1] In our Own Motion Order of Abatement, we granted claimant an opportunity to file a response to the insurer's motion for reconsideration. Claimant has not responded to the insurer's work force contention or to the Board's request.

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. See Ben L. Davis, 47 Van Natta 2001 (1995); Earl J. Prettyman, 46 Van Natta 1137 (1994). Inasmuch as the record lacks evidence supporting a conclusion that claimant was in the work force at the time of his disability, his request for temporary disability compensation is denied. The parties' rights of appeal and reconsideration shall 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.

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[1] The insurer submits a copy of a November 4, 1994 Own Motion Order in which we declined to reopen claimant's claim at that time because claimant had not provided proof that he was in the work force during that period of disability. While a prior finding does not irrevocably commit a claimant to retirement for purposes of workers' compensation benefits, he must show that he is presently willing to seek work and that it is presently futile to seek work. Thus, in absence of evidence establishing that claimant reentered the work force between the date of our prior order and his current disability, we are not persuaded that he is entitled to temporary disability benefits. See Dean L. Watkins, 45 Van Natta 1599 (1993). See also Wausau Ins. Companies v. Morris, 103 Or App 270, 273 (1990).

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

Claimant requests reconsideration of our October 6, 1997 Own Motion Order, as reconsidered on October 30, 1997, and November 18, 1997. With his latest request for reconsideration, claimant submits a November 25, 1997 letter from Dr. McCullough, his treating physician. In our prior orders, we declined to authorize payment for medical services[1] for claimant's February 1997 right hip dislocation condition because the record contained no medical evidence as to the relationship between the current right hip condition and the compensable 1955 injury claim. Given this complete lack of medical evidence regarding causation, we were unable to conclude that claimant had established a causal relationship between his current condition and his compensable injury. However, we invited the parties to supplement the record with medical evidence regarding whether claimant's current right hip dislocation was causally related to the compensable injury.

On December 15, 1997, we abated our prior orders to consider claimant's motion for reconsideration and granted the SAIF Corporation an opportunity to respond. Having received SAIF's response, we proceed with our reconsideration. After further consideration, we replace our prior orders with the following.

We begin with a brief history of this claim. On August 5, 1955, claimant sustained an injury to his left tibia and fibula, his humerus and his right pelvis. The left leg injury eventually resulted in an "above-the-knee" amputation. In addition, claimant eventually underwent a compensable right total hip arthroplasty. On October 9, 1990 and February 5, 1991, the Board reopened claimant's claim for payment of prosthetic repairs and injury-related medical services. On January 10, 1992, the Board authorized payment for a new prosthesis. On October 1, 1992, the Board again reopened the claim for payment of prosthetic services for a modified socket.

On June 9, 1993 and July 8, 1993, the Board issued orders denying payment for medical services related to claimant's right hip dislocation which occurred during a January 1993 skiing accident. The medical record regarding causation consisted of an April 29, 1993 letter from Dr. McCullough. Based on this letter, we determined that the 1993 right hip dislocation was an indirect or "consequential" condition, requiring claimant to prove that the work injury was the major contributing cause of the right hip dislocation pursuant to ORS 656.005(7)(a)(A).[2] Finding that Dr. McCullough's opinion did not meet this standard of proof, we denied authorization of payment for medical services. In response to SAIF's request for reconsideration, we authorized the payment of a diagnostic report by a reconsideration order dated August 6, 1993. Claimant did not request reconsideration or appeal these 1993 orders, which became final by operation of law.

On February 13, 1997, claimant was on vacation at a ski area in Utah. He was not actually skiing at the time of his injury. Instead, he was walking on a flat surface with a ski when he lost his balance and fell. He dislocated his right hip arthroplasty while he was trying to get up. (February 13, 1997 examination report from Dr. Hillyard, the Utah physician who reduced claimant's dislocation, and claimant's undated letter received by the Board on October 20, 1997). That same day, claimant underwent a closed reduction of his dislocated right total hip arthroplasty.

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[1] In a letter dated November 3, 1997, claimant notified us that he is seeking only payment for medical services. Claimant explained that, because he was back to normal function after his right hip dislocation was treated on February 13, 1997, he is not seeking temporary disability compensation.

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

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

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

On August 5, 1997, SAIF submitted claimant's request for medical services for his 1955 right hip and left "above-the-knee" amputation injury, which consisted of the February 1997 reduction described above. SAIF recommended that the Board deny the provision of the requested medical services, contending that the compensable condition did not cause the need for treatment.

Inasmuch as claimant sustained a compensable industrial injury prior to January 1, 1966, he does not have a lifetime right to medical benefits pursuant to ORS 656.245. William A. Newell, 35 Van Natta 629 (1983). However, the Board has been granted own motion authority to authorize medical services and temporary disability compensation for compensable injuries occurring before January 1, 1966. See ORS 656.278(1). Nevertheless, claimant has the burden of proving that the requested medical services are compensably related to the compensable injury. ORS 656.266.

The issue of the contribution of claimant's compensable injury to his current right hip dislocation condition is a complex medical question, the resolution of which requires medical evidence. See Uris v. Compensation Dept., 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986).

The only medical opinion regarding causation comes from Dr. McCullough, who performed claimant's total right hip arthroplasty in 1983 and reduced the hip dislocation claimant suffered in 1993. (Dr. McCullough's November 25, 1997 letter). Dr. McCullough opined that a person who has had a total hip replacement is more prone to dislocation than a person with a normal hip. He explained that this "predisposition related to the nature of the prosthetic implants, the previous partial capsulectomy, and the nature of the repair." Id. Given these factors, Dr. McCullough stated that there was no expectation that claimant's dislocation would have occurred without the total hip replacement. Therefore, he recommended that "the dislocations and treatments therefore be accepted as part and parcel of the responsibility for the condition of total hip arthroplasty." Id.

On this record, we need not determine whether claimant must prove the compensable 1955 injury is a material contributing cause or the major contributing cause of his February 1997 hip dislocation because we find that Dr. McCullough's unrebutted opinion satisfies claimant's burden of proof under either standard. In this regard, although the injury took place at a ski area, there was no skiing incident or injury. Given this factor and reading Dr. McCullough's opinion as a whole, we find that claimant's February 1997 right hip dislocation was caused in major part by the compensable 1955 work injury.[3]

Accordingly, we find that the requested medical services related to the February 1997 right hip dislocation are reasonable and necessary and causally related to the compensable injury. Therefore, we authorize reimbursement for those medical services. See OAR 438-012-0037.

Finally, we note that, claimant's claim remains open pursuant to our October 1, 1992 Own Motion Order to provide medical services to maintain and monitor the status of his prosthetic device for his left above-the-knee amputation. Authorization for those medical services shall continue on an ongoing basis for an indefinite period of time, until there is a material change in treatment or other circumstance. After those medical services are provided, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

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[3] In making this finding, we note that Dr. McCullough's November 25, 1997 letter recommends that claimant's "dislocations" and "treatments therefore" be found compensably related to the compensable total hip arthroplasty. Claimant has had two right hip dislocations since his 1983 total right hip arthroplasty: one in January 1993 and one in February 1997, which is the subject of the present case. However, as noted above, by own motion order dated July 8, 1993, as reconsidered August 6, 1993, we found the 1993 dislocation noncompensable. Because claimant did not request further reconsideration or appeal that order, it has become final by operation of law. Therefore, to the extent that Dr. McCullough's 1997 opinion refers to claimant's 1993 dislocation, we do not rely on it. In any event, such an opinion would represent an unexplained change of opinion, since Dr. McCullough opined in 1993 that a skiing injury caused the 1993 right hip dislocation, although the compensable total hip replacement was a significant predisposition.

In the Matter of the Compensation of
**MARILYN A. HODGES, Claimant**
WCB Case No. 96-05670
CORRECTED ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

It has come to our attention that our February 12, 1998 Order on Review inadvertently omitted an attorney fee award to claimant's counsel. To correct that oversight, we withdraw our February 12, 1998 order and replace it with the following corrected order. The parties' rights of appeal shall begin to run from the date of this order.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Mongrain's order that set aside its denial of claimant's left lateral meniscus tear. Claimant cross-requests review of that portion of the ALJ's order that declined to assess a penalty for the employer's allegedly unreasonable denial and unreasonable resistance to the payment of compensation. On review, the issues are compensability and penalties.

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

Compensability

We adopt and affirm the ALJ's analysis and conclusion that claimant's left lateral meniscus tear is compensable.

Penalties

The ALJ reasoned that, in light of the 1990 injury records and the case law regarding the inadequacy of purely deductive medical opinions, the employer's denial was reasonable.

Claimant cross-requests review, arguing that she is entitled to a penalty for the employer's unreasonable denial and its ongoing resistance to paying the claim.

Claimant is entitled to a penalty if the carrier "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." ORS 656.262(11)(a). The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. International Paper Co. v. Huntley, 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).

On May 17, 1996, the employer denied claimant's left knee condition on the following basis:

> "In reviewing initial medical information in 1990 we note the complaints of the left knee were to the medial side of your knee. The current medical information received indicates a degenerative tear of the lateral meniscus. Based on information received we do not believe your current condition and need for treatment is related to the incident of 2-6-90, therefore, on behalf of [the employer] we must respectfully deny your aggravation claim." (Ex. 22).

Claimant compensably injured her left knee on February 6, 1990 after a fall at work. On February 14, 1990, claimant was examined by Nurse Practitioner Frigaard, who diagnosed a left ankle and left knee sprain. (Ex. 3-1). The employer accepted a low back strain and left ankle/knee strain. (Ex. 6). On March 7, 1990, Frigaard reported that claimant still had left knee pain on the medial side. (Ex. 5-1; Tr. 26). Claimant was examined by Dr. Morgan on March 14, 1990 and he reported that claimant's left knee was no better for the past month. He reported that her knee was "clicking, popping, catching in medial side." (Ex. 7-1). Dr. Morgan diagnosed a medial meniscus tear, left knee.

(Ex. 7-1). On April 13, 1990, Frigaard reported that claimant's left knee still popped and she recorded left medial knee pain. (Id.) Following claimant's treatment for the 1990 left knee injury in April 1990, she did not seek medical attention for her left knee until February 1996.

On February 14, 1996, claimant sought treatment from Dr. James for left knee pain. He diagnosed a degenerative tear, lateral meniscus, left knee. (Ex. 14). On April 3, 1996, Dr. James opined that it was quite possible that claimant's February 1990 injury resulted in progressive degeneration of her meniscus, which now required surgery. (Ex. 17). Dr. James performed surgery on April 11, 1996 and his postoperative diagnosis was severe degenerative tear of the lateral meniscus of the left knee. (Ex. 18-4). Claimant filed an aggravation claim.

Claimant's 1996 left knee condition was a lateral meniscus tear. However, the 1990 medical reports indicated that claimant had a medial meniscus tear as a result of the February 1990 injury. Based on the 1990 medical reports, we conclude that the employer had a legitimate doubt as to its liability at the time it issued the denial on May 17, 1996.

The employer, however, has a continuing obligation to reassess the propriety of its denial in light of "post-denial" medical evidence. Brown v. Argonaut Insurance Company, 93 Or App at 592.

On August 10, 1996, Dr. Cronin examined claimant on behalf of the employer. Dr. Cronin reviewed claimant's history, her operative report and medical records and concluded that there was a direct relationship between her 1990 injury and her current left knee condition. (Ex. 25-4). He based his conclusion on no history of knee problems before 1990 and ongoing knee problems since the 1990 injury, including abandonment of recreational activities. He did not feel that claimant's current knee condition was just degenerative in nature or related to her age and weight, because her right knee was asymptomatic and normal. (Id.) He found the only factor that explained her current left knee condition was the 1990 fall. Dr. Cronin noted discrepancies in previous medical reports between medial and lateral, but he reasoned that the 1990 examinations were not made by an orthopedic surgeon and his experience had been that the sensation of popping within the knee is very hard to localize. (Id.) He concluded that, to a medical probability, claimant had a lateral meniscus injury in 1990 and the 1990 injury was the major contributing cause of her current knee condition and need for surgery. (Ex. 25-4, -5).

In a concurrence letter signed on August 28, 1996, Dr. James agreed that claimant's current knee condition was caused in major part by the February 1990 injury. (Ex. 26). His opinion was based on the absence of left knee symptoms before February 1990, symptoms beginning with the February 1990 injury, symptoms consistent with the nature of the injury, and the findings at surgery that were consistent with an old injury. (Id.) Dr. James also agreed that complaints of medial pain were not inconsistent with a lateral injury because knee pain is often referred to the medial side. (Id.)

Claimant contends that, by the end of August 1996, the medical evidence consisted of two physician's opinions, both of which established her burden of proof under a "major contributing cause" standard. She argues she is entitled to a penalty for the employer's unreasonable persistence with its denial after August 1996. She asserts that, at that point, the employer did not have a legitimate doubt, but rather had mere suspicions and speculation. We disagree.

We find that the reports from Drs. Cronin and James are persuasive and the reliability of the 1990 medical reports referring to medial knee pain should be discounted. Nevertheless, in light of the 1990 medical reports referring to claimant's left medial knee symptoms, we conclude that it was not unreasonable for the employer to maintain its denial while awaiting the ALJ's determination of the reliability and persuasive weight of the opinions of Drs. Cronin and James. The fact remains that the 1990 reports from Nurse Practitioner Frigaard and Dr. Morgan both referred to claimant's medial knee pain. Because claimant's current condition is a lateral meniscus tear, the employer continued to have a legitimate doubt as to its responsibility for claimant's knee condition, even after receiving reports from Drs. Cronin and James.

It is well-settled that even the uncontradicted medical opinion of a physician is not binding on the trier of fact. Randy L. Carter, 48 Van Natta 1271, 1272 (1996); William K. Young, 47 Van Natta 740, 744 (1995) (uncontradicted medical opinion found unpersuasive). Moreover, we are not persuaded that

the reports from Drs. Cronin and James destroyed all legitimate doubt the employer may have had about its liability for claimant's current knee condition. See Tommy V. Arms, 43 Van Natta 1509 (1991) (on remand) (corrected physician's report did not destroy all legitimate doubt from previous medical reports from other physicians); compare Delores Loving, 47 Van Natta 2079, on recon 47 Van Natta 2256 (1995) (the only foundation for the issuance of the "back-up" denial was a physician's initial chart note; once that foundation was destroyed by virtue of the physician's subsequent reports, the carrier's continuation of the denial was unreasonable).

Although Dr. Cronin concluded that claimant had sustained a lateral meniscus tear in 1990, rather than a medial meniscus tear, he noted in his August 10, 1996 report that, based on his own experience, many times the sensation of popping within the knee is very hard to localize. (Ex. 25-4). In a prehearing deposition, he reiterated that the popping and pain from a meniscus is many times poorly described and poorly localized. (Ex. 27-15). He explained:

> "I would have tended to want to look medially certainly from the descriptions that I've seen in the records, but I have many times in my own surgical practice found the pathology on the side opposite of the side where I thought it was. So that is not an unusual occurrence.
>
> "Q. Okay. Let me kind of ask you this then. As a general proposition, if you had a patient come in with medial side complaints and medial clinical findings of clicking or popping, would it be your conclusion, you know, short of going in there and actually seeing the inside of the knee, that this was a medial side problem?
>
> "A. Oh yes, yes." (Ex. 27-17).

Dr. Cronin testified that "sometimes it's very difficult to decide where the clicking or popping is coming from, even in experienced hands." (Ex. 27-19). Dr. Cronin also acknowledged that it was entirely possible that claimant had sustained a minor ligamentous strain or sprain in 1990. (Ex. 27-20). He said that, under that circumstance, it would not be significant that there were not any medial findings in 1996. (Ex. 27-21).

We do not find it unreasonable under the circumstances of this case for the insurer to have awaited the ALJ's ultimate decision regarding compensability when that determination necessarily involved an assessment of the persuasiveness of the opinions of Drs. Cronin and James. See Randy L. Carter, 48 Van Natta at 1272 & n.3 (it was not unreasonable for the carrier to await the ALJ's review of the record and decision on compensability; no penalty allowed). The fact remains that the 1990 reports from Nurse Practitioner Frigaard and Dr. Morgan both referred to claimant's medial knee pain. Furthermore, the opinions from Drs. James and Cronin that questioned the 1990 findings regarding medial pain were not based on a medical certainty. Their opinions did not destroy all legitimate doubt as to the employer's responsibility for claimant's condition. See Tommy V. Arms, 43 Van Natta at 1510. Because claimant's current condition is a lateral meniscus tear, the employer continued to have a legitimate doubt as to its responsibility for claimant's knee condition, even after receiving reports from Drs. Cronin and James. Even Dr. Cronin acknowledged the difficulty in determining the location of popping and pain from a meniscus.

Therefore, while we find that claimant has established a compensable knee claim, we conclude that the employer's continuing denial of the claim was not unreasonable. Accordingly, we agree with the ALJ that claimant is not entitled to a penalty.

Attorney Fee

Claimant's attorney is entitled to an assessed fee for services on review concerning compensability. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services rendered on review regarding her unsuccessful request for a penalty.

ORDER

The ALJ's order dated February 6, 1997 is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by the self-insured employer.

**Board Chair Bock specially concurring.**

Although I agree that claimant's left knee condition is compensable and she is not entitled to a penalty, I write separately to express my concern about the employer's continued denial after receipt of the August 1996 medical opinions. I agree with the lead opinion that, based on the 1990 medical reports referring to claimant's medial knee pain and the fact that the post-denial opinions of Drs. Cronin and James were not stated in terms of medical certainty, the employer continued to have a legitimate doubt as to its liability for claimant's current knee condition. Nevertheless, I believe the employer's rationale for continuing its denial was weak, although legitimate, after it had received the August 1996 reports from Drs. Cronin and James explaining why the 1990 medical reports referring to a medial meniscus tear were not reliable.

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February 13, 1998 Cite as 50 Van Natta 248 (1998)

In the Matter of the Compensation of
**DONALD W. WAGNER, Claimant**
Own Motion No. 66-0450M
OWN MOTION ORDER ON RECONSIDERATION
Phil R. Ringle, Jr., Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant seeks Board authorization of an approved fee for his attorney's services culminating in our January 22, 1998 Own Motion Order. We received the retainer agreement submitted by claimant's attorney. An amount of 25 percent of the increased temporary disability compensation is 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.

Accordingly, our January 22, 1998 order is abated and withdrawn. As amended herein, we adhere to and republish our January 22, 1998 order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**SANDY K. POLYCHRONIS, Claimant**
WCB Case No. 97-02919
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests, and claimant cross-requests, review[1] of Administrative Law Judge (ALJ) Otto's order that increased claimant's unscheduled permanent disability award for a head injury from 32 percent (150.4 degrees), as awarded by an Order on Reconsideration, to 50 percent (180 degrees). On review, the issue is extent of unscheduled permanent disability.

We adopt and affirm the ALJ's order with the following modification and supplementation.[2]

Claimant experienced a compensable head injury. The insurer accepted "cervical right trapezius, head contusion/strain and post-traumatic headache disorder." In October 1996, a Determination Order issued, awarding 47 percent unscheduled permanent disability, which included an impairment value of 30 under OAR 436-035-0390(10), based on a Class II neurologic disorder of the brain and an adaptability value of 4.

The insurer requested reconsideration, in part challenging impairment. (Ex. 37). Claimant cross-requested reconsideration, requesting affirmation of the Determination Order or, alternatively, requesting promulgation of a temporary rule, as the disability standards did not adequately address post-traumatic headache disorder.

Medical arbiters assessed claimant's impairment, and, based on their findings, the Order on Reconsideration decreased claimant's unscheduled permanent disability award to a total of 32 percent. The Department reduced the adaptability value to 3, and the impairment value for claimant's head injury from Class II (30 percent) to Class I (10 percent), and promulgated a temporary rule that awarded an impairment value of 10 percent for claimant's headaches. (Ex. 42).

The ALJ increased the award of unscheduled permanent disability to 50 percent, reinstating the Determination Order's Class II impairment value of 30 percent for claimant's head condition (in lieu of the Class I impairment and the temporary rule), and the value of 4 for adaptability.

On review, the sole issues are impairment and adaptability. The insurer contends that the impairment value for claimant's head condition should be reduced to zero, as it had not accepted any brain condition that could be rated under OAR 436-035-0390(10),[3] and the adaptability value reduced to 1. We disagree.

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[1] Although claimant filed a cross-request for review, she did not raise any additional issues on review.

[2] The extent of scheduled permanent disability is evaluated as of the date of the Order on Reconsideration, applying the standards effective as of the date of the Determination Order or Notice of Closure. ORS 656.283(7); 656.295(5); OAR 436-035-0003(2). Here, claimant became medically stationary on January 27, 1995, and her claim was closed by Determination Order on October 9, 1996. (Ex. 35). Accordingly, the applicable standards are set forth in WCD Admin. Order 96-051 (effective February 17, 1996), as amended by WCD Admin. Orders 93-056 (effective December 14, 1993 (Temp.)), and 96-068 (effective August 19, 1996 (Temp.)). OAR 436-035-0003(1), (2), and (3).

[3] Claimant contends that the insurer is precluded from challenging the ALJ's application of OAR 436-035-0390(10), as the insurer had not raised the issue when requesting reconsideration. We disagree with claimant's contention. The insurer requested reconsideration, expressly challenging both the impairment findings and the rating of unscheduled permanent disability as it pertained to impairment. (Ex. 37). Moreover, claimant cross-requested reconsideration, specifically raising the issue of whether her post-traumatic headache condition was adequately addressed by the Director's rules. (Ex. 39). Under such circumstances, we find that claimant's unscheduled permanent disability, including the application of former OAR 436-035-0390(10), was raised on reconsideration. Moreover, consistent with former OAR 436-030-0115(4), which provides that the Department will do a "complete review" of the closure order, the Department not only promulgated a temporary rule to address claimant's cross-request, but applied former OAR 436-035-0390(10) in its Order on Reconsideration. (Exs. 41, 42). Consequently, we conclude that the insurer was not precluded from raising the application of former OAR 436-035-0390(10) at hearing.

Impairment

To be entitled to permanent disability compensation for her closed head trauma, claimant must establish that the impairment is due to her compensable injury. ORS 656.214(2). If a treating physician or medical arbiter makes impairment findings consistent with a claimant's compensable injury and does not attribute the impairment to causes other than the compensable injury, and the record discloses no other possible source of impairment, we construe the findings as showing that the impairment is due to the compensable injury. See SAIF v. Danboise, 147 Or App 550, 553, rev den 325 Or 438 (1997).

The ALJ found, and the medical record shows, that it is undisputed that the source of claimant's chronic, episodic post-traumatic headaches was the trauma from the compensable injury to her head. (Exs. 13, 31, 40-3, 41-4). Consequently, because there is no other possible source of impairment, and medical opinions rated the impairment as consistent with the compensable injury, we conclude that claimant's impairment is due to the compensable injury.

Adaptability

The insurer agrees that claimant's Base Functional Capacity (BFC) is medium. However, the insurer contends that, as claimant has returned to medium work as a houseworker and home attendant, her adaptability value should be reduced to 1.

For workers who have rateable unscheduled impairment found in former OAR 436-35-320 through 436-35-375, the adaptability value is determined by comparing Base Functional Capacity (BFC) to the worker's maximum Residual Functional Capacity (RFC) at the time of becoming medically stationary. Former OAR 436-35-310 (WCD Admin. Order 93-056). The parties agree that claimant's BFC is medium strength. Therefore, the dispute in this matter concerns claimant's RFC under former OAR 436-35-310.

The ALJ properly applied former OAR 436-35-310(5), which provides that RFC is the greatest capacity evidenced by the attending physician's release or a physical capacities evaluation or other medical evaluation which included measuring the worker's physical capacities. The ALJ relied on the release to sedentary/light work by claimant's attending physician, Dr. Morton, noting that claimant did not have any physical capacities evaluation or other similar medical evaluation after she became medically stationary. We do not consider the mere recitation of claimant's self-employment as a houseworker to be a medical evaluation of claimant's RFC. Consequently, we agree with the ALJ's evaluation of claimant's adaptability value of 4. Former OAR 436-35-310(5); see also former 436-035-0310(6), (8) and (9).[4]

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, 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 and her counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated July 23, 1997 is affirmed. For services on review, claimant's counsel is awarded an attorney fee of $1,500, to be paid by the insurer.

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[4] In comparing this value to the adaptability value for workers who have, as claimant does, rateable unscheduled impairment found in former OAR 436-35-380 through 436-35-450, the adaptability value remains at 4. Former OAR 436-035-0310(8) (WCD Admin. Order 96-068 (Temp.)) and former OAR 436-35-310(9).

In the Matter of the Compensation of
**LARRY R. BASSO, Claimant**
WCB Case No. 97-02705
ORDER ON REVIEW
Mitchell & Associates, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Hall and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that upheld the SAIF Corporation's partial denial of claimant's right shoulder condition. Submitting a post-hearing medical report from a Disability Prevention Consultation, claimant seeks remand to the ALJ for the admission of additional evidence. On review, the issues are remand and compensability. We reverse.

## FINDINGS OF FACT

Claimant worked as a carpenter and general maintenance man for SAIF's insured. On September 9, 1996, claimant suffered injuries in a motor vehicle accident (MVA) that occurred while he was driving on the employer's business. Claimant held his tool bucket and the doors he was transporting in the front seat with his right hand to prevent them from slamming against him. (Tr. 13).

An emergency room (ER) physician diagnosed cervical strain, lumbar strain, headache and elbow contusion. (Ex. 2). On September 13, 1996, in the course of a follow-up examination, claimant reported right shoulder symptoms. (Tr. 16). The right shoulder was examined, although a history was not taken. (Ex. 5-2).

On October 11, 1996, claimant sought treatment for his right shoulder from Dr. Wilson. Claimant reported that he had dislocated his shoulder in an old surfing injury. X-rays revealed a calcified supraspinatus, and Dr. Wilson diagnosed calcific tendinosis of the right rotator cuff and subacromial bursitis, which he treated by injection. (Exs. 7-3, 19).

On October 18, 1996, claimant again complained of pain in his right shoulder. Dr. Winans found tenderness with crepitus and diagnosed a right shoulder strain. (Ex. 8). A week later, claimant's shoulder had not improved. (Exs. 8, 9).

On November 5, 1996, Dr. Fuller, orthopedic surgeon, and Dr. Reimer, neurologist, examined claimant for SAIF. They reported that claimant complained of pain in the right shoulder that came on after working 3-4 hours. The doctors concluded that claimant's right shoulder symptoms were due to calcific tendinitis and residuals from his old shoulder dislocation, which, they opined, had no relationship to the September 1996 injury. (Ex. 11).

On November 15, 1996, SAIF accepted cervical strain, lumbar strain, and left elbow contusion. (Ex. 12).

On November 22, 1996, claimant again sought treatment for his shoulder. Dr. Wilson found decreased range of motion and prescribed physical therapy. (Exs. 14, 16A). Claimant continued to complain of increased pain with work and continued to have crepitus, cramping, and reduced range of motion. (Exs. 16B, 18, 18A).

On November 26, 1996, claimant requested amendment of SAIF's acceptance to include his right shoulder condition. (Ex. 16).

On January 10, 1997, claimant sought ER treatment for shoulder symptoms that increased after moving sheetrock at work. X-rays revealed soft tissue calcifications in the region of the rotator cuff. The ER physician diagnosed a shoulder sprain, suspicious for rotator cuff injury. (Ex. 21).

On January 27, 1997, Dr. McKillop performed a file review for SAIF. He agreed with Dr. Wilson's diagnosis of bursitis and concluded that claimant's shoulder symptoms were not caused by the MVA, but arose spontaneously about one month after the accident. (Ex. 24).

Claimant's shoulder condition failed to improve, and, on February 7, 1997, Dr. Wilson referred claimant to Dr. McWeeney, orthopedist, for further evaluation. (Exs. 28A, 29). Dr. McWeeney ordered an arthrogram, which revealed a rotator cuff tear. Surgery was requested. (Exs. 32, 40).

On February 28, 1997, SAIF issued a partial denial of claimant's right shoulder condition. (Ex. 36).

On April 1, 1997, Dr. Gritzka, orthopedic surgeon, evaluated claimant's right shoulder and performed a records review.

## CONCLUSIONS OF LAW AND OPINION

### Compensability

The ALJ found that claimant's bursitis had resolved subsequent to Dr. Wilson's injection in October 1996, and that the sudden onset of claimant's torn rotator cuff in January 1997 bore no relationship to claimant's injury. On review, claimant argues that his condition had progressively worsened since the September 1996 injury, and that he has carried his burden to prove compensability. We agree.

Claimant was injured in a September 9, 1996 MVA while on the job. In the course of a September 13, 1996 follow-up examination, claimant complained of right shoulder symptoms. His right shoulder was examined, although no history was taken at that time. (Ex. 5-2). On October 11, 1996, claimant requested x-rays of his shoulder, which had become more painful after he had been working several hours. Dr. Wilson diagnosed calcific tendinosis and bursitis, which he treated with an injection.

On October 18, 1996, Dr. Winans found tenderness with crepitus in the right shoulder and diagnosed a right shoulder strain. Claimant's condition continued to deteriorate. (Exs. 14, 16, 16A, 16B, 18, 18A). On January 10, 1997, claimant sought ER treatment after moving sheetrock at work. He was diagnosed with a shoulder sprain, suspicion of a torn rotator cuff, and was taken off work. (Ex. 21). Claimant's shoulder condition did not respond to conservative treatment, and, on February 19, 1997, Dr. McWeeney ordered an arthrogram, which revealed a rotator cuff tear. (Exs. 29, 31).

Claimant has the burden to prove compensability by a preponderance of the evidence. ORS 656.266; Hutcheson v. Weyerhaeuser, 288 Or 51 (1980). Claimant has been diagnosed with preexisting calcific tendonitis that contributed to the development of his right shoulder condition. (Exs. 19, 20, 32). Consequently, claimant must prove that the major contributing cause of the need for treatment of his combined condition is the September 1996 work injury. ORS 656.005(7)(a)(B).

This case is sufficiently complex that medical causation must be established by expert medical opinion. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). Because resolution of the matter involves expert analysis rather than expert external observation, we do not give special deference to evidence from the treating physicians. See Allie v. SAIF, 79 Or App 284 (1986).

Claimant relies on the opinions of Dr. Gritzka (Ex. 42) and Dr. Winans (Exs. 42A, 42B).[1] SAIF relies on the opinions of Drs. Fuller and Reimer (Ex. 11) and Dr. McKillop (Ex. 24).

Dr. Gritzka examined claimant and performed a file review on April 1, 1997, subsequent to the diagnosis of rotator cuff tear. On examination, Dr. Gritzka found atrophy, reduced range of motion, crepitus, and a positive reaction to a formal test for subluxation, and obtained a detailed history of claimant's shoulder dislocation and his worsening shoulder symptoms subsequent to the September 1996 injury. (Ex. 42).

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[1] The record also includes an opinion regarding causation by Dr. Wilson, who treated claimant for right shoulder bursitis. Although he acknowledged claimant's preexisting conditions, Dr. Wilson did not weigh these competing causes nor explain why claimant's work injury was the primary cause. Dr. Wilson simply opined that without the accident, claimant would probably not have developed bursitis, a "but for" analysis which is legally insufficient to carry claimant's burden. See Dietz v. Ramuda, 130 Or App 397 (1994), rev dismissed 321 Or 416 (1995).

Dr. Gritzka evaluated the relative contributions of claimant's old shoulder dislocation, the calcific tendinitis of the rotator cuff and calcific deposits in the subacromial bursa, and concluded that it was medically probable that the major cause of claimant's rotator cuff tear was the September 1996 accident.[2] Dr. Gritzka explained that the mechanism of the injury, given the forces and muscles involved, was consistent with causing a small rotator cuff tear, which, given claimant's history of progressively worsening symptoms, became worse over time. Dr. Winans, who also treated claimant's right shoulder condition until claimant transferred his care to Dr. McWeeney, concurred with Dr. Gritzka's opinion.

We find Dr. Gritzka's opinion more persuasive than those of Dr. McKillop and Drs. Fuller and Reimer, as it is well-reasoned and based on an accurate and complete history. Somers v. SAIF, 77 Or App 259, 262 (1986).

Dr. McKillop, who performed only a records review, concluded that claimant's right shoulder condition came on spontaneously one month after the accident. The doctor based his conclusion on the ground that the records first mention a right shoulder problem on October 11, 1996, and that "[claimant] would have logically developed symptoms within a few days [of the accident]," which is contrary to the record evidence. Moreover, Dr. McKillop did not obtain an oral history from claimant, nor did he have any information about the mechanism of the September 1996 accident. In addition, he apparently was not aware of claimant's rotator cuff tear, as opposed to the diagnosis of calcific deposits and bursitis, an inflammation of the shoulder bursa, thus preventing him from addressing the etiology of the rotator cuff tear.

We also find Drs. Fuller and Reimer's opinion unpersuasive. Like Dr. McKillop, the doctors found that the first mention of claimant's shoulder pain was in Dr. Wilson's October 11, 1996 chart note, in which claimant was diagnosed with calcific tendinitis, which, they opined, had combined with claimant's old shoulder dislocation. On examination they found crepitus and pain in the right shoulder. Nevertheless, the doctors concluded that claimant's shoulder was normal and opined that claimant's complaints of pain were not connected to the MVA, as they did not arise until over a month after the accident. Moreover, they provided their opinion prior to claimant's being diagnosed with a rotator cuff tear, the same deficiency found in Dr. McKillop's report.

In sum, after our de novo review of the record, we conclude that claimant has carried his burden to prove that the September 1996 MVA was the major contributing cause of his need for treatment of his combined shoulder condition.[3,4]

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[2] In evaluating the contribution of claimant's calcific tendinitis and calcific deposits in the subacromial bursa, Dr. Gritzka explained that they are common findings on x-ray that may or may not be symptomatic and, in and of themselves, do not lead to a rotator cuff tear. He also explained that rotator cuff defects do occur in the presence of calcific tendinitis, but the tear develops slowly over time and is caused by the inflamed and calcific rotator cuff being trapped between the humeral head and the acromion when the acromion is abducted in individuals that have Biglioni II or III shoulders, i.e., have a hook or spur on the anterior aspect of the acromion. Dr. Gritzka found that claimant did not have a longstanding history of right shoulder pain and "apparently has a Bigliani I acromion."

Although Dr. McWeeney stated that it "looks like" claimant has a type III acromion (Ex. 31-1), we do not find that statement to be fatal to Dr. Gritzka's analysis, as Dr. Gritzka also relied on his finding that claimant did not have a longstanding history of right shoulder pain, which is supported by the record. Moreover, Dr. Gritzka's opinion relied primarily on the mechanism of injury to conclude that the major contributing cause of the rotator cuff tear was the September 1996 injury, as indicated by his statement that whether claimant had calcific deposits prior to injury was "probably a moot point because [claimant] described a mechanism of injury which can reasonably [be] expected to produce a rotator cuff tear absent any antecedent degenerative conditions." (Ex. 42-13).

[3] We are aware that Dr. Gritzka does not find that either claimant's prior shoulder dislocation or the calcification combined with the injury to cause his need for treatment. Nevertheless, whether or not there is a combination, his opinion establishes the required element of proof, i.e., "major contributing cause."

[4] Because we have found claimant's claim compensable, we find no need to address claimant's request for remand for the taking of additional evidence.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated July 24, 1997 is reversed. The SAIF Corporation's partial denial of the right shoulder condition is set aside and the claim is remanded to SAIF for processing according to law. Claimant's counsel is awarded an attorney fee of $3,500 for his services at hearing and on review, to be paid by SAIF.

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February 17, 1998 Cite as 50 Van Natta 254 (1998)

In the Matter of the Compensation of
**DOUGLAS J. YARINGTON, Claimant**
WCB Case No. C8-00095
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Liberty NW Insurance Corp., Insurance Carrier

Reviewed by Board Members Biehl and Haynes.

On January 14, 1998, the Board acknowledged receipt of the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for his compensable injury. We approve the proposed disposition.

The proposed agreement states, on page 4, number 19 that: "[c]laimant has an outstanding Administrative Order to Withhold Workers' Compensation Benefits, filed in Wasco County. The SED No. is 06500D872641." 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.

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.

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In the Matter of the Compensation of
**MELISSA R. SCHULER, Claimant**
WCB Case No. 97-01397
ORDER ON REVIEW
Charles Robinowitz, Claimant Attorney
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Hazelett's order that set aside its denial of claimant's injury claim for a C6-7 disc condition. In her brief, claimant seeks remand for the ALJ to reconsider the amount of the attorney fee award. On review, the issue is compensability and attorney fees. We reverse.

## FINDINGS OF FACT

Claimant injured her neck and back in a noncompensable motor vehicle accident in February 1995. X-rays revealed degenerative disc disease at C6-7.

On June 8, 1995, claimant was injured when she slipped and fell on some water at work. On November 15, 1995, the employer accepted the claim for low back strain, cervical strain, groin strain and right wrist strain. An MRI revealed a disc herniation at C6-7.

On March 28, 1996, the employer issued a partial denial of claimant's degenerative disc disease at C6-7. Claimant's claim was closed by an April 10, 1996 Notice of Closure which awarded temporary disability, but no permanent partial disability.

In June 1996, claimant reported to Dr. Soot that she had increased difficulty with pains in her neck and left shoulder into the arm. According to Dr. Soot, claimant had not any unusual activity or injury which precipitated the symptoms. In July 1996, claimant reported to Dr. Soot that she had felt a pop in her back while putting in eye drops and was pain free for several days. After moving bark dust, the pain recurred and was much worse than before.

On September 26, 1996, claimant restrained an out of control student at work and had neck and shoulder pain later that evening. On September 30, 1996, Dr. Soot reported that claimant's left shoulder and arm had become progressively worse since the prior week. Dr. Soot indicated that the worsening occurred after some activity at work, but there was no really acute increase following any one particular episode. An MRI dated October 1, 1996 revealed degenerative disc changes at C6-7 with progression of left-sided disc protrusion/herniation with compromise of the left foramen and possibly slight displacement of the left side of the spinal cord. Dr. Soot referred claimant to Dr. Waller, a neurosurgeon.

Dr. Waller diagnosed persistent C7 radiculopathy with increased symptoms due to left C6-7 disc herniation and osteophyte. Dr. Waller performed left C6-7 discectomy and foraminotomy surgery on October 3, 1996. Claimant filed a claim for the September 26, 1996 incident involving the student. On February 7, 1997, the employer denied that claimant's work was the major contributing cause of a worsening of the preexisting degenerative disc disease and herniation at C6-7.

## CONCLUSIONS OF LAW AND OPINION

Relying on SAIF v. Nehl, 148 Or App 101 (1997), the ALJ found that, although the underlying preexisting condition was the major portion of the condition being treated, the immediate cause of the need for treatment was the work injury. On this basis, the ALJ set aside the denial.

In Nehl, the court had held that " * * * regardless of the extent of claimant's underlying condition, if the immediate cause of claimant's need for treatment is an on-the job accident, the treatment is compensable." 148 Or App at 106. Subsequent to the date of the ALJ's order, the court reconsidered its decision in Nehl. SAIF v. Nehl, 149 Or App 309 (1997). On reconsideration, the court modified the language quoted above to provide that: "We conclude that, regardless of the extent of claimant's underlying condition, if claimant's work injury, when weighed against his preexisting condition, was the major cause of claimant's need for treatment, the combined condition is compensable." 149 Or App at 109.

Pursuant to ORS 656.005(7)(a)(B),[1] and consistent with the court's decision in Nehl, claimant must establish that her work injury was the major contributing cause of her disability or need for treatment of the combined condition.[2] Determination of the major contributing cause involves evaluating the relative contribution of different causes of claimant's need for treatment of the combined condition and deciding which is the primary cause. Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev den 321 Or 416 (1995); Gregory C. Noble, 49 Van Natta 764 (1997). Because 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).

Three physicians address the cause of claimant's need for treatment of the disc herniation. Dr. Waller, who operated on claimant's herniated C6-7 disc condition opined that claimant: " * * * had a preexisting condition that was producing fairly minimal symptomatology, certainly not to the point that surgery was being considered, until the event with the unruly student. Therefore, I believe that event should be considered the major contributing cause to the need for surgery." At his deposition, Dr. Waller indicated that the work incident involving the unruly student caused claimant to become symptomatic. Dr. Waller agreed that the student incident was the inciting or precipitating event that lead to surgery. (Ex. 45-18). Dr. Waller explained that the event involving the student precipitated symptoms and prompted the need for surgery. According to Dr. Waller, there was no way to know whether the incident involving the student worsened the disc herniation.

Dr. Soot, who had previously treated claimant and who referred claimant to Dr. Waller, opined that claimant suffered from a severe preexisting degenerative disc disease and a disc protrusion at C6-7 prior to August 1995. Dr. Soot opined that the disc protrusion could have worsened spontaneously over time, or claimant's work activities could have caused the worsening of the C6-7 disc protrusion. Dr. Soot could not determine the major contributing cause of the worsening of the C6-7 disc protrusion.

Dr. Zivin, a neurologist who reviewed claimant's medical records, suggested that claimant's disc condition preexisted her work exposure and could have occurred in the absence of employment exposure.

After reviewing the medical evidence, we are not persuaded that claimant has established that the work injury was the major contributing cause of the disability or need for treatment of the combined condition. In this regard, although Dr. Waller believed that the injury provoked symptoms and precipitated the need for claimant's surgery, we are not persuaded that Dr. Waller weighed the contribution from the work injury against the contribution from the preexisting disc herniation to determine which was the major contributing cause of claimant's need for treatment of the combined condition. See Dietz v. Ramuda, 130 Or App 401-402. Under such circumstances, we find that claimant has not established compensability of the combined condition.

Because of our conclusion regarding compensability, we do not address claimant's motion for remand regarding the amount of the ALJ's attorney fee award.

## ORDER

The ALJ's order dated June 5, 1997 is reversed. The employer's denial is reinstated and upheld. The ALJ's award of an attorney fee is also reversed.

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[1] The statute provides that if an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition.

[2] The employer argues that ORS 656.005(7)(a)(B) and the Nehl case do not apply because "there is no medical evidence that claimant suffered 'an otherwise compensable injury' that combined with her preexisting cervical disc herniation at C6-7." Based on Dr. Waller's opinion, which is summarized in the body of our order, we find that claimant's work injury restraining the student combined with her preexisting herniated C6-7 disc to cause claimant's disability and need for treatment. Under such circumstances, we find that ORS 656.005(7)(a)(B) and the analysis in Nehl are applicable to this case. Because we find ORS 656.005(7)(a)(B) to be the appropriate statute under which to analyze compensability, we likewise reject the employer's argument that ORS 656.225(1) applies. In any case, by its terms, ORS 656.225(1) only applies to accepted claims.

In the Matter of the Compensation of
**LAURA HULL, Claimant**
WCB Case No. 96-10932
ORDER ON RECONSIDERATION
Daniel J. Denorch, Claimant Attorney
Sheridan & Bronstein, Defense Attorneys

Claimant requests reconsideration of our January 23, 1998 Order on Review that adopted and affirmed the Administrative Law Judge's (ALJ's) order that upheld the insurer's denial of claimant's claim for a left ankle fracture. Claimant contends that the ALJ's order did not account for the ALJ's finding that claimant was a traveling employee. In response, the insurer asks that we adhere to our prior decision.

Claimant correctly cites Savin Corp. v. McBride, 134 Or App 321 (1995), for the proposition that a traveling employee is continuously within the course and scope of employment while traveling, even though the employee may not actually be working when the injury occurs. However, the injury does not fall within the rule where the employee has departed on a personal errand so unrelated to her travels as to be excluded from the broad scope of coverage for traveling employees. Savin, 134 Or App at 325.

In his order, the ALJ found, and we agree, that claimant's status as a traveling employee ended when her job was finished at 3:30 on August 11, 1996. Furthermore, we agree with the ALJ's analysis that, even if claimant remained a traveling employee at the time of injury, her "joyride" on the equipment was a personal errand unrelated to her travels. Therefore, the injury did not occur within the course and scope of employment. Consequently, based on the reasoning set forth in the ALJ's order, which we have adopted, we continue to conclude that claimant has not met her burden of proof, and the injury claim is not compensable.

Accordingly, we withdraw our January 23, 1998 order. On reconsideration, as supplemented herein, we adhere to and republish our January 23, 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
**JOYCE A. STAUDENRAUS, Claimant**
WCB Case Nos. 97-02139 & 97-00074
ORDER DENYING RECONSIDERATION
Carney, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

On December 22, 1997, we reversed that portion of an Administrative Law Judge's (ALJ's) order that had found that claimant's claim was prematurely closed. On February 10, 1998, we received a February 9, 1998 letter from the insurer's attorney. Referring to a "January 14 . . . motion for a corrected Order on Review,"[1] the insurer asked whether any action had been taken to correct an erroneous date used in referring to an Order on Reconsideration. (The Board's order referred to an "October 26, 1996" Order on Reconsideration, whereas the correct date for the Order on Reconsideration was December 26, 1996.)

We treat the insurer's submission as a motion for reconsideration of our December 22, 1997 order. Inasmuch as our order has become final, we are without authority to alter our prior decision.

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

Here, the 30th day following our December 22, 1997 order was January 21, 1998. Therefore, the final day that we retained authority to modify our December 22, 1997 order was January 21, 1998. The insurer's February 9, 1998 request for reconsideration was received on February 10, 1998, more than 30 days after the December 22, 1997 order was mailed to the parties.[2]

Inasmuch as our December 22, 1997 order has neither been stayed, withdrawn, modified, nor appealed within 30 days of its mailing to the parties, we are without authority to alter our prior decision. See ORS 656.295(8); International Paper Co. v. Wright, supra; Fisher v. SAIF, supra; Donald J. Bidney, 47 Van Natta 1097 (1995). Consequently, the request for reconsideration is denied.

IT IS SO ORDERED.

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[1] The Board's file has no record of receiving the "January 14" motion referred to in the insurer's recent request.

[2] Had the insurer's "January 14" motion for a corrected order been brought to our attention at a time when the 30-day appeal period from our December 22, 1997 order had not expired, we would have attempted to respond to the motion in an expeditious manner. See Darlene E. Parks, 48 Van Natta 190 (1996); Connie A. Martin, 42 Van Natta 495, recon den 42 Van Natta 853 (1990). Unfortunately, as noted above, we were not aware of the insurer's request until February 10, 1998 (when we received the insurer's attorney's February 9, 1998 letter), which was after expiration of the 30-day "appeal and reconsideration" period.

In the Matter of the Compensation of
**JOANN BUKOVI, Claimant**
Own Motion No. 96-0473M
OWN MOTION ORDER
Roger D. Wallingford, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable acute lumbar strain injury. Claimant's aggravation rights expired on July 13, 1987. SAIF issued a denial of the compensability of claimant's current bilateral disc protrusion L4 & L5 condition on October 3, 1996. Claimant timely appealed that denial. (WCB Case No. 96-09424). In addition, SAIF opposed authorization of temporary disability compensation, contending that: (1) claimant's current condition is not compensably related to the accepted condition; and (2) it is not responsible for claimant's current condition.

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

Here, claimant did appeal the October 3, 1996 denial; however, she withdrew her request for hearing. An Order of Dismissal issued on January 14, 1998. That order has not been appealed. Thus, the current bilateral disc protrusion L4 & L5 condition and ensuing surgery for which claimant requests own motion relief remain in denied status. Consequently, we are not authorized to reopen claimant's claim at this time as SAIF has not accepted claimant's current condition as compensable. Should claimant's circumstances change and SAIF accept responsibility for claimant's condition, 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
**SANDRA L. PIERCE, Claimant**
Own Motion No. 97-0064M
OWN MOTION ORDER
Gordon Gannicott, Claimant Attorney
David Bussman, Defense Attorney

The insurer has submitted claimant's request for temporary disability compensation for claimant's compensable cervical strain injury. Claimant's aggravation rights expired on December 19, 1994. The insurer initially opposed authorization of temporary disability compensation, contending that: (1) claimant's current condition has not worsened resulting in surgery or inpatient hospitalization; (2) claimant's current condition was not causally related to the compensable condition; (3) the insurer was not responsible for claimant's current condition; and (4) surgery or hospitalization is not reasonable and necessary for the compensable injury. Claimant requested a hearing with the Hearings Division. (WCB Case No. 97-01438). The insurer subsequently amended its recommendation and opposed authorization of temporary disability compensation solely on the reasonableness and necessity for the surgery as it related to the compensable condition.

On May 5, 1997, Administrative Law Judge (ALJ) Hoguet approved a Stipulation and Order wherein the parties agreed that the medical issue lies only with the Medical Director. Claimant appealed the medical services issue to the Medical Review Unit (MRU) of the Workers' Compensation Division. On April 1, 1997, the Board issued its order postponing action on the own motion matters pending outcome of the medical services dispute.

On July 25, 1997, the MRU issued Administrative Order No. TX 97-424, which found that the proposed surgery was not appropriate medical treatment for claimant's compensable injury. Claimant requested reconsideration of that decision.

On January 13, 1998, the MRU issued an Amended Order on Reconsideration which reaffirmed its July 25, 1997 order. Claimant has not appealed this order on reconsideration and it became final on February 12, 1998.

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

Here, the dispute regarding the reasonableness and necessity of claimant's proposed surgery has been resolved. ORS 656.327. Because it has been determined that the insurer is not responsible for claimant's proposed medical treatment, we are unable to find that claimant is entitled to temporary disability compensation for surgery which has been determined not reasonable and necessary for claimant's compensable condition. However, should claimant's circumstances change and the insurer accept responsibility for her proposed surgical treatment, claimant may again seek own motion relief.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
**JOSEPH S. BAGGETT, Claimant**
WCB Case No. 92-13133
ORDER ON REMAND
Pozzi, Wilson, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Baggett v. The Boeing Company, 150 Or App 269 (1997). The court has reversed our prior order, Joseph S. Baggett, 48 Van Natta 2117 (1996), which reversed an Administrative Law Judge's (ALJ's) order awarding claimant 54 percent (192.8 degrees) unscheduled permanent disability for a low back injury and decreased claimant's award to 43 percent (137.60 degrees) unscheduled permanent disability. Finding that the administrative rule on which we had relied, former OAR 436-35-300(3), was invalid and contrary to the relevant statute (ORS 656.283(7)), the court has reversed and remanded the case for reconsideration of our determination that claimant's Specific Vocational Preparation (SVP) shall be based on the jobs claimant performed during the five years preceding the October 16, 1995 Determination Order rather than the five years preceding the date of issuance of the Order on Reconsideration.

## FINDINGS OF FACT

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

Claimant compensably injured his low back on November 9, 1990 while working as a machinist. He underwent surgery on November 27, 1990 and again on September 10, 1991. A July 1, 1992 Determination Order awarded 30 percent unscheduled permanent disability, which was affirmed by an September 17, 1992 Order on Reconsideration.

Shortly thereafter, claimant experienced recurrent back pain and the claim was reopened. Claimant underwent two additional low back surgeries, one in May 1994, and another in April 1995. He was found medically stationary on June 29, 1995. An October 16, 1995 Determination Order awarded 37 percent unscheduled permanent disability. A January 9, 1996 Order on Reconsideration increased claimant's total unscheduled permanent disability award to 43 percent, and also awarded 7 percent scheduled permanent disability for loss of use or function of the left leg and 2 percent scheduled permanent disability for loss of use or function of the right leg.

Claimant has been unemployed since his November 9, 1990 injury.

## CONCLUSIONS OF LAW AND OPINION

The only issue in dispute in this case is the proper date for determining the SVP[1] value for purposes of rating the extent of claimant's unscheduled permanent disability.[2] At hearing, the ALJ relied on former OAR 436-35-300(5) (WCD Admin. Order 93-056),[3] and found that claimant's SVP value should be +4 because claimant had not been employed in the five years prior to the January 9, 1996 Order on Reconsideration. On review, we reversed and, applying former OAR 436-35-300(3),[4] concluded that claimant's SVP should be based on the jobs claimant performed in the five years preceding the date of his original determination order, and not as of the date of the subsequent order on reconsideration.

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[1] SVP is the amount of lapsed time required by a typical worker to learn and perform the skills needed for average performance in a specific job-worker situation. The SVP range is from 1 (lowest) to 9 (highest) and is associated with each DOT Code. See former OAR 436-35-300(3)(a); OAR 436-035-0300(3)(a).

[2] The parties agree that claimant is entitled to an adaptability value of 4 and an impairment value of 39.

[3] This rule, which is identical to OAR 436-035-0300(5) (WCD Admin. Order 96-051), provides as follows: "For those workers who have not met the specific vocational preparation training time for any job, a value of +4 shall be granted."

[4] Former OAR 436-35-300(3) (WCD Admin. Order 93-056) provides as follows: "A value for a worker's Specific Vocational Preparation (SVP) time is allowed based on the job(s) the worker has performed during the five (5) years preceding *the time of determination*." (Emphasis added).

On judicial review, the court held that insofar as former OAR 436-35-300 required that a worker's SVP value be determined as of the time of determination, the rule is contrary to ORS 656.283(7), which requires that evaluation of the worker's disability shall be as of the date of the issuance of the reconsideration order. The court explained that although ORS 656.726(3)(f) requires the Board to apply the Director's standards, the statute does not require us to apply those standards as of a time that is contrary to the time that the statutes established. Baggett, 150 Or App at 272. The court reasoned that where the legislature has provided a time certain for evaluating a worker's disability, i.e., the date of the order on reconsideration, the Director cannot, by rule, change that time certain as to SVP more than it could as to any other of the factors that are part of determining the extent of disability. Id. at 272-73.

Consequently, in light of the court's decision, we conclude that the ALJ properly evaluated claimant's disability as of the time of the January 9, 1996 Order on Reconsideration. Because claimant had not been employed in the five years preceding the date of that order (he has not worked since his November 1990 injury), he has not met a specific vocational preparation training time for any job during that time. Therefore, pursuant to former OAR 436-35-300(5), claimant is entitled to a value of +4.

Using a SVP value of +4 entitles claimant to an age/education factor of 4, which, when multiplied by his adaptability value (4) equals 16. Adding 16 to his impairment value (39) entitles claimant to a total unscheduled award of 55 percent.[5]

Accordingly, on reconsideration, the ALJ's order dated May 10, 1996 is modified. In lieu of the ALJ's award and in addition to the 43 percent (137.6 degrees) unscheduled permanent disability for a low back injury awarded by the Order on Reconsideration, claimant is granted 12 percent (38.4 degrees) unscheduled permanent disability for a total award of 55 percent (176 degrees) unscheduled permanent disability. The ALJ's "out-of-compensation" attorney fee award shall be modified according to this 1 percent increase.

IT IS SO ORDERED.

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[5] The ALJ's order, which awarded claimant 54 percent unscheduled permanent disability, included a scrivener's error, as 39 + 16 equals 55, not 54.

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February 13, 1998 Cite as 50 Van Natta 262 (1998)

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

Claimant requests reconsideration of our January 21, 1998 Own Motion Order, in which we declined to reopen his claim for the payment of temporary disability compensation because he failed to establish that he was in the work force at the time of disability. With his request for reconsideration, claimant submits an affidavit regarding the work force issue.

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

IT IS SO ORDERED.

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In the Matter of the Compensation of
**LEAH A. BOYD, Claimant**
WCB Case No. 96-08873
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Lipton's order that set aside its denial of claimant's occupational disease claim for bilateral medial and lateral epicondylitis. On review, the issue is compensability. We reverse.

## FINDINGS OF FACT

Claimant experienced the onset of tingling, numbness and pain in her hands while working in the employer's sandwich shop in January 1996. Claimant's full-time job for the employer included braiding bread dough, preparing food products, making sandwiches, and operating a 10-key for record keeping and inventory. Claimant had no prior history of upper extremity symptoms.

The pain in claimant's hands increased over time and radiated into her forearms. In mid-June 1996, claimant began reporting marked tenderness in the medial and lateral epicondyle, with diffuse aching in the hands, wrists, forearms, neck, back and shoulders. Claimant left her job for the employer in mid-July 1996.

## CONCLUSIONS OF LAW AND OPINION

Claimant contends that her upper extremity symptoms are attributable to a bilateral medial and lateral epicondylitis which is compensable as an occupational disease. Claimant must prove the existence of an occupational disease by medical evidence supported by objective findings. ORS 656.802(2)(d). In addition, claimant must establish that her work activity for the employer is the major contributing cause of the onset or worsening of that occupational disease. ORS 656.802(2)(a) and (b). Resolution of these issues 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 ALJ concluded that the opinion of Dr. Gerry, claimant's treating physician, satisfied claimant's burden of proving a compensable occupational disease claim. We, instead, conclude that there are persuasive reasons not to defer to Dr. Gerry.

First, Dr. Gerry's opinion does not establish a diagnosable anatomic condition supported by objective findings. Dr. Gerry attributed claimant's hand/forearm and elbow pain to a combination of a generalized myofacial pain with a related sleep disturbance, superimposed on medial and lateral epicondylitis. Dr. Gerry does not explain the etiology of the myofacial pain syndrome. Moreover, he concurs with Dr. Peterson's August 1996 opinion that a rheumatologic condition should be ruled out, as claimant's complaints were too widespread and poorly localized to be diagnosed as simple tendinitis. Also, Dr. Gerry's deposition testimony clearly indicates that his diagnosis of epicondylitis was based on poorly localized symptoms, without objective verification. In particular, Dr. Gerry has never related claimant's positive Phalen's maneuver and Tinel's sign to the diagnosed epicondylitis.

Turning to the causation issue, we are not persuaded that Dr. Gerry was sufficiently familiar with claimant's symptomatic history to render an informed opinion. Dr. Layman reported that claimant's symptoms were worse on days when she worked, and claimant testified that the initial onset of her symptoms occurred in January 1996 after braiding bread dough for a party sandwich. Claimant also testified that her symptoms improved after she left the employer in July 1996, and that the pain in her hands woke her up at night. Dr. Gerry's written reports and chart notes do not reflect this history. Dr. Gerry first examined claimant approximately one-half year after the reported onset of her symptoms. In his June 14, 1996 report, Dr. Gerry does not relate claimant's symptoms to braiding dough or any other specific work activity. In that same report, Dr. Gerry dates the onset of symptoms to mid-1995, and he expressly notes that claimant's hand pain "really does not wake her up so much at night." Then, in his August 12, 1996 chart note, Dr. Gerry states that claimant "has really had no significant change in her symptoms[,] and even though she has been fired she has had no improvement."

We also find that Dr. Gerry's opinion is equivocal, based on an uncertain work history, and phrased in terms of possibilities rather than probabilities. Dr. Gerry initially concurred with Dr. Peterson's August 1996 opinion that claimant's work was not the major contributing cause of her condition, as her duties for the employer were many and varied. Dr. Gerry subsequently received a history of repetitive, hand-intensive work activity, including braiding dough approximately four hours a day. Based on this history, Dr. Gerry surmised in early October 1996 that braiding dough approximately four hours a day could cause medial and lateral epicondylitis, but that he would change his opinion if claimant were braiding dough much less than four hours per day. Dr. Gerry then modified this opinion without explanation in a late November 1996 chart note, in which he opined that, if claimant was using her hands braiding dough for even two to three to four hours per day, "that certainly would be consistent with the diagnosis of medial and lateral epicondylitis and that could cause a more diffuse myofacial pain syndrome[.]"

In the meantime, Dr. Gerry opined in a late October 1996 chart note that claimant's hand intensive work activities were more likely than not the major contributing cause of her hand and arm conditions. However, it appears that this opinion is based on the aforementioned history of repetitive, hand-intensive work activity, including braiding dough approximately four hours a day. This history is not consistent with claimant's testimony which, at best, supports a history of cumulative repetitive work activity for no more than four hours a day, including braiding dough roughly three days a week rather than every day.

Finally, Dr. Gerry continued to render equivocal opinions in his deposition testimony on January 30, 1997. After first acknowledging that he still did not have a "good handle" on how much claimant was using her hands at work, Dr. Gerry agreed that claimant's work was most likely the cause of her tendinitis if she was cumulatively in a day doing four to six hours of repetitive, hand-intensive work activity. Dr. Gerry further opined that claimant's work activity still could be the cause of her condition if claimant braided dough roughly three times a week rather than every day, but was engaged in other hand-intensive activities the rest of the time. Dr. Gerry then ended the deposition with the following acknowledgments: that his opinion assumed hand-intensive work on a rather continuous basis; that if claimant's hand-intensive work duties are broken up during the day by other activities, it is less likely that the work duties are the major cause of her condition; and that four hours of cumulative, repetitive hand activity "potentially could cause tendinitis."

In summary, when read as a whole, Dr. Gerry's opinion is uncertain and is framed in terms of possibilities rather than probabilities. Furthermore, we are not persuaded that Dr. Gerry is sufficiently familiar with claimant's symptomatic and work history to render an informed opinion on causation. These are persuasive reasons not to defer to Dr. Gerry, and there is no other supporting medical opinion in the record. Consequently, we conclude that claimant has not established a compensable occupational disease claim.

ORDER

The ALJ's May 15, 1997 order is reversed. The insurer's August 12, 1996 denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

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February 25, 1998 Cite as 50 Van Natta 264 (1998)

In the Matter of the Compensation of
**MICHAEL C. LEGGETT, Claimant**
WCB Case No. 96-04719
ORDER OF ABATEMENT
Popick & Merkel, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

The self-insured employer requests abatement and reconsideration of our February 2, 1998 order that set aside its "pre-closure" denial as procedurally invalid. Specifically, the employer asserts that we erred in construing the May 13, 1996 current condition denial as an attempt to limit responsibility to a resolved condition. The employer further challenges the basis for our $3,800 attorney fee award.

In order to further consider the employer's contentions, we withdraw our February 2, 1998 order. Claimant is granted an opportunity to respond. To be considered, claimant's response must be received within 14 days from the date of this order. Thereafter, we will proceed with our reconsideration.

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In the Matter of the Compensation of
**DONNA F. BROOKS, Claimant**
WCB Case No. 97-04058
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorneys
Charles L. Lisle, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) set aside its denial of claimant's right de Quervain's tenosynovitis claim; and (2) awarded an attorney fee of $3,600. On review, the issues are compensability and attorney fees. We reverse.

## FINDINGS OF FACT

Claimant started working for the employer on September 13, 1996. (Tr. 6). Her previous jobs included repetitive work on an assembly line in 1967 and she spent 20 years as a private investigator, which involved some keyboarding for four years. (Tr. 11, 12, 18).

Claimant was employed in the "specialty pack" area, which involved packing apples and pears. (Tr. 6). Her work involved the repetitive use of her hands. Within two weeks of her employment, she developed pain in her right thumb. (Tr. 10). She had no previous right thumb pain before working for employer. (Tr. 11).

On September 23, 1996, she sought treatment from company nurse Joslin. (Ex. 1). Joslin diagnosed "tendinitis, right thenar eminence-mild." (Ex. 1-1). Joslin recommended ice, medication and a semi-rigid wrist brace. (Id.) Claimant was laid off effective December 15, 1996. (Ex. 1-2). On January 3, 1997, she was examined by nurse Cassidy and she complained of right wrist and thumb pain, even though she was no longer working. (Ex. 1-2). Cassidy recommended the same treatment. (Id.)

On January 16, 1997, claimant sought treatment from Ms. Pylkki, a nurse practitioner.[1] (Ex. 3, Tr. 13). Ms. Pylkki diagnosed right de Quervain's tenosynovitis. (Ex. 3). On January 31, 1997, Ms. Pylkki prescribed hand therapy. (Ex. 5). Claimant was treated by Ms. Pylkki through April 25, 1997.

On March 31, 1997, claimant was examined by Dr. Nathan on behalf of the employer. (Ex. 11). She was examined by Dr. Murdock on August 14, 1997. (Ex. 14).

The employer denied compensability of claimant's right hand/wrist condition on April 11, 1997. (Ex. 12). Claimant requested a hearing.

## CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that Dr. Murdock's opinion satisfied claimant's burden of proving compensability of right de Quervain's tenosynovitis. The employer argues that Dr. Murdock's opinion is not persuasive and claimant did not meet her burden of proving causation.

In evaluating medical opinions, we rely on those that are both well-reasoned and based on an accurate and complete history. Somers v. SAIF, 77 Or App 259, 263 (1986). Absent persuasive reasons to the contrary, we generally defer to the opinion of the treating physician. Weiland v. SAIF, 64 Or App 810 (1983).

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[1] Although the chart notes from Ms. Pylkki also include the signature of Dr. Floyd Naugle, claimant testified that she was seen by Ms. Pylkki and had never talked with Dr. Naugle. (Tr. 17).

Claimant acknowledges that the record does not include an opinion regarding causation from the medical personnel who primarily treated her right thumb and wrist symptoms. She relies, however, on the opinion of Dr. Murdock. Claimant testified that she was examined by Dr. Murdock on one occasion and she saw him because "he was the first doctor that I could get an appointment with." (Tr. 16). Under these circumstances, Dr. Murdock's opinion is not entitled to any particular deference as a treating physician.

Dr. Murdock examined claimant on August 14, 1997 and reviewed some of her medical records. In a concurrence letter from claimant's attorney, Dr. Murdock agreed with the following:

> "You are an orthopedic surgeon, specializing in disorders of and injuries to the upper extremities. On the basis of your examination of [claimant], the history she provided to you about her work at [the employer] and the records, it is your opinion that she has de Quervain's syndrome in the right upper extremity. It is also your opinion that the major contributing cause of the de Quervain's syndrome is clearly found in the nature of her work at [the employer]." (Ex. 14).

The other medical opinion on causation is from Dr. Nathan, who examined claimant on March 31, 1997 and diagnosed de Quervain's and osteoarthritis in both thumbs. (Ex. 11-5). Dr. Nathan discussed claimant's work activities in detail. (Exs. 11-3, -4). He reported that x-rays of claimant's hands and wrists showed early, symmetric degenerative changes at the CMC joints of both thumbs. (Ex. 11-3). He commented that the arthritic changes were "not unanticipated in a female of [claimant's] age range, and the changes cannot be attributed to her brief course of employment at [the employer]." (Ex. 11-5). Dr. Nathan reported that claimant did not demonstrate or describe any component of her work activities that should provoke de Quervain's tenosynovitis. (Id.) He explained that claimant's job did not require resisted pinch prehension with the thumb, combined with ulnar deviation of the wrist. She also did not demonstrate any activities that caused repeated stretch or resistance on the tendons within the first dorsal compartment of either extremity, which are commonly associated with the development of de Quervain's. (Id.) On the other hand, Dr. Nathan opined that part of claimant's symptoms on the right could be attributed to arthrosis at the CMC joint of the thumb. (Id.) He could not develop the specific etiology of the de Quervain's syndrome either on the basis of claimant's work or avocational activities. (Ex. 11-6). In short, Dr. Nathan's opinion does not support compensability.

Although claimant relies on Dr. Murdock's report, we are not persuaded by his conclusory opinion. Dr. Murdock examined claimant on only one occasion and did not discuss any details of her work activities. Claimant testified that Dr. Murdock "didn't really ask" her about her work activities. (Tr. 14). Rather, she said that he read the notes in the file and asked if she was still working. (Id.) Dr. Murdock did not respond to Dr. Nathan's comments that there was nothing about claimant's work activities that should provoke de Quervain's tenosynovitis. Furthermore, Dr. Murdock did not properly evaluate the relative contribution of the arthritis in claimant's CMC joints. See Dietz v. Ramuda, 130 Or App 397 (1994), rev dismissed 321 Or 416 (1995). We conclude that Dr. Murdock's conclusory opinion is not sufficient to establish compensability.[2]

## ORDER

The ALJ's order dated September 18, 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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[2] In light of our conclusion, we need not address the employer's argument that the ALJ's attorney fee award of $3,600 was excessive.

In the Matter of the Compensation of
**JAMES E. CLEMONS, Claimant**
WCB Case No. 97-00968
ORDER ON REVIEW
Flaxel & Nylander, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Hall and Bock.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) McWilliams' order that: (1) held the Department was authorized to award scheduled permanent partial disability in the absence of a specific request for reconsideration on that issue; (2) affirmed an Order on Reconsideration's award of 4 percent (5.40 degrees) scheduled permanent disability for loss of use or function of the left foot; and (3) decreased claimant's unscheduled permanent disability award for a low back condition from 10 percent (32 degrees), as awarded by the Order on Reconsideration, to 9 percent (28.8 degrees). On review, the issues are jurisdiction (of the Department) and extent of scheduled and unscheduled permanent disability.

We adopt and affirm the ALJ's order with the following supplementation regarding the employer's challenge to the Department's authority to consider an issue (here, extent of scheduled permanent disability) not specifically raised by the request for reconsideration.

We have previously held that the Department's review of a timely appealed closure notice is not necessarily limited to only those issues expressly raised by the parties. Cases such as Jason O. Olson, 47 Van Natta 2192, 2194 (1995); Russell D. Sarbacher, 45 Van Natta 2230 (1993) and Darlene K. Bentley, 45 Van Natta 1719, 1722 (1993) stand for the general proposition that the Department may take whatever authorized action it deems necessary in its reconsideration of a closure notice or determination order. See also Estella Rogan, 50 Van Natta 205, n.4 (1998) (Department was authorized to address premature closure issue even though issue was not expressly raised by the parties).

Consequently, we agree with the ALJ's determination that the Department was authorized to address the issue of claimant's entitlement to an award of scheduled permanent disability in 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 $1,000, 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 September 12, 1997 is affirmed. For services on review, claimant's counsel is awarded $1,000, payable by the employer.

In the Matter of the Compensation of
**RICHARD N. HAAG, Claimant**
WCB Case No. 97-01422
ORDER ON REVIEW
Richard A. Sly, Claimant Attorney
Robert E. Nelson, Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The noncomplying employer requests review of Administrative Law Judge (ALJ) Mills' order which set aside the SAIF Corporation's denial, issued on its behalf, of claimant's wrist and shoulder injury claim. On review, the issue is compensability.

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

The employer contends that the ALJ improperly declined to admit testimony offered to undermine claimant's credibility. We disagree.

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).

We are reluctant to consider or permit consideration of evidence of "bad acts" because the prejudicial effect of such evidence tends to outweigh its probative value. John L. O'Day, 46 Van Natta 1756, 1757 n.1 (1994). Here, the employer offered testimony that claimant, a used auto salesman, did not truthfully record three sales transactions. (Trs. I-56; II-14). Even if we assume such evidence was relevant, we find that the probative value of such evidence is outweighed by the danger of undue prejudice. See Robert C. Cook, 47 Van Natta 723 (1995). We, therefore, conclude that the ALJ did not abuse his discretion in declining to admit the evidence.[1]

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

ORDER

The ALJ's order dated January 26, 1995 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by SAIF on behalf of the noncomplying employer.

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[1] Moreover, even if testimony did establish that claimant did not truthfully record prior sales transactions, we would still agree with the ALJ's reasoning and conclusion that claimant met his burden of proving that he sustained a compensable injury.

In the Matter of the Compensation of
**MICHAEL J. KUSEL, Claimant**
WCB Case Nos. 97-04122, 96-10218 & 97-04119
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that: (1) upheld the SAIF Corporation's denial of compensability and responsibility for claimant's low back condition; and (2) upheld the self-insured employer's denial of compensability and responsibility for the same condition. On review, the issues are compensability and, potentially, responsibility.

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

On review, claimant in part asserts that the ALJ improperly applied ORS 656.005(7)(a)(B) to determine compensability of his injury claim. Specifically, claimant contends that his preexisting degenerative disc disease does not constitute a "preexisting condition" under ORS 656.005(24) because such condition "is a normal physical phenomenon which accompanies aging in all people and, therefore, is not a 'disease' nor a 'congenital abnormality[.]'"

When a compensable injury combines with a "preexisting condition," the "combined condition" is compensable only if the compensable injury is the major contributing cause of the need for treatment or disability of the combined condition. ORS 656.005(7)(a)(B). "Preexisting condition" is any "injury, disease, congenital abnormality, * * * or similar disorder that contributes or predisposes a worker to disability or need for treatment[.]"

Here, we fail to find, and claimant does not cite to, any direct evidence that claimant's degenerative disc disease was caused by aging. Instead, medical evidence described disc degeneration as "multifactorial in nature" and the "chief determinant" as "genetics." (Ex. 19-2). Furthermore, the record showed that the preexisting degenerative condition was the sole, or major contributing cause, of claimant's need for treatment or disability. (Exs. 14, 19,20A, 21, 22-8, 22-9, 23-2). Based on such evidence, we find that the degenerative condition qualified as a "disease" or "similar condition" that "contributed" to claimant's need for treatment. Consequently, we also find that the degenerative condition constituted a "preexisting condition" under ORS 656.005(24). See Cindy L. Keen, 49 Van Natta 1055 (1997) (because the medical evidence persuasively established that, prior to the compensable injury, the 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, the ALJ properly applied ORS 656.005(7)(a)(B)).

Finally, contrary to claimant's arguments, in applying ORS 656.005(7)(a)(B), the ALJ did not limit his analysis to the major contributing cause of the combined condition. Rather, the ALJ determined whether the compensable injury, as opposed to the preexisting condition, was the major contributing cause of claimant's need for treatment and disability of the combined condition. See SAIF v. Nehl, 148 Or App 101, mod 149 Or App 309, 315 (1997), rev den 326 Or 389 (1998).

In sum, we agree with the ALJ's analysis of the persuasiveness of the medical evidence and his reasoning that claimant failed to establish a compensable injury under ORS 656.005(7)(a)(B) and a compensable occupational disease under ORS 656.802.

ORDER

The ALJ's order dated July 24, 1997 is affirmed.

In the Matter of the Compensation of
**LLOYD V. LARSON, Claimant**
WCB Case No. 97-04071
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Hall and Bock.

The employer requests review of Administrative Law Judge (ALJ) Mills' order that set aside its denial of claimant's aggravation claim for his current low back condition. On review, the issue is compensability. We affirm.

## FINDINGS OF FACT

We adopt the ALJ's Findings of Fact, with the following correction. The ALJ found that claimant's claim was last closed by a November 29, 1994 Determination Order which awarded 11 percent unscheduled permanent disability. However, we find that the Determination Order actually issued January 9, 1995.

## CONCLUSIONS OF LAW AND OPINION

On review, the employer argues that claimant's current low back condition at L4-5 is not related to his accepted lumbosacral strain. We disagree.

ORS 656.273(1) provides, in part: "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings." Thus, in order to establish a compensable aggravation, claimant must prove two elements: (1) a compensable condition; and (2) an "actual worsening." ORS 656.273(1); Steve L. Piersall, 49 Van Natta 1409 (1997); Gloria T. Olson, 47 Van Natta 2348, 2350 (1995). If the worsened condition is not a compensable condition, compensability must first be established under ORS 656.005(7)(a). Id.

Here, the employer accepted a low back strain as a result of claimant's May 1993 injury. Claimant's current condition has been diagnosed as an L4-5 disc bulge. Because claimant's disc bulge is not an accepted condition, in order to establish a worsened condition resulting from the original injury, he must first establish that the disc bulge is a compensable condition.

The employer argues that the causation opinion of Dr. Brett, claimant's treating doctor, is speculative and not persuasive. The employer contends that the most persuasive argument has been provided by Drs. Platt and Dinneen, who related claimant's current condition to preexisting and degenerative factors.

However, for the reasons stated in the ALJ's order, we agree that Dr. Brett's opinion is most persuasive. Despite an initial diagnosis of lumbar strain, the record shows that, within days of the initial injury, claimant complained of pain radiating into his legs. (Exs. 6, 7, 8). Claimant continued to experience occasional symptoms in the lower extremities and, in August 1993, Dr. Brett report that claimant's lumbar disc protrusion at L4-5 was a result of the May 1993 injury. (Ex. 29). Dr. Brett also explained in 1993 that claimant's lumbar disc protrusion and discogenic pain included some "referred leg pain or possibly early nerve root impingement." (Ex. 30).

Consistent with his earlier opinions, Dr. Brett reported in May 1997 that claimant's need for surgery was a "direct result of his original work injury of 5-19-93 which remains the major contributing factor to his current condition." (Ex. 67). Under the circumstances, we find that the record supports Dr. Brett's conclusion. Furthermore, we disagree with the employer's contention that Dr. Brett's opinion is speculative or unpersuasive. Therefore, based on this reasoning and the additional reasons set forth in the ALJ's order, we agree that claimant has established both a compensable condition and an actual worsening.

Claimant's counsel is entitled to an assessed attorney fee for services on review concerning the issue of compensability. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review is $1,400, 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 September 4, 1997 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,400, to be paid by the employer.

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February 23, 1998 Cite as 50 Van Natta 271 (1998)

In the Matter of the Compensation of
**JEAN M. PARKER, Claimant**
WCB Case No. 97-00022
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Hall and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Baker'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 adopt and affirm the ALJ's order with the following supplementation.[1]

We agree with the ALJ's conclusion that Dr. Kenneth Wilson's opinion is sufficient to meet claimant's burden of proof. We specifically address SAIF's argument that claimant's wheelchair use did not arise out of her employment.

In Ramona Andrews, 48 Van Natta 1652 (1996), the claimant had been an emergency room admitting representative for 20 years and her job involved extensive walking between different areas. The employer remodeled its emergency facilities and doubled the size, which increased the distances the claimant walked. We relied on the opinion of the claimant's treating physician that the change in the claimant's walking requirements constituted more than 51 percent of her need for treatment, and we concluded that the claimant's work injury was the major contributing cause of the disability and need for treatment for her right foot plantar fascitis.

We reach a similar conclusion in this case. We agree with the ALJ that claimant's work activities, including her wheelchair use and keyboarding, were the major contributing cause of the development of her carpal tunnel syndrome. Claimant testified that 75 percent of her manually-propelled wheelchair use occurred at work. (Tr. 11). Because we agree with the ALJ that the majority of claimant's relevant hand/wrist use occurred at work, we are not persuaded by SAIF's argument that claimant's condition did not "arise" out 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 SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

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[1] In light of our disposition, we need not address claimant's alternative arguments as to whether a preexisting condition of being "wheelchair bound" violates Article 1, section 10 of the Oregon Constitution, or the Americans with Disabilities Act (ADA), or whether being "wheelchair bound" constitutes a preexisting condition.

ORDER

The ALJ's order dated July 10, 1997 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by the SAIF Corporation.

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In the Matter of the Compensation of
**MARINA VLASENKO, Claimant**
WCB Case No. 96-04485
ORDER ON REVIEW
Patrick K. Mackin, Claimant Attorney
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Tenenbaum's order that upheld the insurer's denial of claimant's occupational disease claim for a right upper extremity condition. On review, the issue is compensability.

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

All references to upper extremity symptoms and diagnoses in the first paragraph of the ALJ's Findings of Fact should be limited to the *left* upper extremity. Claimant first experienced right elbow/forearm/hand symptoms in late 1995 or early 1996, after she was transferred from transformer winding to amplifier assembly.

We also modify the third sentence of the last paragraph of the ALJ's Findings of Fact to read as follows: "He identifies no reproducible or measurable objective findings, and notes no observable objective findings, *with the exception of reduced right grip strength.*"

Finally, like the ALJ, we do not rely on Dr. Long's opinion that claimant's work for the employer was the major contributing cause of her right upper extremity symptoms. We discount Dr. Long's opinion because it is based on an inaccurate history of the onset of symptoms while claimant was using her right arm in a strenuous manner winding wire on transformers. The preponderance of the evidence establishes that claimant's symptoms during the transformer winding activity were limited to the left upper extremity, and that she first experienced right elbow/forearm/hand symptoms in late 1995 or early 1996, after she was transferred from transformer winding to an assembly job in which she used a power screwdriver. In making this finding, we rely on claimant's testimony at hearing, the contemporaneous medical records, and the histories reported by Drs. Lamb and Nolan.

ORDER

The ALJ's order dated June 25, 1997 order is affirmed.

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In the Matter of the Compensation of
**JOHN R. BENSON, Claimant**
WCB Case No. 96-11459
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that upheld the SAIF Corporation's denial of his neck, left shoulder and right foot injury claim. On review, the issue is whether claimant's injury arose in the course and scope of his employment. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact. We do not adopt the ALJ's ultimate findings of fact.

## CONCLUSIONS OF LAW AND OPINION

Claimant worked as an automobile leasing representative for an employer who sublet premises on the second floor of an office building and the right to park in four unassigned parking spaces in the adjacent parking lot. The employees had scheduled, unpaid lunch breaks, but it was accepted practice for them to work at their desks while they ate lunch. (Tr. 15, 36, 43, 44, 45, 50). Because he had begun working for the employer, claimant left the building three or four days a week to buy lunches for himself, his supervisor and his co-workers, which he brought back to the office so they could eat while working. (Tr. 12, 14, 15, 16, 37, 38). Claimant was paid a monthly salary based on a standard 40-hour week. He received no overtime for any additional hours he worked. On December 6, 1996, while returning with a box of lunches for himself and his co-workers, claimant slipped and fell in some water on the floor of the lobby of the building, injuring his neck, left shoulder and right foot. (Tr. 16, 17, 18). SAIF denied compensability of claimant's injury on the basis that his injury did not arise out of and in the course of employment, and claimant requested a hearing.

The ALJ upheld SAIF's denial. The ALJ reasoned that claimant's injury did not arise out of and in the course of his employment because the employer did not exercise control over the lobby where claimant was injured. In reaching this conclusion, the ALJ determined that claimant was not on a "special errand" for the employer, and that the employer's control was limited to its "premises" on the second floor of the building and access to four parking spaces. The ALJ also concluded that claimant was not at any greater risk associated with the water in the lobby than any other person entering the building.

On review, claimant argues that he satisfied both prongs of the work-connection test under Fred Meyer, Inc. v. Hayes, 325 Or 592 (1997), thus establishing the compensability of his claim. We agree.

A "compensable injury" is an accidental injury arising out of and in the course of employment requiring medical services or resulting in disability. ORS 656.005(7)(a). The phrases "arise out of" and "in the course of" are two elements of a single inquiry into whether an injury is work-related. Fred Meyer, Inc. v. Hayes, 325 Or 592, 596 (1997); Norpac Foods, Inc. v. Gilmore, 318 Or 363, 366 (1994). Each element of the inquiry tests the work-connection of the injury in a different manner. The requirement that the injury occur "in the course of employment" concerns the time, place and circumstances of the injury. The requirement that the injury "arise out of" the employment tests the causal connection between the injury and the employment. Under the "work-connection" test, both elements must be satisfied to some degree. Id. However, the two elements need not be met to the same degree. When the factors supporting one element are many, the factors supporting the other may be minimal. Id.

As a general rule, injuries sustained by employees when going to and coming from their regular workplace are not deemed to arise out of and in the course of their employment. Cope v. West American Ins. Co., 309 Or 232, 237 (1990); SAIF v. Reel, 303 Or 210, 216 (1987). An exception to the going and coming rule, however, is the "parking lot rule." Under that exception, when an employee traveling to or from work sustains an injury in a parking lot or other off-premises area over which the employer has "some" control, the injury may be compensable. Cope, 309 Or at 239.

Application of the rule, however, establishes only that the time, place, and circumstances of the injury are sufficiently work-related to satisfy the threshold "in the course of" element; the second element of the work-connection inquiry must also be satisfied. Gilmore, 318 Or at 366. Thus, to prove compensability, claimant must also establish a sufficient causal connection between his employment and the injury to prove compensability. Id. at 368-69.

In a "parking lot" case, that causal connection must be linked to a risk connected with the nature of the work or a risk to which the work environment exposed claimant, i.e., the claimant's injury was brought about by a condition or hazard associated with premises over which the employer exercised some control. Fred Meyer, 325 Or at 598; Margaret A. Kohl, 48 Van Natta 2492 (1996) (where employer leased a parking lot for employees and lease agreement provided that lessee could maintain premises in a hazard-free condition, there was sufficient "control" of parking lot by employer to prove that injury occurred in course of employment). Thus, claimant must prove that his employment conditions put him in a position to be injured. See Henderson v. S.D. Deacon Corporation, 127 Or App 333, 338-39 (1994).

In this case, there is no dispute that claimant's injury was brought about by a hazard (water on the floor) associated with the building lobby through which claimant customarily passed to get to the employer's second floor premises. The dispositive issue here, then, is whether the employer exercised at least partial control over the lobby at the time the accident took place.[1] In Henderson, the court concluded that sufficient employer control was established by a lease giving the employer a nonexclusive right to use an elevator where the claimant was injured, providing that the employer had the right to require repairs of the elevator, and requiring that the employer pay a share of operating expenses.

In this case, claimant contends that the employer's sublease agreement regarding the building in which claimant was employed gave the employer at least some control over the lobby. SAIF disagrees. For the following reasons, we conclude that, regardless of whether the lobby was part of its leased "premises," the employer had at least some control over the area in which claimant was injured.[2]

The employer's sublease agreement, in the section entitled "Rental," provides that under the first renewal term (beginning February 1, 1996), the sublessee's rental payments included a prorata share of the total increases in rent and operating expenses required to be paid by the sublessor under the underlying lease during the prior year, in proportion to the square feet of the sublet portion.[3] Under "Access," the employer/sublessee was given access to the premises from 7 am to 6 pm, Monday through Friday; and during any weekend hours, provided it paid all operating expenses for weekend use. Thus, we conclude that the employer was given a non-exclusive right to use the lobby, elevator and stairs for ingress and egress to its premises, and that the employer was required to pay a share of the operating expenses.

Although the employer's sublease is silent regarding who was responsible for actual maintenance of the building lobby, there is evidence that a building management company had been hired to perform those duties. (Ex. 20, Tr. 40). In this regard, the employer testified that, if it had a complaint, its normal procedure was to contact the sublessor and ask them to handle it or to direct the employer to the proper person to get it taken care of. The employer also testified that it was not permitted to take care of the problem itself and that the ultimate decision regarding a complaint lay with the owner of the building. (Tr. 40).

We next turn to other provisions in the sublease agreement. In the section entitled "Indemnification and Insurance," the employer agreed to waive all claims against the sublessor for "injury, illness or death of any person in, upon or about the premises and/or the building arising at any

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[1] Claimant need not prove that he was exposed to any "peculiar" or "increased" risk by his employment. Fred Meyer, 325 Or at 601.

[2] It is well-established that ownership or even a leasehold interest in the place where the injury occurred is not always required. Montgomery Ward v. Malinen, 71 Or App 457 (1984); Montgomery Ward v. Cutter, 64 Or App 759 (1983); see also Philpott v. State Ind. Acc. Com., 234 Or 37, 41 (1963) (exception to "going and coming rule" includes injuries sustained off the premises of the employer, but while in close proximity thereto and while using a customary means of ingress and egress).

[3] In the section entitled "Compliance with the Underlying Lease," the sublessee agrees to comply with all of the provisions of the underlying lease, with one exception not relevant here. The underlying lease itself is not a part of the record.

time and from any cause whatsoever other than solely by reason of the negligence or willful act of sublessor or its employees." (Ex. 6-3; emphasis added). Furthermore, the employer agreed that it "shall hold sublessor harmless and defend sublessor against any and all claims or liability for any damage to any property or injury, illness or death of any person (i) occurring in or on the premises or any part thereof arising during the sublease term from any cause whatsoever other than solely by reason of the negligence or willful act of sublessor or its employees and (ii) occurring in, on or about any part of the building other than the premises when, and to the extent, such damage, injury, illness or death shall be caused by the act, neglect, omission or fault of sublessee, its agents, servants, employees, invitees or licensees. (Id.; emphasis added). We conclude that these provisions provide additional evidence that the employer had "some" control over the common areas.

Accordingly, based on the employer's testimony and the terms of the lease, we conclude that, notwithstanding the fact that the employer did not have direct control over the lobby, it had the right (and responsibility) to obtain maintenance of the lobby. Thus, under the particular circumstances in this case, we conclude that the record as a whole provides sufficient evidence that the employer exercised at least some control over the area where claimant was injured. Consequently, claimant's injury occurred in the course of employment.

We next address whether claimant's injury "arose out of" his employment. That inquiry tests the causal connection between claimant's injury and a risk connected with his employment. Fred Meyer, 325 Or at 601. A worker's injury is deemed to "arise out of" employment if the risk of the injury results from the nature of his or her work or when it originates from some risk to which the work environment exposes the worker. The ALJ's premise, that the risk claimant was exposed to must be a greater risk than that to which anyone entering the lobby was exposed, was rejected by the Court in Fred Meyer. Id. As the Court explained, a worker's injury is deemed to "arise out of" employment if the risk of the injury results from the nature of his or her work or when it originates from some risk to which the work environment exposes the worker. Id.

Here, it was customary for claimant to go out to get lunches for his coworkers and to return to his place of work on the second floor by crossing the lobby to take the elevator or the stairs from the first to the second floor. (Tr. 42, 43, 44, 46, 50). Moreover, this activity was acquiesced in by the employer. (Tr. 43, 44). Consequently we conclude that claimant's injury arose out of a risk (water on the lobby floor) to which his employment environment exposed him.

Because claimant has established both prongs of the compensability test, we conclude that the relationship between his injury and his employment is sufficient and his injury is compensable.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $5,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

## ORDER

The ALJ's order dated August 15, 1997 is reversed. The SAIF Corporation's denial is set aside and claimant's claim is remanded to SAIF for processing according to law. Claimant's counsel is awarded an attorney fee of $5,000 for services at hearing and on review, to be paid by SAIF.

In the Matter of the Compensation of
**DAVID L. DYLAN (fka DAVID H. HUBBARD), Claimant**
WCB Case No. 96-04448
ORDER ON REVIEW
Cole, et al, Claimant Attorneys
Ronald W. Atwood, et al, Defense Attorneys

Reviewed by the Board en banc.

The self-insured employer requests review of Administrative Law Judge (ALJ) Baker's order that: (1) found claimant's aggravation claim was timely filed under ORS 656.273(4)(a); and (2) set aside the employer's denial of claimant's aggravation claim for a low back condition. On review, the issues are jurisdiction and, alternatively, aggravation. We vacate.

## FINDINGS OF FACT

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

On April 27, 1990, claimant was performing his regular work as a logger when he began to experience low back and right leg symptoms. He sought treatment on May 2, 1990, and a CT scan showed a central disc bulge at L5-6 and a possible frank disc herniation, right paramedian region at L6-S1 (claimant's spine has six lumbar vertebrae). Claimant completed an 827 Form and an 801 Form, noting the nature of injury was a "herniated disc" in the back.

The employer accepted claimant's claim as a disabling injury on May 21, 1990. Claimant continued with conservative treatment through mid-August 1990. On December 12, 1990, he returned for a closing examination and was deemed medically stationary without permanent impairment. The claim was closed by a January 16, 1991 Determination Order that awarded temporary disability only.

After his December 1990 closing examination, claimant did not seek medical treatment for back symptoms until October 1995. He had quit his logging job in 1993. On October 3, 1995, claimant sought treatment with his family physician complaining of pain radiating down the posterior of the left leg into the left foot.

An October 27, 1995 MRI showed a left paramedian disc herniation L5-6 and a small central disc herniation L6-S1, probably unchanged from the 1990 CT scan. 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 January 10, 1996, Dr. Lewis completed and submitted an aggravation claim on claimant's behalf, which the employer received on January 12, 1996. The claim form was not accompanied by an attending physician's report, nor was such a report received by the employer on or before January 16, 1996, the date claimant's aggravation rights expired.

## CONCLUSIONS OF LAW AND OPINION

The filing requirements of ORS 656.273 are jurisdictional. SM Motor Co. v. Mather, 117 Or App 176 (1992); Timothy D. Beard, 43 Van Natta 432 (1991). A claim for additional compensation made outside the time limits of ORS 656.273 falls within the Board's own motion jurisdiction. See Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988); Edward R. Reuter, 42 Van Natta 19 (1990).

The ALJ determined that claimant's aggravation claim was timely filed under ORS 656.273(4)(a)[1] because Dr. Lewis submitted a signed Notice of Claim for Aggravation of Occupational Injury or Disease (the form prescribed by the Director) within the five year period, even though the form was not

[1] ORS 656.273(4)(a) provides that "[t]he claim for aggravation must be filed within five years after the first determination or the first notice of closure made under ORS 656.268."

accompanied by an attending physician's report. The ALJ found that the filing of the completed form was sufficient to toll the statute of limitations, although the employer was not required to process the claim until it received the physician's report establishing a worsened condition attributable to the compensable injury.

On review, the employer renews its contention that, in the absence of an attending physician's report accompanying the aggravation claim form, claimant's claim for aggravation was not timely filed under ORS 656.273(4)(a). We agree.

As noted above, ORS 656.273(4)(a) requires that the claim for aggravation be filed within five years after the first determination or the first notice of closure. As currently drafted, ORS 656.273(3) provides that "[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 statute further provides that the claim for aggravation "must be accompanied by" an attending physician's report which establishes that the claimant has suffered a worsened condition attributable to the compensable injury.[2]

In construing ORS 656.273(4)(a), both the court and the Board have equated the term "filed" with the concept of "perfecting" the aggravation claim under 656.273(3). For example, in Krajacic v. Blazing Orchards, 84 Or App 127, mod 85 Or App 477 (1987), remanded on other grounds 304 Or 436 (1987), adhered to on recon 90 Or App 593 (1988), the court held that the claimant did not "perfect" his aggravation claim within the five year period because the attending physician's report (which was received by the carrier prior to the expiration of the claimant's aggravation rights) was insufficient to put the carrier on notice that the claimant had a worsened condition resulting from his original injury. Similarly, in Linda Coiteux, 43 Van Natta 364 (1991), we held that the claimant failed to perfect her aggravation claim prior to the termination of her aggravation rights because her medical treatment records failed to provide sufficient notice of a claim for a worsened condition. Compare Juan F. Carrizales, 43 Van Natta 2811 (1991) (Board found that the claimant had "perfected his aggravation claim before the five-year statutory bar" where the carrier had notice that claimant's worsened condition was related to his prior industrial injury 10 days before the claimant's aggravation rights expired). Furthermore, in Lee R. Hancock, 42 Van Natta 391 (1990), we explained that "[t]o perfect an aggravation claim, the claimant must file his claim within five years of the first determination." We noted that filing means receipt by the carrier and concluded that, in the absence of evidence establishing that the carrier received the treating doctor's report within the five year limitation period, claimant could not prove a timely filing of his aggravation claim.

Although the statutory requirements for "perfecting" an aggravation claim were amended in 1995, the legislature did not amend the language of ORS 656.273(4)(a), nor did it alter the judicial doctrine equating "filing" with "perfecting" for purposes of the aggravation statute. For example, in Kelly O. Sullivan, 46 Van Natta 2144 (1994), we dismissed the claimant's request for hearing concerning his aggravation claim for lack of jurisdiction based on our determination that his treating doctor's report, which was submitted a few weeks prior to the expiration of his aggravation rights, did not establish a "prima facie case" for aggravation. The claimant sought judicial review. During the pendency of that appeal, the 1995 amendments were enacted and became retroactively applicable. The court reversed and remanded for "reconsideration in light of ORS 656.273 as amended." Sullivan v. Sears, Roebuck & Co., 136 Or App 302 (1995). On remand, we found nothing in the 1995 amendments to ORS 656.273(3) "which would change our conclusion that claimant did not perfect an aggravation claim prior to the expiration of his aggravation rights." Kelly O. Sullivan, 47 Van Natta 2395 (1995).

We find that, just as former ORS 656.273(3) did before it, the current version of ORS 656.273(3) sets forth the elements of a "perfected" aggravation claim. Prior to SB 369, a claimant was required to file a physician's report establishing a worsening of the compensable condition. Under the amended

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[2] Prior to June 1995, there was no statutory requirement of a specific form along with a physician's report. Former ORS 656.273(3) defined a claim for aggravation as "[a] physician's report establishing the worsened condition by written medical evidence supported by objective findings." To "perfect" an aggravation claim under the former statute, the physician's report had to constitute prima facie evidence that the claimant's compensable condition had medically worsened. See, e.g., Herman M. Carlson, 43 Van Natta 963, 964 (1991), aff'd Carlson v. Valley Mechanical, 115 Or App 371 (1992). The report also had to indicate a causal connection between the claimant's "worsened" condition and the compensable injury. Id.; see also Michael L. Page, 42 Van Natta 1690, 1693 (1990).

statute, there are two essential elements for a "claim for aggravation," the completed Director's form and the accompanying attending physician's report. The timely filing of one without the other does not satisfy the filing requirement of ORS 656.273(4).

Consequently, in this case, we conclude that we lack jurisdiction to address the merits of claimant's claim because he failed to timely perfect a valid claim for aggravation. Although claimant filed a Notice of Aggravation claim form prior to the expiration of his aggravation rights, that document, without an accompanying attending physician's report establishing by written medical evidence supported by objective findings that claimant suffered a worsened condition attributable to his compensable injury, was insufficient to "perfect" the aggravation claim.[3] See, e.g., Melvin L. Shroy, 48 Van Natta 561 (1996) (because the claimant's aggravation claim was not accompanied by an attending physician report, it did not constitute a claim for aggravation under amended ORS 656.273(3)). In other words, to preserve claimant's aggravation rights under ORS 656.273(4)(a), both the prescribed form *and* the accompanying attending physician's report establishing a worsened condition attributable to the compensable injury must have been received by the carrier within five years of the first determination order or notice of closure.[4]

ORDER

The ALJ's order dated May 29, 1997 is vacated. Claimant's request for hearing is dismissed.

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[3] Indeed, the completed Notice of Aggravation claim form did not even identify the body part affected or contain any substantive medical evidence concerning the nature of claimant's condition. Thus, the completed claim form by itself cannot be construed as notice to the insurer that claimant's compensable condition has medically worsened.

[4] Unlike the dissent, we decline to presume that, in amending ORS 656.273(3), the legislature necessarily determined that the completed Notice of Aggravation Claim form was sufficient to put the carrier on notice of a worsened condition attributable to the compensable injury. We further believe that, had the legislature intended to alter the judicial doctrine equating "filing" with the "perfecting" of the claim for purposes of ORS 656.273(3) and (4)(a), it would have expressed such an intent. See, e.g., Fifth Avenue Corp. v. Washington County, 282 Or 591, 597-98 (1978) (amendatory acts do not change the meaning of preexisting language further than is expressly declared or necessarily implied). Finally, to find, as would the dissent, that the filing of the claim form alone is sufficient to "toll" the limitations period not only creates a claim processing status not contemplated by the statute (i.e., a situation where the carrier has notice of an aggravation claim but no evidence documenting a worsened condition, and therefore no obligation to begin processing the claim), this approach also ignores the express requirement in ORS 656.273(3) that the claim for aggravation form "be accompanied by" the attending physician's report. We decline to construe the statute in a way that renders this provision meaningless. See, e.g., Vaughn v. Pacific Northwest Bell Telephone, 289 Or 73, 83 (1980) (a court should endeavor to avoid a construction which creates a conflict between statutes or renders one statute ineffective).

**Board Members Biehl and Hall dissenting.**

The majority concludes that the Board lacks jurisdiction to consider claimant's aggravation claim because claimant did not "perfect" his claim by submitting an attending physician's report prior to the expiration of his aggravation rights. Because we would find, for the reasons set forth below, that claimant in this case timely "filed" his "claim for aggravation" under to ORS 656.273(4)(a), we respectfully dissent.

ORS 656.273(4)(a) provides, in pertinent part, that "the claim for aggravation must be filed within five years" after the first determination or notice of closure. Contrary to the majority's determination, this subsection does not require that the aggravation claim be "perfected" for purposes of ORS 656.273(3), nor does it expressly require the "filing" of an attending physician's report within the five year deadline in order to "perfect" the filing of the claim itself in a timely manner. Rather, the limitations section of the aggravation statute (the provision that dictates our jurisdiction to consider the aggravation claim)[1] requires only that the "claim for aggravation" be "filed" within five years. Because the record in this case establishes that the carrier received claimant's completed "Notice of Claim for

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[1] See SM Motor Co. v. Mather, 117 Or App 176 (1992) (the time limitations for filing an aggravation claim are jurisdictional, and may not be waived by the parties or the court).

Aggravation" form (the form prescribed by the Director) within five years of the January 16, 1991 Determination Order,[2] we believe claimant has met this statutory requirement and that we have jurisdiction to consider the aggravation claim.

We acknowledge that both the court and the Board have previously equated the term "filed" in ORS 656.273(4)(a) with "perfecting" of the aggravation claim under former ORS 656.273(3).[3] Although, as explained below, this approach was appropriate under the former law, we believe these "pre-SB 369" cases are not controlling or relevant in light of the 1995 amendments to ORS 656.273.

As the majority opinion notes, prior to the enactment of SB 369, there was no specific aggravation claim form. Under former ORS 656.273(3), a claim for aggravation was defined as "[a] physician's report establishing the worsened condition by written medical evidence supported by objective findings." Therefore, under the former law, the attending physician's report was the "claim" for purposes of ORS 656.273(3) and (4)(a). It was in this context that the court and Board held that a claimant must "perfect" his or her aggravation claim within the five year period, i.e., provide the carrier a physician's report documenting a "prima facie" case for aggravation. See Krajacic, 84 Or App at 130; see also Wendy Youravish, 47 Van Natta 1999 (1995); Linda Coiteux, 43 Van Natta 364 (1991).

Under the new law, however, the "claim for aggravation" is the Director's form, rather than the report of the attending physician. ORS 656.273(3) specifically provides that "[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 statute further separates the "claim for aggravation" from the attending physician's report by requiring that the claim for aggravation "be accompanied by" the attending physician's report.

This distinction between the claim (i.e., the Director's form) and the supporting medical opinion is further supplemented by ORS 656.273(6). This subsection provides that a "claim" submitted in accordance with this section shall be processed in accordance with ORS 656.262, except that the first installment of compensation due shall be paid no later than the 14th day after the employer has notice or knowledge of a medically verified inability to work resulting from the compensable worsening. Thus, the form is filed and processing of the claim begins but no time loss is due until 14 days after the medical verification is received.

Although ORS 656.273 subsection (3) refers to both the "claim for aggravation" and an accompanying attending physician's report, subsection (4)(a), the limitations provision, requires only that the "claim for aggravation" be filed within the five year period. Apparently, in amending the statute, the legislature considered a completed "claim for aggravation" (i.e., the Director's form) sufficient to put the carrier on notice that the claimant has suffered a worsened condition attributable to the compensable injury, because it did not change the wording of subsection (4)(a). Therefore, so long as the "claim for aggravation" is received by the carrier within the five year period, the requirements of ORS 656.273(4)(a) have been satisfied.

We recognize that ORS 656.273(3) expressly requires that the claim for aggravation be "accompanied by" the attending physician's report documenting a worsened condition attributable to compensable injury and that, in this case, the record does not establish if or when (subsequent to January 16, 1996) the insurer received such a report. We would find, however, that in the absence of a specific statutory provision requiring that the attending physician's report be filed within the five year period, the fact that such a report was not received by the employer on or before January 16, 1996 in this case does not, as a matter of law, render the aggravation claim time-barred under ORS 656.273(4)(a). Like the ALJ, we would find that the timely submission of a completed Director's Notice of Aggravation Claim form was sufficient to toll the five year limitations period, even though the employer had no obligation to begin paying timeloss until it received the attending physician's report.

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[2] As the majority notes, the term "filed," as used in workers' compensation provisions requiring that claims be filed within certain time restrictions, means "receipt." See Barr v. EBI Companies, 88 Or App 132 (1987).

[3] See, e.g., Krajacic v. Blazing Orchards, 84 Or App 127, modified 85 Or App 477 (1987) and other cases cited by the majority.

In the Matter of the Compensation of
**RAYMOND I. FRAZIER, Claimant**
WCB Case No. 66-0453M
OWN MOTION ORDER OF DISMISSAL
Saif Legal Department, Defense Attorney

Claimant filed an occupational disease claim for hearing loss. On February 12, 1998, the SAIF Corporation denied that claim. SAIF's denial advised claimant that if he disagreed with SAIF's decision, he could request a hearing before the Board's Hearings Division. To date, no hearing request has yet been received. If claimant disagrees with SAIF's contention that his hearing loss is not caused by noise exposure at work and intends to request a hearing, he must follow the instructions provided in SAIF's denial and request a hearing within 60 days from the date of SAIF's denial. In other words, claimant must request a hearing by April 13, 1998, if he intends to do so.[1]

Although denying claimant's occupational disease claim, SAIF also interpreted that claim as a request for own motion relief and recommended that the request be denied. In the remainder of our order, we explain why we find that this occupational disease claim is not within the Board's own motion jurisdiction. However, we stress that our finding regarding the Board's lack of own motion jurisdiction in this matter does not affect claimant's right to request a hearing with the Board's Hearing Division.

Claimant worked for a plywood mill from 1951 to 1969 and retired in 1969 at age 62. In 1962 or 1963, claimant first purchased binaural hearing aids on his own behalf. Claimant is now 90 years of age and has recently filed an occupational disease claim for hearing loss, apparently contending that his employment noise exposure from 1951 to 1969 is the major contributing cause of his current hearing loss condition. On February 12, 1998, SAIF issued a denial of claimant's "claim for an occupational disease to [claimant's] ear, internal which occurred on or about June 3, 1963." This denial advised claimant that if he disagreed with SAIF's decision, he could request a hearing before the Board's Hearings Division. To date, no hearing request has yet been received.

The Board's own motion jurisdiction is provided in ORS 656.278., which states, in relevant part:

> "(1) Except as provided in subsection (6) of this section, the power and jurisdiction of the Workers' Compensation Board shall be continuing, and it may, upon its own motion, from time to time modify, change or terminate former findings, orders or awards if in its opinion such action is justified in those cases in which:
>
> "(a) There is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. 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, as determined by the board; or
>
> "(b) The date of injury is earlier than January 1, 1966. In such cases, in addition to the payment of temporary disability compensation, the board may authorize payment of medical benefits." (Emphasis added).

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[1] 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

Here, SAIF's denial stated that claimant filed an occupational disease claim occurring "on or about June 3, 1963." While ORS 656.278(1)(b) mentions injuries occurring before "January 1, 1966" in listing the requirements of the Board's own motion jurisdiction, it is clear from the statute as a whole that that date is not intended to be read in isolation. In this regard, ORS 656.278(1) provides that the Board may, on its own motion, "modify, change or terminate former findings, orders or awards." Thus, the Board's own motion jurisdiction is limited to addressing "former findings, orders or awards" under limited circumstances, i.e., where the compensable condition requires hospitalization or outpatient surgery, and/or the injury occurred earlier than January 1, 1966. Here, there is no such former finding, order or award because, while claimant may be contending his occupational disease occurred before 1966 (and it is not clear from this record that claimant is limiting his claim to pre-1966 work exposure), this is claimant's initial claim for an occupational disease claim for hearing loss. In other words, no prior decision regarding compensability of claimant's initial claim has been made.

Furthermore, the statement in ORS 656.278(1)(b) regarding benefits "in addition to the payment of temporary disability compensation" obviously refers to the provision of temporary disability compensation pursuant to ORS 656.278(1)(a), which explicitly relates to a "compensable" injury. See also, OAR 438-012-0001(1)(b) (defining an "Own Motion Claim," in part, as a claim for "[m]edical benefits for a compensable injury that occurred before January 1, 1966" (emphasis added)).

Moreover, the Board's own motion jurisdiction extends only to claims for worsened conditions which arise after the expiration of aggravation rights. Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988). Aggravation rights necessarily refer to compensable claims, with aggravation rights expiring five years after the first closure of a compensable claim, unless the injury was in nondisabling status for one or more years after the date of injury, in which case the aggravation rights expire five years after the date of injury. See ORS 656.273(4); see also Thomas L. Runft, 43 Van Natta 69 (1991) (Board in its own motion authority found it had no jurisdiction over an occupational disease claim for which the aggravation rights had not run).

In other words, where an injury or occupational disease claim has been accepted by the carrier either voluntarily or pursuant to a litigation order finding the claim compensable, and the aggravation rights have run on that claim, any future request for relief regarding that claim is within the Board's own motion jurisdiction. ORS 656.273(4); 656.278(1). Thus, a prerequisite for own motion jurisdiction is the existence of a compensable claim for which the aggravation rights have expired.

Here, that prerequisite is not met. Although claimant has made an occupational disease claim regarding his hearing loss condition, SAIF has denied that claim. Furthermore, claimant is still within the 60-day period during which he may appeal SAIF's denial to the Board and request a hearing with the Hearings Division regarding that denial. Thus, initial compensability of the occupational disease claim has not yet been determined, let alone the expiration of aggravation rights, should that claim be found compensable.

In conclusion, the Board's own motion jurisdiction does not extend to issues of compensability of initial claims, even pre-1966 claims. Instead, the Hearings Division has initial jurisdiction over such compensability issues. Under the circumstances of this case, the Board in its own motion authority does not have jurisdiction over this occupational disease claim. Review authority over the claim would rest with the Board's Hearings Division in the event that claimant files a request for hearing contesting SAIF's denial. However, in order to be considered, claimant's hearing request must be filed within the time constraints set forth in SAIF's denial.

Accordingly, we dismiss the request for own motion relief.

IT IS SO ORDERED.

In the Matter of the Compensation of
**LELAND C. GLASPY, Claimant**
WCB Case No. 97-04374
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Meyers, Radler, 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 self-insured employer's partial denial of his occupational disease claim for bilateral ulnar compression neuropathy at the elbows. The employer cross-requests review of that portion of the order that set aside its partial denial of claimant's occupational disease claim for myofascial tightness of the forearm flexors and neck and shoulder girdle. 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

### Ulnar Neuropathy

Although finding that employment conditions were the major contributing cause of claimant's bilateral ulnar neuropathy, the ALJ concluded that the condition was not compensable because it did not require treatment or cause disability. Based on our review of the medical record, we find that the ulnar neuropathy did require treatment and is therefore compensable.

In Finch v. Stayton Canning Co., 93 Or App 168 (1988), the Court of Appeals held that the need for diagnostic medical services is sufficient to support an otherwise compensable occupational disease claim, even if no further medical treatment is available for the disease.[1] Here, the record shows that claimant sought treatment from Dr. Long in May 1996 to determine the cause of the pain and numbness in the forearms and hands. (Ex. 19B). Based on clinical examinations and electrodiagnostic testing, Dr. Long ultimately diagnosed median compression neuropathy at the elbows. (Ex. 19E-3). Although Dr. Long stated that claimant "did not require any specific treatment" for this condition, (Ex. 21-2), we interpret that statement as referring to curative treatment for the already diagnosed condition.

Because the record shows that diagnostic services were sought to determine the cause of his bilateral arm symptoms, we are satisfied that claimant has met the requirement of "medical services" to establish his occupational disease claim under ORS 656.802(1)(a). Accordingly, we reverse the ALJ's order on this issue and set aside the employer's partial denial of the ulnar neuropathy condition.

### Myofascial Tightness

We adopt the ALJ's conclusions and opinion regarding this issue, with the following supplementation.

On review, the employer contends that "myofascial tightness" is only a symptom and does not constitute a medically recognized diagnosis of a disease. It relies on the opinion of Dr. Zimmerman that "myofascial tightness" is a symptom diagnosis rather than a clinical diagnosis. (Ex. 23-2). However, Dr. Zimmerman's opinion was rebutted by Dr. Long who stated in part:

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[1] The employer argues that the court in Finch was addressing the compensability of diagnostic medical services, not the compensability of an occupational disease claim. We disagree. The Finch court specifically reversed the Board's holding that the claimant's occupational disease was not a compensable claim because it required only diagnostic medical services. The court reasoned that the statutes did not distinguish between diagnosis and treatment and that the need for diagnostic services satisfied the requirement of "medical services" under the statutory definition of "compensable injury." Id. at 173.

> "[T]he basis for the diagnosis of myofascial tightness in the forearm and shoulder girdle muscles was a combination of clinical symptoms, physical findings, and a clinical judgment regarding diagnosis, all contributing to a specific clinical diagnosis. Without limited extensibility of the forearm flexors and extensors, without limited shoulder girdle ranges of motion, without specific muscle tenderness, and without a clinical history consistent with the diagnosis of myofascial trigger points in the involved shoulder girdle and upper extremity muscles, the clinical diagnosis of myofascial tightness could not be appropriately made." (Ex. 27-2).

Dr. Long persuasively explains that his diagnosis of myofascial tightness was not based merely on a report of symptoms. The diagnosis was based on specific, objective physical findings such as limited extensibility of forearm flexors and extensors, limited shoulder ranges of motion, and specific muscle tenderness, and on claimant's clinical history which was consistent with myofascial trigger points in the affected muscles. The physical findings (e.g., diminished ranges of motion) were sufficient to meet the statutory definition of "objective findings" under ORS 656.005(19). Accordingly, we agree with the ALJ that the myofascial tightness condition is compensable as an occupational disease.

Attorney Fees

Claimant's attorney is entitled to an assessed fee for services on review. See ORS 656.382(2), 656.386(1).[2] After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's cross-appellant/ respondent's brief), the complexity of the issues, the value of the interest involved, and the risk that claimant's attorney's services may go uncompensated.

ORDER

The ALJ's order dated September 22, 1997 is reversed in part and affirmed in part. That portion of the ALJ's order that upheld the employer's denial of the bilateral ulnar compression neuropathy is reversed. The employers denial is set aside and the bilateral ulnar neuropathy claim is remanded to the employer for processing according to law. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,200, payable by the employer.

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[2] Ordinarily, we would also award claimant's attorney an assessed fee for services rendered at hearing in ultimately prevailing against the denial of the ulnar neuropathy condition. See ORS 656.386(1). In this case, however, the ALJ has already awarded claimant's attorney an assessed fee for all services rendered at hearing (O & O p. 3), and the parties do not challenge that award. Accordingly, we address claimant's entitlement to an assessed fee for services on review only.

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In the Matter of the Compensation of
**LOWELL L. SCOTT, Deceased, Claimant**
WCB Case Nos. 97-03539, 94-01499, 97-03537, 94-01496, 97-03532, 94-01491, 97-00974 & 93-13519
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Royal Insurance, on behalf of Northern Industrial Contractors, requests review of those portions of Administrative Law Judge (ALJ) Galton's order that: (1) set aside its responsibility denials of an occupational disease claim for asbestosis; and (2) assessed penalties for Royal's allegedly unreasonable denial of Mrs. Scott's claim. On review, the issues are responsibility and penalties.

We adopt and affirm the ALJ's order with the following change. In the third full paragraph on page 5, we change the second sentence and citation to read: "NIC may assert that another employer is responsible only if it complied with former ORS 656.308 by specifically disclaiming against that employer, i.e., Contractors, Inc. Norstadt v. Murphy Plywood, 148 Or App 484, mod 150 Or App 245 (1997)."

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, payable by Royal Insurance. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review concerning the penalty issue. See Saxton v. SAIF, 80 Or App 631, rev den 302 Or 159 (1986).

ORDER

The ALJ's order dated July 1, 1997 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by Royal Insurance.

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February 24, 1998 Cite as 50 Van Natta 284 (1998)

In the Matter of the Compensation of
**DONALD L. HALVORSEN JR., Claimant**
WCB Case No. 97-02909
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that: (1) determined that the self-insured employer's request for reconsideration was timely; and (2) affirmed an Order on Reconsideration that increased claimant's award of unscheduled permanent disability, as awarded by a Determination Order, from 40 percent (128 degrees) to 43 percent (137.6 degrees) and that eliminated claimant's award of 7 percent (13.44 degrees) scheduled permanent disability for loss of use or function of the left arm. On review, the issues are timeliness of the employer's reconsideration request and scheduled and unscheduled permanent disability. We reverse the ALJ's order and reinstate the Determination Order's awards of permanent disability.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable cervical injury on July 5, 1995. A Determination Order issued on November 5, 1996, which awarded 40 percent unscheduled permanent disability and 7 percent scheduled permanent disability.

The employer requested reconsideration through an unsigned, obsolete "request for reconsideration" form dated January 3, 1997. (Ex. 14). Claimant did not challenge the validity of the employer's request for reconsideration during the reconsideration proceedings. An Order on Reconsideration issued on April 2, 1997. (Ex. 17). It stated that the employer requested reconsideration on January 7, 1997, which was more than 60 days after issuance of the November 5, 1996 Determination Order. See ORS 656.268(5)(b) (request for reconsideration must be made within 60 days of the date of the Determination Order). The reconsideration order increased claimant's unscheduled permanent disability award to 43 percent, but eliminated claimant's scheduled award.[1]

Claimant then requested a hearing from the reconsideration order, alleging that the employer's reconsideration request was untimely and, thus, that the reconsideration order was void. Alternatively, claimant sought an award of scheduled permanent disability.

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[1] There was a $3,389.09 net reduction in the dollar value of claimant's permanent disability.

The ALJ initially rejected the employer's argument that claimant's timeliness issue could not be considered because of claimant's failure to raise the issue in the reconsideration proceedings. Concluding that the timeliness issue concerned a jurisdictional argument that could be raised at any time, the ALJ proceeded to address the merits of the issue. The ALJ then found that the evidence did not establish that the employer's request for reconsideration was mailed on a date other than January 3, 1997, which was within 60 days of the November 5, 1996 Determination Order. Accordingly, the ALJ determined that the employer's reconsideration request was timely. After concluding that the reconsideration order was validly issued, the ALJ then held that the medical evidence did not establish claimant's entitlement to an award of scheduled permanent disability. Therefore, the ALJ affirmed the April 2, 1997 reconsideration order.

On review, claimant makes several contentions in support of his argument that the employer's reconsideration request was invalid/untimely and that the reconsideration order was void. Claimant asserts that the reconsideration request was invalid because it was unsigned and made on an obsolete "request for reconsideration" form. Claimant also argues that the reconsideration request was untimely because the employer failed to offer sufficient evidence to show its reconsideration request was in fact timely mailed on January 3, 1997. The employer responds by maintaining its position that claimant's challenge to the validity of the reconsideration order should not be considered because of claimant's failure to raise the timeliness/validity issue in the reconsideration proceedings.

For the following reasons, we agree with the ALJ that claimant's failure to contest the validity of the employer's reconsideration request before the Department did not preclude consideration of the timeliness/validity issue at hearing. Moreover, we need not address the effect of the employer's use of an obsolete reconsideration request form or of its failure to sign the document. That is, even if the alleged defects did not void the employer's request for reconsideration, we would still conclude that the record does not support a conclusion that the employer timely mailed its reconsideration request to the Department.

We turn first to the employer's own timeliness argument. ORS 656.283(7) provides in part that: "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). ORS 656.268(8) also provides that: "No hearing shall be held on any issue that was not raised and preserved before the department at reconsideration. However, issues arising out of the reconsideration order may be addressed and resolved at hearing." (Emphasis added).

The issue here is whether claimant's failure to raise the issue of the validity of the employer's reconsideration request in the reconsideration proceedings precluded him from raising it at hearing. The answer depends on whether the issue "arises out of the reconsideration order itself." ORS 656.283(7). We answer that question in the affirmative.

As previously noted, the employer's reconsideration request was dated January 3, 1997, which was within the 60-day period in which to request reconsideration of the November 5, 1996 Determination Order. If mailed on that date, the request would have been timely. See OAR 436-030-0115(1). There was no reason to question the timeliness of the reconsideration request (i.e., whether the request was made within 60 days of the Determination Order) until the reconsideration order itself had issued. That is, until the reconsideration order issued stating that the employer's reconsideration request was made on January 7, 1997, one day late, there was no apparent issue with respect to the timeliness of the reconsideration request. Under such circumstances, we conclude that the timeliness issue "arose out of the reconsideration order." Accordingly, we agree with the ALJ that it was proper to address the timeliness issue. However, having made that determination, we nevertheless disagree with the ALJ's conclusion that the employer's reconsideration request was timely.

In Madewell v. Salvation Army, 49 Or App 713 (1980), the issue was whether the claimant filed a timely request for hearing from a denial. The carrier's denial letter was dated, but the denial was not sent by registered or certified mail and the employer offered no proof of the mailing date. The court held that, while there is a presumption that a writing is truly dated, and that a letter directed and mailed was received in the regular course of mail, there is no presumption that a letter was mailed on the day it is dated or written. 49 Or App at 716.

In this case, the employer's reconsideration request was dated January 3, 1997, but the record does not establish when the request was mailed to the Department. See OAR 436-030-0005(5). Moreover, the reconsideration order stated that the employer requested reconsideration on January 7, 1997, which was after the 60th day from the Determination Order. (Ex. 17-1). Under such circumstances, we are not persuaded that the filing of the employer's reconsideration request was timely under the statute. See Rickey A. Stevens, 49 Van Natta 1444, 1445 (1997).

Accordingly, we conclude that the Department lacked authority to alter the Determination Order. Consequently, the November 5, 1996 Determination Order must be reinstated.

Because we have reinstated the unscheduled and scheduled permanent disability awarded by the Determination Order, our order results in increased compensation. Therefore, claimant's attorney is entitled to an out-of-compensation fee equal to 25 percent of the increased compensation created by this order (the $3,389.09 "increase" between the Order on Reconsideration award of permanent disability and the Determination Order's award), not to exceed $3,800. See ORS 656.386(2); OAR 438-015-0055(1). In the event that this substantively increased permanent disability award has already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed in Jane A. Volk, 46 Van Natta 681, on recon 46 Van Natta 1017 (1994), aff'd Volk v. America West Airlines, 135 Or App 565 (1995).

ORDER

The ALJ's order dated September 25, 1997 is reversed. In lieu of the April 2, 1997 Order on Reconsideration, the November 5, 1996 Determination Order is reinstated and affirmed. Claimant's attorney is awarded an out-of-compensation attorney fee equal to 25 percent of the "increased" compensation awarded by this order ($3,389.09), not to exceed $3,800. In the event that this "increased" unscheduled and scheduled permanent disability award has already been paid to claimant, claimant's attorney may seek recovery of the fee in accordance with the procedures set forth in Jane A. Volk.

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February 24, 1998 Cite as 50 Van Natta 286 (1998)

In the Matter of the Compensation of
**KELLY R. HOLIFIELD-TAYLOR, Claimant**
WCB Case No. 97-02318
ORDER ON REVIEW
Cole, Cary & Wing, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board en banc.

The self-insured employer requests review of Administrative Law Judge (ALJ) McWilliams' order affirming an Order on Reconsideration that awarded claimant 38 percent (57 degrees) scheduled permanent disability for the loss of use or function of her left leg (knee). On review, the issue is extent of scheduled permanent disability.

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

We do not adopt the last sentence of the ninth (next to last) paragraph of the ALJ's findings of fact, which reads: "Claimant is also permanently precluded from walking or standing for more than two hours in an eight-hour period." (Ex. 42-5).

The employer contends that claimant has failed to show that she has sustained a permanent pathological worsening of her compensable condition and, therefore, is not entitled to a redetermination of disability upon closure of her accepted aggravation claim. The employer argues, relying on the court's decision in SAIF v. Walker, 145 Or App 294 (1996), that claimant must show a "pathological worsening" of her compensable condition in order to trigger redetermination of disability upon claim closure. We disagree.

The court's decision in Walker addressed the meaning of the phrase "actual worsening" in the context of a worker's burden of proof in establishing a compensable aggravation in the first instance under ORS 656.273(1). The court did not address the meaning of a "worsening" in the context of a worker's entitlement to redetermination of disability upon closure of an aggravation claim.

The Supreme Court did, however, address the meaning of worsening in the context of a worker's entitlement to redetermination of disablity upon closure of an aggravation claim in Stepp v. SAIF, 304 Or 375, 381 (1987). There, the Court held that, in order to obtain a redetermination of permanent disability upon closure of an aggravation claim, a claimant must show a permanently worsened condition. The Court noted that the threshold requirement to recover increased permanent disability "is a greater permanent disability than formerly existed." In imposing this standard, the Court rejected the claimant's contention that he was entitled to redetermination following a compensable aggravation based upon "a new body of operative facts reflecting present inability to work." The Court explained that the claimant's approach would result in employers and insurers paying for a host of disabilities (such as increasing age and other health conditions) that are unrelated to the earlier injury. In order to avoid compensating the claimant for the worsening of other (noncompensable) factors and to avoid relitigation of the prior permanent disability award, the Court held that a claimant must show a permanently worsened condition to be entitled to redetermination on closure of the aggravation claim. Thus, the requirement that a claimant establish a permanently worsened condition to establish entitlement to a redetermination of permanent disability on closure of an aggravation claim is a court-made doctrine intended to limit increased awards to those situations where injury-related conditions have permanently worsened.

In William A. Kendall, 48 Van Natta 583 (1996), we held that a permanent worsening of a scheduled body part is demonstrated by permanently increased loss of use or function of that body part, compared with the worker's condition at the time of the previous award. Here, the employer accepted claimant's aggravation claim, thereby conceding that claimant had proved a compensable aggravation. To impose a permanent "pathological worsening" standard to the redetermination of permanent disability would effectively require a claimant to again prove a compensable aggravation upon claim closure. We are not persuaded that the statute imposes such a requirement. Nor do the concerns addressed by the Court in Stepp require proof of more than a permanent worsening of the worker's compensable condition. Therefore, we decline to extend the court's decision in Walker as suggested by the employer.

We agree with the ALJ that claimant has demonstrated a permanent worsening of her compensable left knee condition, because claimant has greater loss of use or function of her left knee compared with her medical condition at the time of the last award. (Compare Ex. 15 with Exs. 35, 42-4). Therefore, she is entitled to a redetermination of her disability upon closure of the aggravation claim. See Stepp v. SAIF, 304 Or App at 380.

Regarding the extent of claimant's permanent disability, we are not persuaded that the employer has carried its burden of proving that the Order on Reconsideration award should be reduced. See Deborah S. Amundsen, 49 Van Natta 1156 (1997); Roberto Rodriguez, 46 Van Natta 1722, 1723-24 (1994). Consequently, we agree with the ALJ's affirmance of the 38 percent scheduled permanent disability award for claimant's left leg (knee).

The employer also asserts that the ALJ's award of an assessed fee of $2,500 is excessive, and should be reduced. We disagree. After considering the factors set forth in OAR 438-015-0010(4), and applying them to this case, we find that $2,500 is a reasonable attorney fee award for claimant's attorney's services at hearing regarding the extent of disability issue, to be paid by the employer. In reaching this conclusion, we have considered the time devoted to the issue (as represented by the hearing record), the average complexity of the issue, the value of the interest involved (claimant's 38 percent permanent disability award), and the risk that claimant's counsel might go uncompensated. Accordingly, we affirm the ALJ's assessed fee award.

Claimant is also entitled to an assessed attorney fee for prevailing against the employer's appeal of the permanent disability award. 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 $1,000, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

## ORDER

The ALJ's order dated July 9, 1997 is affirmed. Claimant is awarded an attorney fee in the amount of $1,000 for her counsel's services on review, payable by the self-insured employer.

In the Matter of the Compensation of
**GORDON J. PUTNAM, Claimant**
WCB Case No. 96-02423
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Poland's order that set aside its partial denial of claimant's occupational disease claim for a cervical condition. On review, the issue is compensability. We reverse.

## FINDINGS OF FACT

On July 25, 1995, claimant sought treatment for tingling and numbness of the left arm into the hand. Dr. Brauer diagnosed overuse syndrome. On August 8, 1995, the insurer accepted "mild overuse syndrome, left upper extremity." (Ex. 8). Claimant continued to work. After the pain in his left arm increased, Dr. Brauer took him off work. (Ex. 9). On October 24, 1995, Dr. Mason performed a neurosurgical evaluation. Mason diagnosed CTS, worse on the left, and cervical spondylosis with radiculopathy, for which he requested surgery. (Exs. 33, 34, 35). On February 15, 1996, the issurer partially denied claimant's current cervical condition. (Ex. 38).

## CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's current cervical condition (cervical radiculopathy), was caused and pathologically worsened in major part by claimant's work activity for the employer. The employer argues that claimant failed to carry his burden to establish a compensable occupational disease under ORS 656.802. Specifically, the employer contends that, because claimant has preexisting cervical spondylosis, he must prove that the spondylosis pathologically worsened. We agree.

ORS 656.802(2) provides:

> "(a) The worker must prove that employment conditions were the major contributing cause of the disease.
>
> "(b) If the occupational disease claim is based on the worsening of a preexisting disease or condition pursuant to ORS 656.005(7), the worker must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease.
>
> "* * * * *
>
> "(d) Existence of an occupational disease or worsening of a preexisting disease must be established by medical evidence supported by objective findings.
>
> "(e) Preexisting conditions shall be deemed causes in determining major contributing cause under this section."[1]

Here, the uncontroverted evidence indicates that claimant's cervical spondylosis "preceded the onset of [claimant's] initial claim for [his] occupational disease." See ORS 656.005(24) (defining "preexisting condition"). Moreover, although the ALJ characterized claimant's condition as being cervical radiculopathy, both Dr. Mason, claimant's treating surgeon, and Dr. Laycoe, who examined claimant for the insurer, indicate that the radiculopathy is a symptom of claimant's nerve root

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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 * * * ."

compression, which is caused in part by claimant's spondylotic condition. In fact, Dr. Mason has repeatedly and consistently diagnosed claimant's condition as cervical spondylosis with nerve root involvement. (Exs. 33; 36-2; 45A-1; 53-9, -18, 19, -21, -22, -26, -30). Thus, to the extent that claimant's occupational disease claim is based on the worsening of his preexisting disease or condition, i.e., his spondylosis, claimant must prove that his employment conditions were the major contributing cause of his combined condition and a pathological worsening of the disease. ORS 656.802(2)(b).

Here, Dr. Mason's ultimate opinion was that claimant's work activities were the "precipitating cause" of his nerve edema and symptoms. (Exs. 51-A, 53-29). But see SAIF v. Nehl, 148 Or App 101, on recon 149 Or App 309, 313 (1997), rev den 326 Or 389 (1998), ("immediate" cause not appropriate standard to determine major contributing cause). Moreover, Dr. Mason expressly indicated that he was unable to state that claimant's spondylosis was worsened, in major part, by his work activities. Because claimant has not established that employment conditions were the major contributing cause of a pathological worsening of his preexisting degenerative condition, and because "[p]reexisting conditions shall be deemed causes in determining major contributing cause" under ORS 656.802, we conclude that claimant has failed to carry his burden to prove the compensability of his occupational disease claim for his neck condition.

## ORDER

The ALJ's order dated March 26, 1997 is reversed. The insurer's partial denial of the cervical condition is reinstated and upheld. The ALJ's attorney fee award is reversed.

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February 24, 1998 Cite as 50 Van Natta 289 (1998)

In the Matter of the Compensation of
**MITCHELL J. THOMPSON, Claimant**
WCB Case No. 96-00583
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Moscato, Hallock, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) upheld the self-insured employer's denials of claimant's osteoarthritis, morbid obesity, lateral epicondylitis conditions, C7 disc, denervation of triceps muscle left arm, C5 disc and innervated muscles, C5 and C7 cervical disc dysfunctions, C5 and C7 disc herniations, C6-7 disc protrusion/bulge/hernation and C5-6 disc protrusion/bulge/herniation with spurring; (2) upheld the employer's denial of claimant's current radiculopathy condition; and (3) declined to award penalties and attorney fees for allegedly unreasonable claim processing. On review, the issues are compensability, penalties and attorney fees. We vacate in part and affirm in part.

## FINDINGS OF FACT

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

On March 14, 1995, claimant sought treatment from Dr. Eubanks for pain in his left neck after lifting cases of frozen food at work. The next day, claimant's pain worsened, resulting in reduced range of motion in the neck and numbness into the left hand. Dr. Rosenbaum performed nerve conduction studies and opined that claimant had left C7 radiculopathy with weakness and denervation in the triceps and extensor radialis muscles, and minor denervation in some C5 innervated muscles. (Ex. 18a). Dr. Eubanks opined that claimant suffered from a herniated disc at C7 with mild denervation of the triceps muscle of the left arm. (Ex. 21).

On May 9, 1995, Drs. Marble and Zivin evaluated claimant's condition. X-rays demonstrated degenerative changes at C5-6 with spurring and narrowing of the disc space. The doctors diagnosed preexisting degenerative disc disease (DDD) at C5-6, with the onset of cervical radiculopathy in the neck and left arm due in major part to claimant's lifting injury. (Exs. 42, 43). On October 2, 1995, the employer accepted disabling "cervical radiculopathy." (Ex. 91).

On November 29, 1995, Drs. Gambee and Reimer examined claimant. Based on Dr. Rosenbaum's neurological evaluation and the absence of definitive MRI or CT studies, they opined that claimant's C7 radiculopathy and need for treatment was more than 51 percent causally related to his preexisting cervical osteoarthritis. (Exs. 107, 108). In addition to cervical radiculopathy, they diagnosed osteoarthritis, lateral epicondylitis, and morbid obesity. Thereafter, the employer denied cervical osteoarthritis, lateral epicondylitis, and morbid obesity. (Exs. 107, 115).

On March 28, 1996, as amended at hearing, claimant requested acceptance of the following "new medical conditions": C7 disc, denervation of triceps muscle left arm, C5 disc and innervated muscles, C5 and C7 cervical disc dysfunctions, C5 and C7 disc herniations, C6-7 disc protrusion/bulge/hernation and C5-6 disc protrusion/bulge/herniation with spurring. (Ex. 128A, Tr. 7, 8). The employer denied each of these conditions. (Ex. 135, Tr. 7, 8).

On March 18, 1996, Dr. Zivin performed a records review, from which he concluded that claimant had not experienced a specific injury in February or March 1995 that precipitated his radiculopathy, and that, in any case, claimant's cervical radiculopathy had resolved. (Ex. 124).

On May 28, 1996, Drs. Zivin and Marble reexamined claimant and found persistent radicular pain and discomfort in the left upper extremity. They noted that claimant's C6 radicular pain had improved since a prior examination in November 1995 and opined that the major contributing cause of claimant's current cervical radiculopathy appeared to be DDD. (Ex. 131).

On June 13, 1996, x-ray and MRI studies of claimant's cervical spine were performed. Dr. Zivin interpreted these studies as revealing DDD at C4-5, C5-6 and C6-7, and a possible herniated disc on the left at C5-6. He opined that the date of onset of radicular symptoms would provide the best information regarding the date of the herniation. (Ex. 140).

On June 18, 1996, the employer denied claimant's current cervical radiculopathy condition on the basis that his 1995 injury was no longer the major cause of his current condition and related disability. (Ex. 133).

In October 1996, Dr. Brett conducted a neurosurgical evaluation of claimant's condition. (Ex. 143).

## CONCLUSIONS OF LAW AND OPINION

### Compensability

#### Lateral Epicondylitis

The ALJ upheld the employer's denial of claimant's lateral epicondylitis, cervical osteoarthritis and morbid obesity conditions after concluding that there was no medical evidence establishing that these conditions were related to claimant's work. Insofar as the ALJ's opinion addressed the compensability of the lateral epicondylitis condition,[1] we adopt and affirm his opinion with the following supplementation.

The only medical opinion regarding the cause of claimant's lateral epicondylitis condition was provided by Dr. Gambee, orthopedist. He opined that no injury occurred to claimant's left elbow while working and that it was more probable than not that claimant's obesity was the cause of the elbow condition. (Ex. 126). In light of this unrebutted opinion, we agree with the ALJ's conclusion that claimant's lateral epicondylitis condition is not compensable.

### New Medical Conditions

The ALJ upheld the insurer's "new medical condition" denials of C6-7 and C5-6 disc protrusion/bulge/herniations, denervation of triceps muscle left arm, C5 disc and innervated muscles, C5 and C7 disc dysfunctions, C5 and C7 disc herniations, and C5-6 spurring, reasoning that: (1) the disc dysfunctions are preexisting, non-compensable conditions; (2) the denervation is a consequence of non-compensable neck conditions; and (3) the C5-6 spurring is evidence of a preexisting condition.

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[1] Although the employer's December 22, 1995 denial denied lateral epicondylitis, cervical osteoarthritis and morbid obesity conditions, claimant withdrew his Request for Hearing regarding the latter two conditions at hearing. (Ex. 115, Tr. 6, 7). We consequently vacate that portion of the ALJ's opinion in regard to these conditions. Jeffrey D. Ward, 45 Van Natta 1513 (1993) (ALJ's review limited to issues raised by the parties).

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

Current Condition Denial

The ALJ found that the employer's preclosure denial of claimant's current radicular condition was not an inappropriate "back-up" denial, as it met the requirements of ORS 656.225 and 656.262(6)(c). Although ORS 656.225[2] is inapplicable in this case, we conclude that the employer's preclosure denial was nevertheless valid.[3]

ORS 656.262(6)(c)[4] allows an employer to subsequently deny a previously accepted "combined or consequential" condition if the "otherwise compensable injury ceases to be the the major contributing cause" of that condition. 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 as a result of a judgment or order. Elizabeth B. Berntsen, 48 Van Natta 1219, 1221 (1996).

Consequently, in order to determine whether ORS 656.262(6)(c) applies in this case, it is first necessary to make a factual decision regarding what condition(s) (combined or otherwise) have been accepted by the carrier. SAIF v. Tull, 113 Or App 449, 454 (1992) (whether an acceptance occurs is an issue of fact).

Here, we find the acceptance is ambiguous concerning whether or not the employer voluntarily accepted claimant's radiculopathy as a combined condition, because the notice of acceptance does not state that claimant's "radiculopathy" was accepted as a combined condition. However, the record supports the employer's assertion that the claimant's cervical radiculopathy was accepted as a combined condition. We base this conclusion on the following reasoning.

Prior to the employer's acceptance, Dr. Marble and Dr. Zivin diagnosed claimant with preexisting degenerative disc disease at C5-6 with cervical radiculopathy. They opined that the DDD made claimant more likely to experience radicular symptoms as a result of a minor injury and attributed the major contributing cause of claimant's cervical radiculopathy to the lifting injury. (Exs. 42, 43). Dr. Eubanks disagreed with Marble and Zivin's opinion that claimant's radicular symptoms arose from DDD at C5-6, opining instead that claimant suffered from DDD and a herniated disc at C7. However, regardless of the level involved, we find on this record that claimant suffered from a preexisting degenerative disc condition and cervical radiculopathy, which combined with his lifting injury at work. Consequently, we conclude that the employer voluntarily accepted claimant's cervical radiculopathy condition as a combined condition under ORS 656.005(7)(a)(B).

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[2] ORS 656.225 provides, in material part:

"In accepted injury or occupational disease claims, disability solely caused by or medical services solely directed to a worker's preexisting condition are not compensable unless:

"(1) In occupational disease or injury claims other than those involving a preexisting mental disorder, work conditions or events constitute the major contributing cause of a pathological worsening of the preexisting condition.

"* * * * *

"(3) In medical service claims, the medical service is prescribed to treat a change in the preexisting condition as specified in subsection (1) or (2) of this section, and not merely as an incident to the treatment of a compensable injury or occupational disease."

[3] 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." See Linda F. Hansen, 48 Van Natta 2560 (1996). Here, the persuasive medical evidence establishes that claimant's DDD preexisted and combined with his work injury. Thus, although the DDD contributed to claimant's radiculopathy and need for treatment, it was not the sole cause. (See Exs. 18a, 42, 43, 107, 108). Accordingly, ORS 656.225 does not apply. See Paul E. Hargreaves, 48 Van Natta 1676 (1996) (where the current condition is a "combined condition," ORS 656.225 is not germane).

[4] ORS 656.262(6)(c) provides:

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

Because the insurer has voluntarily accepted claimant's radiculopathy condition as a combined or consequential condition, for ORS 656.262(6)(c) to apply, the compensable injury must "cease" to be the major contributing cause of claimant's current condition. Claimant has the burden of proving compensability of the denied current radiculopathy condition. ORS 656.266; State Farm Ins. Co. v. Lyda, 150 Or App 554 (1997). Determining the "major contributing cause" involves evaluating the relative contributions of different causes of an injury or disease and deciding which is the primary cause. Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev dismissed 321 Or 416 (1996); Gregory C. Noble, 49 Van Natta 764, 765-66 (1997).

On March 18, 1996, subsequent to his opinion that claimant's lifting injury was the major contributing cause of the radiculopathy condition, Dr. Zivin performed a medical records review. Based upon this review, he was unable specifically to conclude that there was ever a job injury that started claimant's radicular symptoms. He explained that cervical spondylosis is an insidiously progressive disorder, which sometimes produces "pinched nerve" symptoms and/or findings. (Ex. 124). Zivin also noted that claimant's radiculopathy had been mild, and that neurological testing on November 11, 1995 was normal, in comparison to the minor changes revealed on May 9, 1995. (Id.) Finally, Dr. Zivin concluded that claimant's radiculopathy had resolved and no longer required treatment, based on the normal November 11, 1995 findings. (Id.) Dr. Eubanks and Dr. Rosenbaum concurred with Dr. Zivin's opinion. (Exs. 127, 129).

On May 28, 1996, claimant was reexamined by Drs. Zivin and Marble. Claimant reported that his left arm was somewhat better. The doctors opined that the major cause of claimant's current radicular symptoms and restriction of motion was the preexisting DDD. (Ex. 131).

On June 13, 1996, x-rays and an MRI of claimant's cervical spine were performed. Dr. Zivin concluded that claimant had preexisting and ongoing DDD at C4-5, C5-6 and C6-7, with a possible herniated disc at C5-6 on the left, which could best be dated by the onset of radicular symptoms. He declined to change his prior opinion regarding causation. (Ex. 140).

Although Dr. Eubanks concurred with Dr. Zivin's March 18, 1996 records review, he subsequently opined that the 1995 injury was the major contributing cause of claimant's herniated cervical disc and left radiculopathy. (Ex. 141).

In October 1996, Dr. Brett, neurosurgeon, evaluated claimant. He found that claimant had DDD at C4-5, C5-6 and C6-7, with a superimposed disc herniation on the left at C6-7 with C7 radiculopathy, which he based on neurological findings of reduced reflex and weakness in the left triceps and early wasting in the left arm in the C7 myotome. He opined that claimant's current radiculopathy and disability were a direct result of claimant's March 1995 work injury.[5]

Due to the passage of time, the causation issue is complex and requires expert medical evidence. Uris v. Compensation Department, 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). We ordinarily give great weight to the opinion of the treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find persuasive reasons to do otherwise.

Although it appears from the medical record that claimant experienced a herniated disc in 1995, it is clear that claimant also had preexisting DDD in his neck. Dr. Eubanks initially concurred with Dr. Zivin's opinion that claimant had not experienced an injury in 1995 and that claimant's radiculopathy had been due from the outset to DDD. Dr. Eubanks also opined that the 1995 injury was the major contributing cause of claimant's herniated disc and radiculopathy. However, Dr. Eubanks failed to explain why his opinion had changed from his earlier concurrence with Dr. Zivin's opinion.

Moreover, neither Dr. Eubanks nor Dr. Brett, who opined that claimant had a herniated disc at C6-7, which arose directly from the 1995 injury, and was superimposed on claimant's DDD, discussed the relative contributions of the injury and degenerative condition to claimant's current need for treatment, as required under Deitz v. Ramuda, 130 Or App at 401.

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[5] This opinion is congruent with Dr. Zivin's indication that the date of the onset of claimant's radicular symptoms provides the best clue to date the onset of claimant's herniated disc. (Ex. 138).

When medical opinions differ, we rely on opinions that are well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). Here, we find Dr. Zivin's opinions to be most persuasive. Dr. Zivin provided consistent, well-reasoned opinions, based on a complete and accurate medical history. Moreover, in contrast to Dr. Eubanks' and Dr. Brett's opinions, Dr. Zivin's opinions provide a clear discussion of the relative contributions of claimant's injury and preexisting DDD to his current condition and need for treatment. Therefore, we rely on Dr. Zivin's opinion to find that claimant's injury has ceased to be the major contributing cause of his current condition and need for treatment. See ORS 656.262(b)(c). Consequently, we uphold the employer's denial.

Penalties And Attorney Fees

Inasmuch as no condition has been found compensable, we agree with the ALJ's conclusion that no penalty nor attorney fee award is warranted.

ORDER

The ALJ's order dated November 7, 1996 is vacated in part and affirmed in part. That portion of the order purporting to uphold the employer's denials of cervical osteoarthritis and morbid obesity is vacated and claimant's request for hearing, insofar as it is related to the denial of those conditions, is dismissed. The remainder of the order is affirmed.

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February 26, 1998 Cite as 50 Van Natta 293 (1998)

In the Matter of the Compensation of
**JERALD J. COOPER, Claimant**
WCB Case No. 96-02211
ORDER OF ABATEMENT
Burt, Swanson, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Claimant requests reconsideration of our February 2, 1998 Order on Review that did not award his attorney an assessed fee under ORS 656.382(2) for successfully defending against the insurer's request for authorization to offset an alleged overpayment of compensation against future disability awards. The insurer responds 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).

In order to allow us sufficient time to consider claimant's motion and the insurer's response, our February 2, 1998 order is withdrawn. After completing our reconsideration, we will announce our decision.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**FRANK E. WEIGELE, Claimant**
WCB Case No. 96-07029
ORDER ON REVIEW
Bottini, Bottini, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Moller and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Howell's order that affirmed a "post-authorized training program" Determination Order that awarded 28 percent (89.60 degrees) unscheduled permanent disability for a cervical injury. In its respondent's brief, the SAIF Corporation challenges that part of the ALJ's order that declined to award an offset of overpaid permanent disability against future compensation. On review, the issues are extent of unscheduled permanent disability and offset. We modify in part and reverse in part.

FINDINGS OF FACT

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

Claimant, age 54 at the time of hearing, worked as a heavy equipment operator (DOT #859.683-010) in the employer's rock crushing business. On July 10, 1991, he compensably injured his left shoulder. Thereafter, on March 9, 1993, he compensably injured his neck, which required surgery to remove herniated disc material at C5-6 and C6-7.

Claimant's attending physician, Dr. Newby, found claimant to be medically stationary with permanent limitations on September 20, 1994. The neck injury claim was closed pursuant to an October 21, 1994 Notice of Closure that awarded 39 percent unscheduled permanent disability. Claimant requested reconsideration, and was awarded 37 percent unscheduled permanent disability and 13 percent scheduled permanent disability (for loss of use or function of the left arm). SAIF requested a hearing, challenging the scheduled permanent disability award. The January 12, 1995 Order on Reconsideration was affirmed by way of a May 25, 1995 Opinion and Order.

In June 1995, claimant entered an authorized training program. A July 1995 Determination Order closed claimant's July 1991 left shoulder injury claim and awarded claimant 11 percent unscheduled permanent disability. Claimant requested reconsideration and was examined by a medical arbiter. An October 27, 1995 Order on Reconsideration increased claimant's unscheduled permanent disability award to 19 percent.

Claimant's authorized training program was interrupted in June 1996. A July 25, 1996 Determination Order redetermined permanent disability related to his cervical injury and awarded 38 percent unscheduled permanent disability and no scheduled permanent disability. Claimant requested a hearing challenging this order.

Meanwhile, during the fall of 1996, claimant returned to an authorized training program, which he completed in December 1996. Dr. Newby examined claimant on December 16, 1996 and reported, among other things, that claimant was medically stationary and permanently restricted from repetitive lifting over 30 pounds or overhead work. A January 21, 1997 Determination Order again redetermined claimant's permanent disability and awarded 28 percent unscheduled permanent disability and no scheduled permanent disability.[1] Claimant also filed a request for hearing on this order.

Dr. Newby examined claimant again on March 20, 1997 and found that he remained medically stationary. Dr. Newby found reduced cervical range of motion and normal strength throughout except for collapsing weakness in claimant's right triceps due to pain.

[1] A corrected Determination Order issued on February 27, 1997. Claimant's permanent disability award did not change.

## CONCLUSIONS OF LAW AND OPINION

### Extent of Permanent Disability

Based on Dr. Newby's March 1997 impairment findings, the ALJ determined that claimant was entitled to an impairment value of 28 percent. The ALJ further found that claimant was entitled to an adaptability value of zero pursuant to former OAR 436-35-310(3) because his residual functional capacity (RFC) was medium, the same as his base functional capacity (BFC).

On review, claimant asserts that his RFC should be light or medium/light. We disagree. Like the ALJ, we conclude, based on Dr. Newby's December 1996 and March 1997 reports, that claimant is capable of performing medium strength work.[2] The only physical restriction placed on claimant following completion of his authorized training program is that he do "no repetitive lifting over 30 pounds of overhead work." Dr. Newby's restriction of no repetitive lifting over 30 pounds indicates that claimant can repetitively lift or carry objects weighing 25 pounds or less. Dr. Newby did not permanently preclude claimant from lifting 50 pounds occasionally, nor did he restrict claimant from frequently performing any other activity, such as reaching, pushing or pulling. See former OAR 436-35-310(3)(h) (defining "restrictions" for purposes of classifying a worker's RFC). Therefore, claimant has not established by a preponderance of the evidence that he cannot perform medium strength work.[3]

We nevertheless modify the adaptability value of zero assigned by the ALJ. The administrative rules relied on by the ALJ have been found invalid as inconsistent with ORS 656.726(3)(f)(A), and cannot be used in determining the extent of claimant's unscheduled permanent disability. See, e.g., Joe R. Ray, 48 Van Natta 325, 334-35 (1996) (relying on Carroll v. Boise Cascade Corp., 138 Or App 610 (1996)). Consequently, when a worker's BFC and RFC are the same, the worker shall be given an adaptability value of 1. Id.; see also OAR 436-35-0310(6) (WCD Admin. No. 96-068).

The total value of claimant's age, education and skills is 3.[4] That value, when multiplied by an adaptability value of 1, totals 3. Former OAR 436-35-280(6). When this value (3) is added to the value for impairment (28), the result is 31. Former OAR 436-35-280(7). Therefore, claimant's total unscheduled permanent disability is 31 percent (99.2 degrees). Consequently, we modify the ALJ's order to increase claimant's unscheduled permanent disability award from 28 percent to 31 percent.

### Offset

The ALJ declined to grant SAIF an offset, noting that the record did not disclose what, if any, permanent disability SAIF has paid to claimant. On review, SAIF does not seek to offset any specific amount, but argues that, to the extent it has previously paid claimant permanent disability compensation to which he is no longer entitled, it is statutorily authorized to offset those overpayments against any future compensation. We agree.

ORS 656.268(15)(a) allows a carrier to offset any compensation payable to the worker to recover an overpayment from a claim with the same carrier. The January 21, 1997 Determination Order, as amended February 25, 1997, specifically authorized SAIF to deduct any overpaid benefits from benefits due claimant. Claimant has not challenged SAIF's contention that he was overpaid, nor has he objected

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[2] Like the ALJ, we are not persuaded by the findings of claimant's September 1994 physical capacities evaluation or the December 1994 medical arbiter's examination because they are not probative evidence of claimant's residual functional capacity following his completion of the authorized training program in December 1996.

[3] Pursuant to former OAR 436-35-310(3)(h), "medium" means the worker can occasionally lift 50 pounds and can lift or carry objects weighing up to 25 pounds frequently. As the ALJ noted, claimant's limitation from overhead lifting is not a "restriction" defined by the administrative rules.

[4] The parties do not dispute that claimant is entitled to a value of 1 for age under former OAR 436-35-290(2), and a value of 2 for training (based on an SVP 6) under former OAR 436-35-300(6).

to SAIF's entitlement to an offset at hearing or on review.[5] Accordingly, to the extent SAIF has paid claimant permanent disability compensation in excess of the 31 percent unscheduled permanent disability awarded by this order, it is entitled to offset the overpayment from future compensation.

ORDER

The ALJ's order dated September 3, 1997 is modified in part and reversed in part. In addition to the Determination Order and ALJ's award of 28 percent unscheduled permanent disability, claimant is awarded 3 percent unscheduled permanent disability for a total unscheduled award of 31 percent (99.2 degrees). 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. SAIF's request for an offset of overpaid permanent disability compensation against future compensation is approved.

[5] Because SAIF is not seeking to establish an offset in an amount certain, this case is distinguishable from Jerald J. Cooper, 50 Van Natta 146 (1998). There, we explained that although ORS 656.268(15) entitles a carrier to offset any overpaid temporary disability, an ALJ may deny authorization for an offset if the carrier alleges an overpayment of a specific amount but fails to present evidence at hearing establishing the amount of its alleged overpayment.

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February 24, 1998 Cite as 50 Van Natta 296 (1998)

In the Matter of the Compensation of
**EULA M. ZARLING, Claimant**
WCB Case No. 96-07070
ORDER ON REVIEW
Nancy Chapman, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Tenenbaum's order that assessed a penalty for allegedly unreasonable claims processing. Claimant cross-requests review of that portion of the ALJ's order which determined that SAIF properly recalculated claimant's temporary partial disability rate. On review, the issues are rate of temporary disability and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

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

Claimant began work for the employer in August 1994. On May 1, 1995, claimant received a demotion which resulted in a wage decrease from $7 an hour to $6.50 an hour. On October 4, 1995, claimant compensably injured her low back, which SAIF denied. Claimant returned to modified work, but was laid off on November 6, 1995 for reasons related to her injury. On April 2, 1997, a prior ALJ found the claim compensable.

On April 12, 1996, SAIF calculated claimant's temporary total disability (TTD) benefits on the basis of a 40 hour, five-day work week at $6.50 an hour, based on the "801" form. (Ex. 1; Tr. 54, Day 2). On the same date, SAIF contacted claimant regarding the hours she worked from the date of injury until she was laid off. Claimant reported that she had been receiving unemployment benefits of $180.00 per week since November 21, 1995. (Exs. 9-2, -3). SAIF then calculated claimant's accrued temporary partial disability payment, taking into account her reduced earnings from October 10, 1995, to November 9, 1995, and her unemployment earnings from November 21, 1995 to April 6, 1996, which resulted in a total amount of $1,569.37. (Ex. 9-4, -5). SAIF made an error in entering claimant's reduced earnings amount and sent claimant a check for $1,836.05, which resulted in an overpayment of $266.68 ($1,836.05 less $1,569.37). (Exs. 9-2, -4, 50). On the same date, SAIF sent a letter to claimant explaining how her temporary partial disability had been calculated, and notifying her of the error and overpayment, which it would recover from claimant's future disability payments. (Ex. 10).

Also on the same date, SAIF sent a letter to the employer requesting claimant's gross wages for the year prior to the date of injury, an explanation of any changes in the employer/employee relationship, and payroll records from the date of injury through the date of layoff. (Ex. 9-1). On April 23, 1996, the employer provided the requested payroll information, which showed that claimant had been demoted to a different position, with a reduction in her hourly rate of pay, on June 1, 1995, and that claimant had not worked any overtime after her demotion. (Ex. 15).

On April 27, 1996, claimant's unemployment benefits expired. (Exs. 18, 19, 22, 24). Claimant wrote to the prior ALJ regarding her concerns, among others, regarding the recovery of the overpayment and the unemployment offset. She also wanted SAIF to repay her unemployment benefits. (Ex. 23). The ALJ sent a copy of claimant's letter to SAIF and referred claimant to her attorney.

On May 24, 1996, SAIF wrote to claimant, explaining the overpayment and the amounts of claimant's future payments in greater detail. (Ex. 27).

On May 31, 1996, SAIF advised claimant that it had recalculated her temporary disability rate based on the employer's payroll records, which reduced claimant's future payments. (Exs. 29, 30, 31). On June 21, 1996, SAIF advised claimant that an audit of her file had revealed an overpayment of $413.42, which would be recovered from future payments. (Exs. 35, 38). On July 11, 1996, claimant requested a hearing on the rate of temporary disability and requested penalties and attorney fees.

Claimant was declared medically stationary on September 26, 1996 and SAIF issued a Notice of Closure on October 22, 1996 which awarded temporary and permanent disability. The hearing on the rate of temporary disability was convened on October 24, 1996.

## CONCLUSIONS OF LAW AND OPINION

### Temporary Partial Disability Rate

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

Claimant argues that the ALJ erroneously interpreted former OAR 436-60-025(5)(a), asserting that there was no change in the amount or method of the wage earning agreement during the 52 week period before the injury, as the change in the amount of her wages showed that she not only worked varying hours and shifts, but also received varying wages. Thus, according to claimant, her time loss should be computed by using the "actual weeks of employment with the employer at injury up to the previous 52 weeks."

Former OAR 436-60-025(5)(a)[1] provides:

> "For workers employed on call, paid by piece work or with varying hours, shifts or wages, insurers shall use the worker's average weekly earnings 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." (Emphasis added).

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[1] Claimant's rate of temporary disability compensation is based on her wage at the time of injury. ORS 656.210. Claimant was injured on October 4, 1995. Therefore, WCD Admin. Order No. 94-055 (Eff. August 28, 1994) and 95-058 (Temp.) (Eff. August 18, 1995) apply in this case. The ALJ's application of WCD Admin. Order No. 96-053 (Eff. February 12, 1996) does not affect the outcome of this case, as the language of the rule remained the same.

The question in this case is whether there has been a "change in the amount or method of the wage earning agreement during the previous 52-week period." According to claimant, although her pay rate changed from $7.00 to $6.50 per hour, she still received an amount equal to the actual hours worked and still received varying hours and shifts.

We previously held in Patsy G. Harper, 48 Van Natta 1454 (1996), that former OAR 436-60-025(5)(a) clearly refers to the "amount" of the wage earning agreement, not the "rate" of the wage earning agreement. Although claimant's rate of pay was $6.50 per hour, the amount of her wages was calculated based on the rate of pay and the number of hours she worked. Consequently, for workers paid an hourly wage, the amount of earnings depends on both the hourly wage rate and the number of hours worked. Therefore, a change in the "wage earning agreement" may involve a change in the hourly rate, a change in the hours to be worked, or both.

Here, the wage earning agreement between claimant and the employer changed effective May 1, 1995, when claimant's hourly wage rate was changed from $7.00 to $6.50 upon her demotion. Moreover, there was a change in the hours to be worked, as the wage earning agreement at the time of injury provided for claimant to work approximately eight hours a day, five days a week, and the prior agreement entailed regular overtime. (Exs. A, 1). Thus, claimant's wage earning agreement was changed in the "amount," in that claimant's hourly rate was reduced, and it was changed in the "method," in that claimant did not work overtime. Former OAR 436-60-025(5)(a) provides that, when a change in the amount or method of the wage earning agreement occurs, a weekly wage is determined based upon the actual weeks under the wage earning agreement at time of injury. We accordingly agree with the ALJ that SAIF correctly computed claimant's TTD rate.

Penalty

The ALJ concluded that there was "some kind" of dispute between claimant and SAIF regarding the calculation of claimant's wages, and, because claimant was not contacted by SAIF as part of the process of determining a reasonable wage, the ALJ assessed a penalty of 25 percent of any amounts "then" due. SAIF contends that there was no "dispute," and that SAIF contacted claimant numerous times in the course of determining a reasonable wage. We do not find SAIF's conduct to have been unreasonable.

ORS 656.262(11)(a) provides for an assessment of penalties against a carrier if it "unreasonably delays or unreasonably refuses to pay compensation," and ORS 656.382(1) requires an employer to pay an attorney fee if it "unreasonably resists the payment of compensation." "Unreasonableness" is to be considered in the light of all the evidence available to the carrier at that time. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988).

Here, claimant asserts that SAIF failed to resolve claimant's dispute regarding the calculation of her wage by contacting claimant as well as the employer to determine a reasonable wage. First, the record does not indicate that there was a dispute between claimant and the employer regarding the calculation of claimant's wage.[2] In addition, the record indicates that SAIF contacted claimant regarding the calculation of her wage on April 12, 1996. (Exs. 9, 10). Moreover, SAIF contacted the employer to confirm the correct wage and provided claimant an explanation of any wage change different from that reported on the claim Form 801, pursuant to former OAR 436-60-025(3). We find that SAIF's claims processing, in light of the information it received from the employer, was not unreasonable. Accordingly, no penalty or related attorney fee is warranted.

ORDER

The ALJ's order dated May 15, 1997 is reversed in part and affirmed in part. That portion of the order assessing a penalty for unreasonable claims processing is reversed. The remainder of the order is affirmed.

[2] At the time of her July 11, 1996 request for hearing, claimant was confused by SAIF's recalculations of her temporary disability rate, the overpayments and their recovery. She also wanted SAIF to repay her unemployment account. There is no evidence that claimant disputed the employer's wage and hour reports. (Exs. 23, 29, 35, 38).

In the Matter of the Compensation of
**PATRICIA A. LANDERS, Claimant**
WCB Case No. 95-12560
ORDER ON REMAND
Flaxel & Nylander, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Bay Area Hospital v. Landers, 150 Or App 154 (1997). The court has reversed our prior order, Patricia A. Landers, 49 Van Natta 330 (1997), which set aside the self-insured employer's partial denial of claimant's left knee chondromalacia patella condition and its denial of claimant's aggravation claim for a left knee condition. Citing the 1997 amendments to ORS 656.262(10), the court has remanded for reconsideration of our determination that the employer was precluded from contesting the compensability of claimant's chondromalacia patella condition because it did not appeal prior litigation orders awarding permanent disability based, in part, on that condition.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of finding No. 28, and with the following supplementation:

Claimant began working for the employer in June 1981. In December 1983, she sought treatment in connection with a long history of left knee complaints. She was diagnosed with, among other things, patellar chondromalacia and an unstable patella. Claimant underwent arthroscopic surgery with debridement on December 20, 1983.

On April 19, 1986, claimant twisted her left knee at work, and developed pain and popping in the knee. She was diagnosed with a medial collateral ligament strain. In August 1986, claimant underwent a second arthroscopic surgery, debridement and excision of medical synovial plica, left knee. The surgeon, Dr. Witney, noted chondromalacia of the patella.

On August 4, 1987, claimant's left knee popped when she stood up at work. She was initially diagnosed with a subluxing patella and chondromalacia. Dr. Whitney then diagnosed an acute injury (possible torn meniscus) along with "well known" chondromalacia of the medial femoral condylar patella. Claimant filed a left knee injury claim, which the employer accepted as disabling on September 4, 1987.

Claimant developed increasing left knee pain. In early January 1988, she sought treatment after her knee again popped while walking at work. On about August 28, 1988, while at work, claimant's left knee gave out and she fell on her right knee. She was diagnosed with a right knee contusion and sprain of the medial collateral ligament.

Claimant filed a workers' compensation claim for an injury to both knees arising out of her fall on August 28, 1988. The employer accepted a disabling injury claim on September 28, 1988.

Claimant underwent a third arthroscopic surgery on her left knee in November 1988, and subsequently continued to experience chronic symptoms. She underwent a fourth arthroscopic surgery on her left knee in October 1989, but still continued to have symptoms.

On March 26, 1990, Dr. Bert reported that claimant's left knee was medically stationary "with moderate impairment based upon recurrent chondromalacia." On June 22, 1990, Dr. Bert noted that claimant continued to complain about both knees from the chondromalacia patellae. He confirmed her medically stationary status on October 30, 1990.

Claimant's 1988 injury claim was closed by a Determination Order issued November 20, 1990, awarding 7 percent scheduled permanent disability for loss of use or function of the right knee. Claimant's 1987 injury claim was closed by a Determination Order issued November 21, 1990, awarding 12 percent scheduled permanent disability for loss of use or function of her left knee.

Claimant appealed the Determination Orders seeking, among other things, to increase her scheduled permanent disability awards. An Opinion and Order issued December 3, 1991, which increased claimant's award of scheduled permanent disability for the left leg (knee) to 17 percent.

Meanwhile, claimant participated in an authorized training program, which she completed in October 1991. On November 6, 1991, her 1987 left knee injury claim was reclosed by a Determination Order, which awarded no additional permanent disability. Claimant requested reconsideration. A June 17, 1992 Order on Reconsideration reduced claimant's left leg scheduled permanent disability to 9 percent. Claimant then requested a hearing, seeking to increase the permanent disability award by 8 percent, for a total of 17 percent.

By Opinion and Order dated March 16, 1993, a prior ALJ (then Referee) found that because claimant's prior 17 percent permanent disability award for the left leg (as granted in the December 3, 1991 Opinion and Order) had become final, that award could not be reduced by the Appellate Unit on reconsideration. In modifying the June 17, 1992 Order on Reconsideration, the ALJ specifically noted that the parties had stipulated that claimant had a 17 percent permanent loss of use or function in her left knee.

Claimant's left patellar chondromalacia condition progressively worsened. On August 28, 1995, claimant made an aggravation claim arising out of her accepted 1987 left knee injury. The insurer denied the claim on September 22, 1995, and claimant requested a hearing.

At hearing, the parties identified the issues being litigated as part of the aggravation denial, to include the compensability of the chondromalacia of claimant's left patella.

## CONCLUSIONS OF LAW AND OPINION

The ALJ found that the employer's acceptance of claimant's 1987 left knee injury included the chondromalacia patella. In addition, the ALJ found that claimant's 1987 knee injury, her subsequent work injuries and her treatment for those injuries remain the major contributing cause of her current chondromalacia condition, and set aside the employer's partial denial.

On review, we determined that the employer did not accept claimant's preexisting chondromalacia condition when it accepted a disabling "injury sustained August 4, 1987." We concluded, however, based on Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996) (Messmer II), that the employer was nevertheless precluded from contesting the compensability of claimant's chondromalacia patella condition because it did not appeal the orders which awarded permanent disability based, in part, on the chondromalacia of the left patella.

Subsequent to 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).

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. See also Leslie Mossman, DCD, 49 Van Natta 1602 (1997) (holding that the amendments to ORS 656.262(10) apply retroactively to cases existing on the effective date of HB 2971).

Here, as in Topits, the employer is not precluded from denying claimant's chondromalacia condition under the amended statute (even if claimant's prior left knee permanent disability award was based in part on that condition and the employer failed to appeal the litigation orders which upheld that award). Accordingly, we proceed to the merits.

The medical evidence establishes that claimant's patella chondromalacia condition preexisted her 1987 compensable left knee injury. (See, e.g., Exs. 24, 27). In addition, the evidence establishes that claimant's 1987 work injury combined with her preexisting condition 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 August 1987 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).

In this case, the only report that tends to support the compensability of claimant's chondromalacia patella is the June 1992 response of Dr. Bert (Ex. 195-4), and we find this report insufficient to sustain claimant's burden of proof. First, Dr. Bert's opinion does not address claimant's condition as of the pertinent time period (September 1995). Second, although Dr. Bert wrote "yes" when asked if the major cause of the chondromalacia patella was the trauma received in the August 4, 1987 accident, the record provides no explanation or foundation for this conclusion.[1] Indeed, Dr. Bert's opinion does not address the fact that claimant's chondromalacia patella preexisted the August 1987 incident, nor does it explain how the work incident (standing up from a squat) may have caused or worsened the degenerative condition. In other words, although Dr. Bert identified the 1987 work incident accident as the major contributing cause of the chondromalacia, his opinion lacks a comparison of the relative contribution of claimant's preexisting left knee condition (including the "well known" chondromalacia, and her prior injuries and surgery) and the work-related incident, as required by the major contributing cause standard. See Dietz v. Ramuda, 130 Or App 397 (1994) ("major contributing cause" analysis involves evaluating the relative contribution of different cause of an injury or disease and deciding which is the primary cause). Because Dr. Bert's opinion does not address the pertinent time period and is devoid of foundation and analysis, we give it little weight. See Moe v. Ceiling Systems, 44 Or App 429 (1980) (rejecting conclusory medical opinion); see also 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 this regard, we are more persuaded by the updated, complete and well-explained opinion of Dr. Colletti, who examined claimant at the employer's request on a number of occasions between 1991 and 1995. In September 1995, Dr. Colletti opined that claimant's left knee chondromalacia dated back to before 1983, but had progressed through recurrent injury and recurrent surgical treatments. Dr. Colletti did not identify the 1987 injury (or any particular work-related event or activity) as the major cause of her chondromalacia. Rather, he determined that claimant's current condition results from a combination of factors (specifically, her chondromalacia condition prior to her 1983 injury, the 1983 injury, the 1987 injury, the 1988 injury and the surgical procedures performed) and concluded that probably all of these factors "contribute equally" to her condition.[2] (Ex. 193-6).

In summary, after reconsidering the record, we find the evidence insufficient to establish that claimant's chondromalacia patella was caused (or worsened) in major part by the accepted 1987 injury. Having found the chondromalacia condition not compensable, we further conclude that claimant has failed to prove a compensable aggravation.[3] See Gloria T. Olson, 47 Van Natta 2348 (1995) (ORS 656.273(1) "requires proof of two specific elements to establish a worsened condition: (1) "actual worsening"; and (2) a compensable condition. Both elements must be satisfied in order to establish a "worsened condition resulting from the original injury.").

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[1] In May 1992, claimant was also examined by Dr. Burr in connection with her August 1987 injury. Dr. Burr determined, among other things, that claimant had severe chondromalacia patella that preexisted her compensable injury and that was worsening with age. (Ex. 159-4). Dr. Burr attributed a torn meniscus to the 1987 injury, but did not indicate that the work incident had caused or worsened the chondromalacia condition in any way. Id.

[2] In an April 1993 report, Dr. Colletti similarly concluded that claimant's chondromalacia preexisted the 1987 injury, noting that claimant had undergone surgery to address the problem in 1983. He reported that chondromalacia patella "has a natural progression" which progression had been hastened by repeat surgical procedures and injuries. (Ex. 175-5).

[3] As indicated in our prior order, the preponderance of medical evidence established an "actual worsening" of the chondromalacia condition. Because that condition is not compensable, however, claimant has failed to prove a worsened condition resulting from the original injury.

Accordingly, on reconsideration, the ALJ's order dated March 8, 1996 is reversed. The self-insured employer's September 22, 1995 denial is reinstated and upheld. The ALJ's attorney fee is also reversed.

IT IS SO ORDERED.

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February 26, 1998 Cite as 50 Van Natta 302 (1998)

In the Matter of the Compensation of
**RONALD D. ALLEN, Claimant**
Own Motion No. 98-0074M
OWN MOTION ORDER
Daniel M. Spencer, Claimant Attorney
Liberty NW Insurance Corp., Insurance Carrier

The insurer initially submitted claimant's request for temporary disability compensation for his compensable ruptured left rotator cuff. Claimant's aggravation rights on that claim expired on December 4, 1994. The insurer opposes authorization of temporary disability compensation, contending that claimant was not in the work force at the time of his 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.

Claimant was scheduled to undergo a left shoulder open rotator cuff revision/repair on February 5, 1998. Thus, we conclude that claimant's compensable injury worsened requiring surgery.

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

In this instant case, the insurer contends that claimant was not in the work force at the time of his current disability. In its recommendation form, the insurer asserts that "[b]y [claimant's] own statement, he was not in the work force at the time he resumed treatment for his left shoulder. Per Dr. Carroll's 12-10-96 chart note, [claimant] had previously been laid off."[1] The insurer contends that the relevant time period during which claimant must establish he was in the work force begins with his seeking treatment for his compensable condition on December 10, 1996. We disagree.

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

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[1] The insurer also relies on an October 7, 1997 Own Motion Order in which we declined to reopen claimant's claim at that time because claimant had not provided proof that he was in the work force during that period of 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, he must show that he was in the work force at the time of the current disability. Here, claimant has submitted paycheck stubs which evidence his being in the work force at the time of his surgery and thus, we are persuaded that he is entitled to temporary disability benefits. 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).

is the time prior to his February 5, 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).

Claimant's attorney submitted claimant's pay stubs dating from October 17, 1997 through January 29, 1998 (six days before the scheduled surgery). Thus, we conclude 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 to provide temporary disability compensation beginning February 5, 1998, the date he was hospitalized for surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

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

IT IS SO ORDERED.

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In the Matter of the Compensation of
**BOBBI J. BLAKELY, Claimant**
Own Motion No. 97-0529M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Martin J. McKeown, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant, through her attorney, requests reconsideration of our December 1, 1997 Own Motion Order, as reconsidered on December 16, 1997, which denied reopening claimant's claim for temporary disability compensation because claimant failed to prove she was in the work force at the time of disability. With her request for reconsideration, claimant submitted additional evidence regarding her inability to work due to the work injury.

In order to consider claimant's motion, we withdrew our prior orders and granted the SAIF Corporation 14 days within which to respond to claimant's motion. Having received SAIF's response and claimant's reply to that response, we proceed with our reconsideration. After further consideration, we replace our prior orders with the following.

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

On November 21, 1997, claimant underwent arthroscopic surgery for her compensable right knee injury. Thus, claimant has met the prerequisite of requiring surgery or hospitalization. Id. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, and is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989). Claimant has the burden of proof regarding the work force issue. ORS 656.266.

Here, claimant's right knee injury claim was last reopened by an April 9, 1997 Own Motion Order [Own Motion No. 96-0530M] authorizing reopening of the claim as of November 19, 1996, the date claimant underwent a prior arthroscopy for her right knee condition. Bobbi J. Blakely, on recon 49 Van Natta 463, on recon 49 Van Natta 660 (1997). In determining the work force issue regarding that

earlier reopening, we found that claimant had established that she was in the work force as of November 19, 1996, based on a March 1997 decision from the Social Security Administration (SSA) that claimant was not entitled to social security benefits beginning August 1994 because claimant had performed "substantial gainful work."

The current record [Own Motion No. 97-0529M] contains a March 26, 1997 letter from Dr. Mohler, claimant's treating physician, stating that claimant had reached medically stationary status regarding the November 19, 1996 surgery. Apparently, this earlier claim was subsequently closed by the SAIF Corporation and claimant did not request review of that closure. We base this assumption on the following: (1) in our prior order, we directed SAIF to close the claim pursuant to OAR 438-012-0055 when claimant was medically stationary; (2) OAR 438-012-0055(1) provides that the carrier must include a notice of claimant's right to seek Board review when closing an own motion claim; (3) there is no evidence that claimant requested review of any closure regarding Own Motion No. 96-0530M; and (4) on August 18, 1997, claimant requested that her claim be reopened for the right knee arthroscopy that is at issue in the current claim. Thus, during the time claimant's claim relating to the November 19, 1996 surgery was open, claimant was in the work force by virtue of being entitled to temporary disability benefits due to her compensable injury. Morris B. Grover, 48 Van Natta 2325 (1996); William L. Halbrook, 46 Van Natta 79 (1994).

However, the relevant issue in the current claim is whether claimant was in the work force at the time of disability related to the current claim, i.e., the date claimant underwent the current surgery in November 1997. John R. Johanson, 46 Van Natta 2463 (1994). For the following reasons, we find that claimant has meet her burden of proving she was in the work force at the time of disability.

In a June 2, 1997 chart note, Dr. Mohler stated that he and claimant had discussed a return to work and claimant "is not yet ready to return to work activities." In a June 30, 1997 chart note, Dr. Mohler discussed claimant's right knee symptoms and stated that claimant "is not able to work." Finally, with her request for reconsideration, claimant submitted additional evidence regarding the work force issue. Specifically, by letter dated December 11, 1997, claimant's attorney requested that Dr. Mohler comment on whether he thought claimant was able to pursue employment or hold a job since her bilateral knee arthroscopy on November 19, 1996. Dr. Mohler responded that claimant "has had severe right knee pain since her last arthroscopic knee surgery on 11/19/96 and in my opinion could not be a part of the work force during that time." Dr. Mohler's unrebutted statements establish that claimant was unable to work due to the work injury since November 19, 1996, the date of surgery regarding her previously reopened own motion claim.

We have previously found that claimant remained in the work force and, thus, remained willing to work at the time of her November 19, 1996 surgery. Furthermore, Dr. Mohler's opinion establishes that claimant remained unable to work due to the compensable injury after that November 19, 1996 surgery. Thus, there was essentially no change in claimant's work status from the time of the November 19, 1996 surgery until the November 21, 1997 surgery. Because there was no change in claimant's work status, we find that she remained in the work force by virtue of our prior findings regarding the work force issue. Consequently, at the time of the November 21, 1997 surgery, claimant met the third criteria of Dawkins -- she was not employed, but she was willing to work and was not seeking work because a work-related injury had made such efforts futile. 308 Or at 258.

Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning November 21, 1997, the date of claimant's current 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.

**Board Member Haynes dissenting.**

I agree with the majority that, prior to claimant's November 1997 surgery, claimant's own motion claim had been reopened for a November 1996 surgery and subsequently closed. I also agree that the relevant issue in the current claim is whether claimant was in the work force at the time of disability related to the current claim, i.e., November 21, 1997, the date claimant underwent the current surgery. However, because I disagree with the majority that, on this record, claimant has established the willingness to work factor of the work force issue, I respectfully dissent.

As the majority finds, Dr. Mohler's unrebutted statements establish that claimant was unable to work due to the work injury since November 19, 996, the date of surgery regarding her previously reopened own motion claim. However, although Dr. Mohler's statements establish that claimant was unable to work due to the work injury since November 19, 1996, they do not establish that claimant was willing to work. Furthermore, the Court has determined that workers who are unable to work due to a work injury are nevertheless required to establish that they remained willing to work but for the injury. Dawkins v. Pacific Motor Trucking, 308 Or at 258.

By letter dated February 5, 1998, claimant's attorney states that some evidence of claimant's willingness to work is established by claimant's records being sent by Dr. Mohler to vocational rehabilitation on March 21, 1997, and a May 12, 1997 mental status report stating that claimant was discouraged by her inability "to depend upon her body to do meaningful work any longer." However, no evidence was submitted to support these statements. Furthermore, claimant's attorney's unsupported statements do not meet claimant's burden of proving the willingness to work element of the work force issue. Earl J. Prettyman, 46 Van Natta 1137 (1994).

Claimant's attorney argues that, without evidence that claimant sought work when it was futile to do so due to her inability to work, "the issue of willingness to work becomes purely subjective and virtually impossible to prove with objective evidence." In Fendrich v. Curry County, 110 Or App 409, 413 (1991), the court addressed this dilemma, holding that:

> "A worker's efforts [to find work] may be indicative of a worker's willingness to work, but it is not determinative of willingness to work in all circumstances. Under Dawkins, the definition of 'willingness to find employment' is more inclusive. Willingness can also exist if the referee finds that a claimant has a desire to obtain employment and that efforts to obtain it would be futile."[1] (Emphasis in original).

Thus, although willingness to work ultimately may be a subjective factor, claimant still has the burden of proving that factor, as well as the other elements of the work force issue. Here, given the fact that claimant has proved that, due to the compensable injury, any reasonable work search would have been futile, proof of willingness to work could include a sworn affidavit from claimant regarding her willingness to work if not for her work injury. See Thomas L. Barnett, 45 Van Natta 1559 (1993).

Although claimant previously established the work force issue, which resulted in her own motion claim being previously reopened, that claim was subsequently closed and remained closed for a period of time. Furthermore, claimant has submitted no evidence regarding her willingness to work during the relevant time regarding her current own motion claim, i.e., her November 1997 surgery. Unlike the majority, I am unwilling to "relate back" a finding of willingness to work to meet claimant's burden of proof for her.

Therefore, on this record, I would continue to find that claimant has submitted no persuasive evidence regarding whether she was willing to work during the relevant time. Consequently, I would find that claimant has failed to meet her burden of proving that she was in the work force at the time of disability.

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[1] Amendments enacted in 1995 changed the title of the hearings officers in the Hearings Division from "referee" to "Administrative Law Judge." Here, since claimant's aggravation rights have expired, the claim is within the Board's own motion authority. Therefore, the decision as to whether claimant has established that she remained willing to work rests with the Board in its own motion capacity.

In the Matter of the Compensation of
**GRACIELA KASPRZYK, Claimant**
WCB Case No. 97-03018
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Mannix, Nielsen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Nichols' order that: (1) set aside its denial of claimant's current condition claim including claims for 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 its allegedly unreasonable denial dated February 14, 1997. On review, the issues are compensability and penalties and attorney fees. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

## CONCLUSIONS OF LAW AND OPINION

### Compensability

Relying on the opinion of claimant's treating doctor, Dr. McNabb, the ALJ found that claimant had established compensability of her current condition, including trochanteric bursitis, SI joint dysfunction, right carpal tunnel syndrome and post-traumatic synovitis conditions. We disagree.

We begin by recounting the pertinent facts. Claimant slipped and fell at work on November 13, 1996. Claimant first treated with Dr. Wilson after her fall. At that time, claimant primarily complained of back pain. On December 9, 1996, claimant began treating with a chiropractor, Dr. Holton. Dr. Holton eventually referred claimant to Dr. Lewis, who noted claimant's complaints of pain in the right hip, right hand and wrist. In his referral letter, Dr. Holton stated that claimant's low back pain had essentially resolved.

On January 23, 1997, claimant was examined by Dr. Kirschner on behalf of the insurer. Dr. Kirschner diagnosed deQuervain's tenosynovitis, low back and leg pain of undetermined etiology, possible remote lumbosacral strain, resolved, and possible remote right shoulder strain, resolved. Dr. Kirschner noted symptoms suggesting carpal tunnel syndrome, but found no objective signs of that condition. Dr. Kirschner also reported that any condition related to the fall was medically stationary, and there was no evidence of any permanent impairment from the work injury.

On January 24, 1997, claimant began treating with Dr. McNabb. Dr. McNabb diagnosed right wrist sprain/strain, right carpal tunnel syndrome, trochanteric bursitis and SI joint dysfunction on the right.

Drs. Holton and Wilson essentially concurred with Dr. Kirschner's report. Dr. McNabb did not concur.

On February 14, 1997, the insurer denied claimant's lumbosacral strain, right shoulder strain, low back and leg pain, and deQuervain's condition.

In late February 1997, claimant was seen by Dr. Welch, upon referral from Dr. McNabb. Dr. Welch felt that it was likely that the work accident was the cause of synovitis condition, but he did not relate claimant's carpal tunnel condition to the fall, unless claimant fell directly on her wrist.

On June 5, 1997, the insurer amended its February 1997 denial, and claimant's right shoulder strain, lumbosacral strain, right wrist strain and right hip contusion were accepted as nondisabling. On June 13, 1997, the insurer denied claimant's current condition, as of January 23, 1997, on the ground that such conditions had fully resolved, without residuals, as of January 23, 1997. The insurer also specifically denied claimant's tenosynovitis, trochanteric bursitis, SI joint dysfunction, and right carpal tunnel syndrome, on the ground that such conditions were not related to work or to the industrial accident of November 13, 1996.

On July 1, 1997, claimant was examined by Drs. Brooks and Strum, on behalf of the insurer. Drs. Brooks and Strum opined that claimant's current condition was not related to the November work incident.

After reviewing the medical record, we conclude that the most persuasive medical opinion regarding causation has been provided by Dr. Kirschner. At the time he examined claimant, Dr. Kirschner found that the injuries related to claimant's fall were medically stationary, with no evidence of permanent impairment. Dr. Kirschner was unable to relate claimant's tenosynovitis condition to her fall. Finally, although Dr. Kirschner did not believe that secondary gain was involved, he noted that claimant's pain behavior was clearly exaggerated.

We conclude that Dr. Kirschner's opinion is persuasive as it is consistent with the opinions provided earlier by claimant's initial treating doctor and chiropractor. Dr. Wilson, who first treated claimant five days after her injury, opined that claimant was almost completely resolved by January 10, 1997.[1] Dr. Holton found that claimant's lower back condition had essentially resolved, and although he noted claimant's continuing complaints regarding her wrist and hip, he further noted that back x-rays and wrist films were essentially normal. (Ex. 15A). Finally, both Drs. Wilson and Holton concurred in the report of Dr. Kirschner.

For the following reasons, we are not persuaded by the opinions of Drs. McNabb and Welch. Claimant did not treat with Dr. McNabb until late January 1997, and did not treat with Dr. Welch until late February 1997. Consequently, we do not find that they were in a superior position, for purposes of observation, to the doctors that treated claimant soon after her November 1996 injury. Additionally, Drs. McNabb and Welch have not responded to issues raised regarding pain behavior, an absence of objective findings, and the question of why claimant's mild injuries would not have resolved sooner after the injury. See Ex. 42-8.

Consequently, we conclude that claimant has failed to prove that her current condition, including her tenosynovitis, bursitis, SI joint dysfunction, and right carpal tunnel syndrome, are related to the November 1996 work injury. We, therefore, reverse the ALJ's order. The ALJ's attorney fee award is also reversed.

Penalty

The ALJ found that the insurer's February 1997 denial was unreasonable. We disagree. The standard for determining an unreasonable resistance to the payment of compensation is whether the carrier had a legitimate doubt as to its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the evidence available. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988).

At the time of its February 14, 1997 denial, the insurer had the report of Dr. Kirschner, who diagnosed tenosynovitis, low back and leg pain, possible remote lumbosacral strain and possible remote shoulder strain. Dr. Kirschner reported that the etiology of claimant's low back and leg pain was "undetermined." He further found that claimant only had "possible" remote lumbosacral and right shoulder strains. Finally, Dr. Kirschner noted exaggerated pain behavior and no objective abnormalities. With respect to the tenosynovitis, Dr. Kirschner reported that he could not relate the condition to a fall at work. (Ex. 18). At the time of the denial, the insurer also had a concurrence letter from Dr. Holton, claimant's chiropractor.

Under the circumstances, we conclude that the insurer had a legitimate doubt as to its liability for claimant's various conditions. Therefore, we reverse the ALJ's penalty and attorney fee award, which was based on the February 14, 1997 denial.

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[1] The ALJ discounted the opinion of Dr. Wilson, claimant's original treating doctor, on the basis of a communication problem. However, claimant also testified that she had difficulty communicating with Drs. McNabb, Lewis and Welch. (Tr. 28). Accordingly, we do not find that Drs. McNabb and Welch had any "communication" advantage in their treatment of claimant. Moreover, although Dr. Wilson stated that it was "somewhat" difficult to obtain a history, there is no indication that the history he did eventually obtain was inaccurate. Therefore, we do not discount his opinion or find it unpersuasive.

ORDER

The ALJ's order dated July 29, 1997 is reversed. The insurer's denial dated June 13, 1997 is reinstated and upheld. The ALJ's attorney fee award is reversed. The ALJ's penalty and related attorney fee for an allegedly unreasonable denial dated February 14, 1997 is also reversed.

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In the Matter of the Compensation of
**JOHN B. REID, Claimant**
WCB Case No. 95-02098
ORDER ON REVIEW
Bottini, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that increased claimant's unscheduled permanent disability award from 23 percent (73.6 degrees), as awarded by a post-authorized training program (ATP) Notice of Closure, to 53 percent (169.6 degrees). On review, the issue is extent of unscheduled permanent disability.

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

The ALJ found Dr. Stanulis' impairment findings inconsistent with an award for a Class 3 depressive or conversion reaction under OAR 436-035-0400(5). We agree.

OAR 436-035-0400(5)(c)(B) describes a Class 3 Depressive Reaction as follows:

> "Depressive Reactions: Include an obvious loss of interest in the usual activities of daily living, including eating and self-care. These problems are long-lasting and result in loss of weight and an unkempt appearance. There may be retardation of physical activity, a preoccupation with suicide, and actual attempts at suicide. The worker may be extremely agitated on a frequent or constant basis."

A Class 3 Conversion or Hysterical Reaction is described as:

> "Including loss of physical function occur often and last for weeks or longer. Evidence of physical change follows such events. A long reaction (18 months of [sic] more) is associated with advanced negative changes in tissues and organs. This includes (but is not limited to atrophy of muscles in the legs and arms. A common symptom is general flabbiness."

Dr. Stanulis noted that claimant's psychological symptoms include nightmares about falling, crying, depressions, a feeling of uselessness because his wife and children performed his former activities, sexual difficulties and narcotics dependence. Dr. Stanulis stated that claimant also has elements of anxiety in that he needs constant reassurance and has long lasting periods of anxiety that interfere with personal relationships. Dr. Stanulis reported that claimant continues to be depressed with a loss of interest in usual activities of daily living and becomes agitated on a frequent basis. Dr. Stanulis further noted that "there appears to be some occasional preoccupation with suicide as well." Finally, Dr. Stanulis noted elements of post traumatic stress disorder because of continued nightmares, emotional numbing and hyper-vigilance.

Based on Dr. Stanulis' findings which are summarized above, we are unable to find that claimant meets a Class 3 conversion disorder. In this regard, Dr. Stanulis does not describe physical changes resulting from claimant's disorder. In addition, we agree with the ALJ that Dr. Stanulis' impairment findings do not support an award for a Class 3 Depressive Disorder. There is no indication that claimant's loss of interest in the usual activities of daily living have resulted in loss of weight and an unkempt appearance. Moreover, based on Dr. Stanulis' findings, it is unclear whether claimant suffers from frequent or constant extreme agitation, as required by the rule.

Although claimant has not established an entitlement to an award for a Class 3 Depressive or Conversion Reaction, we agree with the ALJ that Dr. Stanulis' findings support entitlement to an award for a Class 2 Depressive Reaction at a mild level.[1]

ORDER

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

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[1] Under OAR 436-035-0400(5)(b)(B), a Class 2 Depressive Reaction: "Lasts for several weeks. There are disturbances in eating and sleeping patterns, loss of interest in usual activities, and moderate retardation of physical activity. There may be thoughts of suicide. Self-care activities and personal hygiene remain good."

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In the Matter of the Compensation of
**LADELL Y. SCHWAB, Claimant**
Own Motion No. 97-0130M
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 November 4, 1997 Notice of Closure which closed her claim with an award of temporary disability compensation from April 16, 1997 through July 23, 1997. SAIF declared claimant medically stationary as of October 23, 1997.

In a January 7, 1998 letter, we requested the parties to submit copies of materials considered in closing the claim. Upon submission of these materials, claimant was allowed 15 days to submit additional materials. SAIF submitted its response on January 12, 1998. No further response has been received from claimant. Therefore, we proceed with our review.

Premature Closure

A claim may not be closed unless the claimant's condition is medically stationary. See OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that 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 November 4, 1997 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12, (1980).

On October 23, 1997, claimant was examined by claimant's treating physician, Dr. Straub. He stated in a chart note dated October 23, 1997 and concurrence letter of that same date, that "I think she [claimant] can be considered medically stationary." This opinion is unrebutted.

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

Entitlement to Temporary Total Disability/Rate

It is unclear from claimant's December 31, 1997 request whether she is contending she is entitled to additional temporary total disability and/or whether the temporary total disability rate at which she was paid is incorrect. In any event, we proceed with our review of the November 4, 1997 Notice of Closure based on the record before us.

In order to be entitled to substantive benefits prior to claim closure, claimant must establish that she was disabled due to the compensable injury prior to being declared medically stationary. ORS 656.210; Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992); Donna Anderson, 46 Van Natta 1160 (1994); Randy Boydston, 46 Van Natta 2509 (1994); Debra Dale, 47 Van Natta 2344 (1995).

Here, claimant was declared medically stationary on October 23, 1997. Furthermore, temporary disability compensation was paid from April 16, 1997 through July 23, 1997. Therefore, claimant must establish that she was disabled between July 23, 1997, when SAIF terminated temporary disability, and October 23, 1997, her medically stationary date. Dr. Straub's October 23, 1997 chart note indicates that claimant "remains released to her work." Claimant submits no evidence to establish that she was disabled after July 23, 1997. Further, there is nothing in the record which would evidence that the rate of disability at which claimant was paid is incorrect.[1] Therefore, we find claimant has failed to meet her burden of proving entitlement to additional temporary disability compensation.

Accordingly, we affirm SAIF's November 4, 1997 Notice of Closure in its entirety.

IT IS SO ORDERED.

[1] The Board requested information from all parties by letters dated January 7, 1998, January 15, 1998 and February 4, 1998. Claimant did not respond and did not submit any materials for our consideration.

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In the Matter of the Compensation of
**TIMOTHY A. WOOSLEY, Claimant**
WCB Case No. 97-02411
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Neal's order that set aside its denial of claimant's L4-5 disc bulge 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

In 1979, claimant underwent back surgery at L5-S1. In 1980, claimant underwent another back surgery at L4-5. In November 1996, claimant injured his low back at work and, in February 1997, the insurer accepted a claim for "lumbar strain."

Claimant's attorney then asked the insurer to include an "L1-2 disc bulge" and "L4-5 disc protrusion" in the acceptance. The insurer denied the request and the parties went to hearing concerning the compensability of the two conditions. Although finding that claimant did not prove the compensability of the condition at L1-2,[1] the ALJ set aside the insurer's denial of the L4-5 condition.

On review, the insurer disputes the ALJ's conclusion concerning the L4-5 condition, asserting that the record lacks persuasive medical evidence to prove compensability. We agree with the insurer.

[1] That portion of the ALJ's order concerning the L1-2 condition is not contested on Board review.

The ALJ relied on the last opinion from claimant's treating neurosurgeon Dr. Calhoun. This report was drafted by claimant's attorney and summarized Dr. Calhoun's statements to claimant's attorney. The report stated that claimant had a "preexisting condition" at L4-5; specifically Dr. Calhoun explained that "the L5-S1 fusion caused increased stress on the L4-5 disc, which resulted in some preexisting degenerative changes at L4-5." (Ex. 33A-2). The report further stated that the November 1996 injury "is the major cause of his L4-5 disc herniation, symptoms, disability, and need for treatment"; this opinion was "based upon the mechanism of the November 1996 injury in that fall and twisting probably exerted a large amount of stress on the L4-5 disc, causing it to herniate and press on the nerve root on the right side," which in turn caused claimant's "symptoms in his low back, right buttock, and right leg." (Id.) The report also stated that Dr. Calhoun "weighed the relative contribution of the preexisting condition and the November 1996 injury and decided * * * the November 1996 injury played the greater role in the L4-5 disc herniation." (Id. at 3).

As the insurer points out, the ALJ did not discuss evidence from Dr. Calhoun rendered before this report. Dr. Rosenbaum, examining neurosurgeon, diagnosed lumbar strain with "a prominent functional overlay." (Ex. 20-3). According to Dr. Rosenbaum, claimant's symptoms were not consistent with abnormalities found on diagnostic studies and he demonstrated symptoms that were functional in nature. (Id.) Dr. Calhoun eventually concurred with this report, except for that portion that recommended against a pain management program. (Ex. 24).

Dr. Calhoun then sent a letter to claimant's family physician in part stating that he did not think "the disc bulges themselves were caused by the injury; however, it did cause them to become symptomatic." (Ex. 30).

Based on an entire review of Dr. Calhoun's opinion, we find it inconsistent. As shown above, Dr. Calhoun first agreed with Dr. Rosenbaum that claimant displayed "prominent functional overlay" and his symptoms were not caused by the abnormalities shown on diagnostic studies. Dr. Calhoun also himself reported that he thought the injury did not cause claimant's disc bulges. In a complete reversal from this position, however, Dr. Calhoun concurred with the letter from claimant's attorney stating that the November 1996 injury was the major contributing cause of the L4-5 disc herniation. Based on this inconsistency, and because Dr. Calhoun provides no explanation for his changed opinion, we find Dr. Calhoun's opinion unreliable. See Kelso v. City of Salem, 87 Or App 630, 634 (1987) (physician who changed his opinion found to be reliable because he provided a reasonable explanation for his changed opinion).[2]

The remaining opinion supporting causation is from Dr. Thompson, who only concurred with the report drafted by claimant's attorney (Exhibit 33A). We find Dr. Thompson's unexplained concurrence with this letter no more persuasive than Dr. Rosenbaum's contrary opinion.

In sum, we conclude that claimant failed to provide persuasive medical evidence showing that the November 1996 injury caused the L4-5 disc herniation. Therefore, claimant did not establish the compensability of this condition.

## ORDER

The ALJ's order dated August 12, 1997 is reversed. The insurer's denial of the L4-5 disc condition is reinstated and upheld. The ALJ's attorney fee award is reversed.

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[2] Claimant argues on review that we should find Dr. Calhoun's opinion more persuasive than Dr. Rosenbaum's opinion for a number of reasons. As we have explained, the difficulty with Dr. Calhoun's opinion is that he has both concurred with Dr. Rosenbaum's opinions as well as indicated his concurrence with a letter from claimant's attorney that expressed opinions that are inconsistent with those of Dr. Rosenbaum.

In the Matter of the Compensation of
**ROGER C. BISHOP, SR., Claimant**
WCB Case No. 97-04217
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Thaddeus J. Hettle, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Thye's order that set aside its denial of claimant's occupational disease claim for a right shoulder condition. On review, the issue is compensability.

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

We delete the following statement on page 3 of the ALJ's order: "There is no evidence that Dr. Jones viewed the arthrogram films."

Claimant's treating orthopedist, Dr. Eilers, provided a well-reasoned opinion based on an accurate history. We find no persuasive reasons for not deferring to Dr. Eilers' opinion. Consequently, we agree with the ALJ that Dr. Eilers' opinion carried claimant's burden of proof. See Weiland v. SAIF, 64 Or App 810 (1983).

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 September 10, 1997 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the self-insured employer.

In the Matter of the Compensation of
**RUSSELL L. MARTIN, Claimant**
WCB Case No. 97-03643
ORDER ON REVIEW
Heiling, Dodge & Associates, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by the Board en banc.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Otto's order that: (1) set aside its denial of claimant's consequential condition claim for major depression; (2) directed it to recalculate claimant's temporary total disability (TTD) rate based on the value of his accrued vacation time; and (3) awarded claimant's attorney an assessed fee of $4,000 for services rendered in obtaining SAIF's pre-hearing acceptance of claimant's adjustment disorder and in prevailing over SAIF's denial of his major depression claim. Claimant cross-requests review of those portions of the ALJ's order that: (1) directed SAIF to recalculate claimant's TTD rate based on an average weekly wage of $368.19; and (2) did not assess penalties and attorney fees for SAIF's allegedly unreasonable calculation of his TTD rate, its allegedly untimely acceptance of a non-union fracture of the left arm, and its allegedly untimely amended acceptance of claimant's adjustment disorder. On review, the issues are compensability, TTD rate, penalties, and attorney fees.

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

Penalties

On review, claimant contends that SAIF should be assessed penalties and related attorney fees for the following reasons: (1) failure to properly calculate claimant's TTD rate; (2) untimely acceptance of the nonunion fracture of the left elbow; and (3) untimely acceptance of the adjustment disorder with depressed and anxious mood. However, based on our review of the hearing transcript, we find that claimant did not raise all of these bases for penalties and related attorney fees. Rather, at hearing, claimant agreed with the ALJ's statement that claimant's penalty request was for SAIF's "failure to timely accept psychological conditions, plus failure to pay various medical bills and refusal to authorize treatment." (Tr. 4). Therefore, the sole basis that claimant raised in support of his penalty request at hearing was the untimely acceptance of the psychological condition and failure to pay medical bills and authorize treatment. Because the remaining bases for penalties were not raised at hearing, we decline to consider them for the first time on Board review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247, 252 (1991).

Attorney Fees

For claimant's attorney's services in obtaining SAIF's acceptance of the adjustment disorder condition and in prevailing over SAIF's denial of the major depression claim, the ALJ awarded an assessed fee of $4,000 payable by SAIF. The ALJ determined that the fee amount was reasonable "[a]fter considering the factors set forth in OAR 438-015-0010(4)[1] and applying them to this case." The

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[1] 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."

ALJ stated that he "particularly considered the time devoted to the issues, the complexity of the issues, the value of the interest involved, and the risk that counsel may go uncompensated."

On review, SAIF contends that the assessed fee award was excessive and that the ALJ failed to "articulate a rational connection" in determining the fee amount. Citing Schoch v. Leupold & Stevens, 325 Or 112, on remand 49 Van Natta 788 (1997), SAIF asserts that the ALJ did not state a sufficient rationale to support the $4,000 fee award. We find, however, that Schoch is distinguishable on its facts and that the ALJ's stated rationale for the fee award was sufficient given the record at hearing.

In Schoch, the Board awarded the claimant's attorney an assessed fee of $3,000 for services in obtaining authorization for proposed back surgery. In determining a "reasonable" fee, the Board stated that it had considered the factors in its attorney fee rule, "particularly" the time devoted to the case, the complexity of the issue, the value of the interest involved, and the risk that the claimant's attorney might go uncompensated. The Board's order did not specifically explain how the factors were weighed in determining the amount of the fee awarded.

The claimant requested reconsideration of the Board's fee award. Submitting an affidavit and summary of services rendered by her attorney, the claimant requested that the fee award be increased to $19,897.50. The summary of services detailed the attorney's experience in Workers' Compensation Law and documented 75.8 hours of service at an hourly rate of $175. On reconsideration, the Board adhered to its original order without further explanation. The Court of Appeals affirmed.

The Supreme Court reversed. The Court observed that the legislature delegated to the Board the discretion to determine, on a case-by-case basis, what constitutes a "reasonable" attorney fee, and that it is the court's function to review the Board's decision to see that it is within the range of discretion granted by the legislature. Id. at 117-18. The Court stated:

> "It is crucial that an agency's order reveal a rationale for an award of attorney fees. At a minimum, where the basis for an agency's discretionary choice is not obvious, an agency must provide sufficient explanation to allow a reviewing court to examine the agency's action in relation to the range of discretion granted by the legislature, the agency's own 'rule, officially stated agency position, or a prior agency practice,' and other statutory and constitutional provisions." Id. at 118 (citation omitted).

The Court concluded that the Board's recitation of the rule-based factors was not sufficient to explain the discrepancy between the fee requested and the fee awarded; instead, the Court sought an explanation of how the Board's consideration of those factors led to the fee awarded. Id. at 118-19. The Court ultimately remanded the case to the Board for reconsideration of the fee award.

SAIF argues that the Schoch decision sets forth "requirements for a reviewable award of an attorney fee." Implicit in its argument is the notion that all attorney fees awarded by ALJ's and the Board must be supported by specific findings regarding the factors set forth in the Board's attorney fee rule, OAR 438-015-0010(4). We disagree.

SAIF overlooks a critical fact that led to the Court's holding in Schoch. Before the Court pointed to the shortcomings of the Board's explanation for its fee award, it noted the substantial discrepancy between the fee amount requested by the claimant's attorney ($19,897.50) and the $3,000 fee awarded by the Board. Although suggesting several reasons for the discrepancy, the Court concluded that it could not review the reasonableness of the fee awarded, because the Board did not sufficiently explain how any of the rule-based factors weighed in its decision-making process and led to the reduced fee that it awarded. 325 Or at 119-20. Thus, the Schoch Court was looking for a "sufficient explanation" of how the rule-based factors were weighed in deciding that a "reasonable" fee award was substantially less than the amount requested. Because the Board's order did not contain that explanation, but merely a recitation of the factors considered, the Court reversed and remanded to the Board for reconsideration of the fee award.

In this case, however, the record does not contain a 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. The absence of a fee request or argument on the rule-based factors distinguishes this case from Schoch. Under these circumstances, the ALJ was not obligated to make specific findings regarding the rule-based factors, in order to have a

reviewable order. It was enough for the ALJ to state that he had considered the rule-based factors, with particular emphasis on four of the factors (i.e., time, complexity, value, and risk), in reaching his decision that $4,000 was a reasonable fee. Therefore, under the circumstances of this case, the ALJ's explanation for the fee award was sufficient compliance with the Schoch Court's instruction to provide a rational connection between consideration of the factors and the amount of the fee awarded.[2]

On review, SAIF submits, apparently for the first time, specific arguments regarding the rule-based factors of time devoted to the case, complexity of the issue(s), and nature of the proceedings. SAIF argues that consideration of those factors does not justify a $4,000 fee in this case. Because SAIF 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.

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 to obtain SAIF's acceptance of the depression condition and, ultimately, filed a hearing request to compel acceptance. (Exs. 27A, 39). In addition to the substantial time devoted to this case, there was the significant value of claimant's interest in obtaining acceptance of the psychological condition. Given the application of the "major contributing cause" standard and the conflict in medical opinions, claimant's attorney assumed a great 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 psychological condition) for claimant. 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 $4,000 is a reasonable attorney fee. Therefore, as supplemented herein, we affirm the ALJ's fee award.

Claimant argues that his attorney was also entitled to an assessed fee under ORS 656.386(1) for obtaining SAIF's "pre-hearing" acceptance of the nonunion fracture of the left arm. (Ex. 45A). However, we find no evidence that SAIF expressly denied the compensability of the nonunion fracture prior to its acceptance of that condition on August 5, 1997. Therefore, no "denied claim" for that condition has been established under ORS 656.386(1). See William B. Nolan, 49 Van Natta 2091, 2092 (1997). Furthermore, although the definition of "denied claim" in ORS 656.386(1) was amended in 1997 to include an insurer's non-response to a claimant's request for expansion of the acceptance notice to include additional conditions, that amendment was not made retroactive to this case. See Stephenson v. Meyer, 150 Or App 300, 304 n 3 (1997). Moreover, after amended ORS 656.386(1) went into effect on July 25, 1997, SAIF issued its amended acceptance of the nonunion fracture within 30 days, on August 5, 1997. Therefore, claimant is not entitled to an assessed fee for the nonunion fracture condition under amended ORS 656.386(1).

Claimant's attorney is entitled to an assessed fee for services rendered in defending against SAIF's request for review regarding the compensability and TTD issues. 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 those services is $800, to be paid 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. Claimant's attorney is not entitled to an assessed fee for defending the ALJ's fee award and for claimant's cross-appeal.

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[2] Our conclusion in this regard is not only based on the most reasonable interpretation of the Schoch opinion; it also promotes administrative economy and is consistent with notions of fundamental fairness. Rather than requiring that all attorney fee awards be supported by specific findings as to the rule-based factors (a decision that would significantly impact our administrative demands and costs), we believe it is more efficient (and less costly) for the parties to bear the onus of presenting to the ALJ or the Board their fee requests and/or arguments addressing the factors. If the claimant's attorney's fee request is uncontested, it would be unnecessary to explain how the factors were applied, unless a lesser fee is awarded. If, on the other hand, the fee request is contested or there are arguments addressing the factors, then the ALJ or the Board must, in accordance with Schoch, provide "sufficient explanation" of how consideration of the factors led to the fee awarded. That explanation need not include findings as to all of the factors. See Weyerhaeuser Co. v. Fillmore, 98 Or App 567, 571, rev den 308 Or 608 (1989) (the Board is not required to make a finding as to each of the factors in the attorney fee rule). Rather, as the Schoch Court explained, all that is required is a "rational connection" between consideration of the factors and the fee awarded. Thus, the Schoch Court did not overrule Fillmore to the extent it held that findings need not be made as to each of the factors to support a fee award.

ORDER

The ALJ's order dated September 29, 1997 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $800, payable by SAIF.

**Members Moller and Biehl specially concurring.**

We write separately to express our agreement with our colleagues' interpretation of the Supreme Court's opinion in Schoch. We do not, however, pass any judgment on the reasonableness of the fee awarded in this particular case or the merits of the remaining issues.

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In the Matter of the Compensation of
**RANDY B. BAKER, Claimant**
WCB Case No. 96-09302
ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

On December 19, 1997, we abated our November 19, 1997 order that reversed that portion of an Administrative Law Judge's (ALJ's) order that held that the SAIF Corporation's denial of claimant's current right median neuropathy condition was precluded, and affirmed those portions of the ALJ's order which alternatively found that SAIF's denial was not an invalid "back-up" denial and that claimant's current condition was not compensable. Challenging the ALJ's reasoning regarding the appropriate statutory compensability standard and the medical evidence, claimant seeks reconsideration of our decision to adopt and affirm the ALJ's conclusion that his current right median nerve condition was not compensable. Having received SAIF's response and claimant's reply, we proceed with our reconsideration.

To begin, we address claimant's arguments in his reply brief on reconsideration that we erred by stating there was no evidence that Dr. Green had examined claimant and he had not discussed claimant's preexisting condition. Claimant refers to pages 2 and 3 from Dr. Green's report. However, the record on review contains only one exhibit from Dr. Green, Exhibit 26A, which consists of a one-page letter dated December 13, 1996. The record also indicates that Exhibit 26A (renumbered from Exhibit 27) was submitted by claimant's attorney on January 3, 1997 and was described as consisting of one page. (See Tr. 3). We sought clarification from the parties to determine whether a multi-page report from Dr. Green was admitted as an exhibit in the record.

In response, claimant's attorney submitted a copy of a three-page report from Dr. Green dated December 3, 1996. SAIF responded that it had not received a copy of the December 3, 1996 report and that the report was not submitted as an exhibit at hearing. According to SAIF, the only document from Dr. Green that was submitted was Exhibit 26A, which consisted of a one page letter dated December 13, 1996. In reply, claimant contends that, because at least one party thought the document had been admitted, the Board should admit that document in the interest of substantial justice. Claimant asserts that, if necessary, we should remand the case. SAIF objects to the admission of the December 3, 1996 document or a remand to the ALJ.

We find that the only document from Dr. Green that was submitted at hearing was Exhibit 26A, which consisted of a one page letter dated December 13, 1996. Our record on review consists only of that one-page document. Moreover, the record establishes that claimant's attorney submitted Exhibit 26A, previously marked Exhibit 27. Claimant's attorney's cover letter dated January 3, 1997 refers to a "12/13/96 report by Sean Green, M.D., to [claimant's attorney], 1 page." Thus, it is clear from claimant's attorney's cover letter that Exhibit 26A consisted of a one page report from Dr. Green dated December 13, 1996.

Because our review is confined to the record developed before the ALJ, we treat claimant's submission of Dr. Green's December 3, 1996 report as a motion to remand for the taking of additional evidence. 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). Remand is

appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988).

Here, claimant provides no explanation as to why Dr. Green's December 3, 1996 report was not obtainable with due diligence at the time of the hearing. Moreover, we are not persuaded the additional document submitted by claimant is likely to affect the outcome of this case. Dr. Green's opinion is already present in the record through his December 13, 1996 medical report. Furthermore, we note that, in his brief on review, claimant relies primarily on the opinion of Dr. Bufton to establish compensability and refers to Dr. Green's opinion because it is consistent with Dr. Bufton. For the reasons discussed in the ALJ's order, we did not find Dr. Bufton's opinion persuasive. We conclude that the record was not improperly, incompletely or otherwise insufficiently developed and that there is no compelling reason to remand. Therefore, we decline to remand the case to the ALJ for additional proceedings.

After considering the remaining arguments in claimant's motion, we have nothing further to add to our previous order. We adhere to our previous opinion that claimant has failed to meet his burden of proof under either ORS 656.005(7)(a)(B) or ORS 656.802(2)(b).

On reconsideration, as supplemented herein, we adhere to and republish our November 19, 1997 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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February 27, 1998 Cite as 50 Van Natta 317 (1998)

In the Matter of the Compensation of
**LESLIE A. CREWS, Claimant**
WCB Case No. 96-11168
ORDER ON RECONSIDERATION
Neil W. Jackson & Associates, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Claimant requests reconsideration of our February 5, 1998 Order on Review that reversed an Administrative Law Judge's (ALJ's) order which set aside the insurer's denial of claimant's injury claim for an L4-5 herniated disc condition. Specifically, claimant argues that we erred in failing to consider whether claimant's injury was the major contributing cause of her need for treatment for her low back. See SAIF v. Nehl, on recon 149 Or App 309 (1997).

However, as we explained, "We find no persuasive evidence indicating that claimant's current need for treatment for her low back is medically separable from her combined low back condition." Leslie A. Crews, 50 Van Natta 193, n.2 (1998). Thus, because the cause of claimant's need for treatment is no different from the cause of her condition in this case, the Nehl rationale does not apply. See Robinson v. SAIF, 147 Or App 157, 162 (1997) ("The fact that a work injury caused or precipitated a claimant's condition does not necessarily mean that a work injury was the major contributing cause of the condition.") (citing Dietz v. Ramuda, 130 Or App 397, 401, rev dismissed 321 Or 416 (1995).

Accordingly, we withdraw our February 5, 1998 order. On reconsideration, as supplemented herein, we republish our February 5, 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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In the Matter of the Compensation of
**PAMELA G. FRANK, Claimant**
WCB Case No. 96-06575
ORDER ON RECONSIDERATION
Foss, Whitty, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

The self-insured employer requests reconsideration of our February 10, 1998 Order on Review that affirmed the Administrative Law Judge's (ALJ's) order which, among other directives, remanded for acceptance of a "disabling" claim and payment of temporary disability from September 25, 1996 through November 25, 1996. In affirming the ALJ's order, we declined to address the employer's request that the ALJ's order be "corrected" to state that an aggravation, not the original, claim is reclassified to disabling. In declining the employer's request, we determined that this was a claim processing issue separate from the issues litigated at hearing and instructed the employer to process the claim in accordance with the ALJ's order. We noted that claimant could request a hearing if she became dissatisfied with the employer's processing.

Contending that the ALJ's order could be read to preclude acceptance of the claim as an "aggravation," and expressing concern that the ALJ's order might become binding on the manner of subsequent litigation, the employer requests that we revise the ALJ's order to state that "the matter is remanded for acceptance and processing according to law and payment of appropriate benefits including time loss for the period September 25, 1996 through November 25, 1996."

The employer's request notwithstanding, we decline to revise the ALJ's order. The ALJ's order remanded to the employer for acceptance of a "disabling claim" and payment of temporary disability. The employer does not dispute that the claim has become disabling. Although the employer expresses concern that the order may preclude acceptance as an "aggravation" claim, the ALJ's order clearly does not do so.[1] It merely remanded for acceptance of a "disabling" claim. The exact manner of the employer's processing (i.e., whether as an "aggravation" or as part of the initial claim) is within the claim processing discretion of the employer, as long as its processing is in accordance with law. Once again, should claimant become dissatisfied with that processing, she may request a hearing.

Finally, claimant requests an attorney fee for services rendered in responding to the employer' reconsideration request. Given that the employer does not contest the ALJ's award of temporary disability or "disabling" classification, we do not consider claimant's compensation to have been at risk as a result of the employer's reconsideration request. ORS 656.382(2); Gerald A. Zeller, 48 Van Natta 501, on recon 48 Van Natta 735, 736 (1996). Therefore, we decline to award an attorney fee for services on reconsideration.

Accordingly, we withdraw our February 10, 1998 order. On reconsideration, as supplemented herein, we adhere to and republish our February 10, 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] Indeed, claimant did not challenge the ALJ's findings that: (1) she did not establish that her nondisabling injury became disabling within one year of the injury; or (2) she was required to bring her claim to reclassify as an aggravation claim pursuant to ORS 656.277(2). Moreover, she has not contested the Board's affirmance of the ALJ's order. Thus, it appears that the employer's proposed claim processing may be appropriate. However, we reiterate that the manner of claim processing is an issue separate from the issues litigated at hearing and, thus, we need not determine the precise manner in which the "disabling" claim is to be processed.

In the Matter of the Compensation of
**ROBERT HOLLINGSWORTH, Claimant**
WCB Case No. 93-08868
ORDER ON REVIEW
Reinisch, et al, Claimant Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant, pro se, requests review of those portions of Administrative Law Judge (ALJ) Otto's order that: (1) granted the insurer's motion to strike the issue of the compensability of his orthostatic tremor; (2) declined to award penalties and attorney fees for the insurer's allegedly unreasonable claim processing; (3) upheld the insurer's denial of his cervical aggravation claim; and (4) dismissed for lack of jurisdiction claimant's hearing request regarding the insurer's denial of his request for surgery. The insurer cross-requests review of those portions of the ALJ's that: (1) set aside its alleged denial of claimant's current cervical condition; and (2) awarded a $2,000 attorney fee pursuant to ORS 656.386(1). On review, the issues are compensability, scope of denial, aggravation, jurisdiction, motion to strike, penalties, and attorney fees.

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

The ALJ awarded claimant's attorney a $2,000 attorney fee for services rendered at hearing regarding the insurer's denial of his current cervical condition. On review, the insurer contends that, in the event we agree with the ALJ's finding that it denied claimant's current cervical condition, the attorney fee should be reduced. For the following reasons, we find that the ALJ's attorney fee award was appropriate.

We initially note our agreement with the ALJ's reasoning and conclusion that the insurer denied claimant's current cervical condition. On de novo review, we consider the amount of claimant's counsel's attorney fee for services at the hearings level by applying the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Our review of the record reveals the following information. The issue in dispute was whether the insurer had denied the compensability of claimant's current cervical condition, and, if so, whether that condition was compensable.[1] Although approximately 175 exhibits were received into evidence, most if not all dealt with issues other than the compensability of claimant's current cervical condition. There were two depositions, but concerned issues other than the compensability of the current cervical condition. The hearing lasted one hour and the transcript consists of twenty-nine pages. No witnesses testified.

As compared to typical compensability cases, the issue here was of below average complexity because the insurer did not contest the compensability of the cervical condition. However, legal argument was made on the issue of whether the insurer's denial of aggravation also contained a denial of claimant's current cervical condition. The claim's value and the benefits secured are of average proportions. Finally, there was a risk that claimant's counsel's efforts might have gone uncompensated had the ALJ agreed with the insurer's argument that it did not deny claimant's current cervical condition.

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[1] The argument at hearing concerned whether, in fact, the insurer denied claimant's current cervical condition. The insurer did not dispute the compensability of claimant's current cervical condition in its arguments to the ALJ. However, after determining that the insurer's July 15, 1993 denial contained an express denial of claimant's current cervical condition, the ALJ made a finding on the merits of the compensability issue, concluding that claimant's compensable injury and subsequent surgery were the major contributing cause of his current cervical condition.

After consideration of the aforementioned factors, we conclude that $2,000 is a reasonable assessed attorney fee for claimant's counsel's services at hearing regarding the compensability of claimant's current cervical condition. In particular, we have considered the complexity of the issue, the value of the interest involved, the benefits obtained, the nature of the proceeding and the risk that claimant's counsel might go uncompensated.

ORDER

The ALJ's order dated August 29, 1997 is affirmed.

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March 2, 1998 Cite as 50 Van Natta 320 (1998)

In the Matter of the Compensation of
**VANCE T. FERGUSON, Claimant**
WCB Case Nos. 97-01897, 96-09497 & 97-01220
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

RFI Electronics (RFI) requests review of those portions of Administrative Law Judge (ALJ) Otto's order that: (1) set aside its denial of claimant's claim for a current left lateral epicondylitis condition; and (2) upheld the SAIF Corporation's denial of claimant's new injury or occupational disease claim for the same condition. Claimant requests review of those portions of the order that: (1) found RFI responsible for claimant's left lateral epicondylitis condition; and (2) did not award an attorney fee for services related to obtaining SAIF's pre-hearing acceptance of his left carpal tunnel syndrome condition claim. Claimant also requests additional attorney fees for services related to the epicondylitis claim beyond the $1,000 award granted by the ALJ's order. On review, the issues are responsibility and attorney fees. We modify in part and affirm in part.[1]

FINDINGS OF FACT

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

Claimant's counsel was instrumental in obtaining SAIF's pre-hearing acceptance of his previously denied claims for left carpal tunnel syndrome and SAIF's pre-hearing concession of compensability regarding claimant's left epicondylitis conditions.

Prior to the hearing, both SAIF and RFI conceded the compensability of claimant's left epicondylitis condition. Thus, responsibility was the only issue litigated at hearing regarding the left epicondylitis condition.

Claimant's counsel appeared and participated in the responsibility hearing in an active and meaningful manner.

CONCLUSIONS OF LAW AND OPINION

Responsibility/Left Lateral Epicondylitis

We adopt and affirm the ALJ's "Conclusions of Law and Opinions" regarding this issue, with the following correction.

The first sentence on page 7 is corrected to read: "There are two reasons why Dr. Van Allen's opinion regarding the cause of claimant's left epicondylitis is unpersuasive."

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[1] We also note that Exhibits 86A, 87A, 109 and 110 were admitted at hearing, as were those described in the Opinion and Order. (See Tr. 5).

Attorney Fees

We adopt and affirm the ALJ's "Conclusions of Law and Opinions" regarding this issue, except for the section entitled "2. Attorney fee from NW Air/SAIF regarding right carpal tunnel syndrome," with the following correction and supplementation.

The first sentence of the section entitled "Attorney fee from NW Air/SAIF regarding right carpal tunnel syndrome" is corrected to read: "Claimant contends that he is entitled to an assessed attorney fee from NW Air/SAIF pursuant to ORS 656.386(1) for the efforts of his attorney in obtaining SAIF's pre-hearing acceptance of his right carpal tunnel syndrome claim."

Claimant requests an attorney fee under ORS 656.386(1) for his attorney's services in obtaining SAIF's pre-hearing acceptance of his previously denied left carpal tunnel syndrome under ORS 656.386(1). SAIF agrees that it owes a fee on this basis. (See Tr. 10; see also Exs. 99, 109).

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services in obtaining SAIF's pre-hearing acceptance of the left carpal tunnel syndrome claim is $750, 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.

Claimant also requests an attorney fee for pre-hearing services associated with rescission of the compensability portion of SAIF and/or RFI's denial(s) of the left lateral epicondylitis condition.

RFI argues that it is not liable for a fee under ORS 656.386(1), because it never denied the claim for left lateral epicondylitis. We agree. (See Exs. 70, 73, 79; see also Exs. 86, 102).

SAIF, on the other hand, expressly denied the left lateral epicondylitis claim on compensability grounds (on January 23, 1997). (Ex. 99). Sometime before April 29, 1997, SAIF agreed that responsibility was the only issue, thereby withdrawing its compensability denial. (See Ex. 108). Because we find that claimant's counsel was instrumental in obtaining compensation for claimant under this claim (by virtue of his February 10, 1997 request for hearing from the denial), we further find that claimant is entitled to an attorney fee on this basis. See Kerry L. Vanwagenen, 46 Van Natta 1786, 1788 (1994); David K. Krueger, 45 Van Natta 1131 (1993) (request for hearing preserved claimant's right to challenge the employer's denial and was sufficient to warrant an assessed 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 find that a reasonable fee for claimant's attorney's services in obtaining SAIF pre-hearing rescission of its denial of claimant's left lateral epicondylitis claim is $750, payable by SAIF.[2] In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record, including SAIF's argument against such an award), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

Finally, we acknowledge claimant's request for additional attorney fees under ORS 656.307 or 656.308(2)(d) for his counsel's services at hearing regarding the left lateral epicondylitis condition.

The ALJ awarded a $1,000 attorney fee under ORS 656.308(2)(d). However, because this case arises under ORS 656.307, 656.307(5) applies. See Bremmer v. Dean Warren Plumbing, 150 Or App 422, 427 (1997). Consequently, claimant is entitled to a carrier-paid attorney fee for his attorney's active and meaningful participation in the "307" proceeding.[3]

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[2] In reaching this conclusion, we reiterate that RFI never denied claimant's left lateral epicondylitis condition on compensability grounds. Under these circumstances, SAIF is liable for the attorney fee under ORS 656.386(1), even though RFI is responsible for the claim. See Ronald L. Swan, Sr., 47 Van Natta 2412, 2416 (1995).

[3] Claimant's attorney was instrumental in making a claim against RFI (the responsible carrier). Moreover, claimant's counsel appeared at the hearing and actively participated in the proceeding.

After considering the factors set forth 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 "307" proceeding regarding the left lateral epicondylitis condition was $2,500. In reaching this conclusion, we have particularly considered the time devoted to the responsibility issue (as represented by the record), the complexity of the issue, and the value of the interest involved. See Joann S. Robison, 48 Van Natta 1699 (1996) (citing Dan J. Anderson, 47 Van Natta 1929 (1995) (ORS 656.308(2)(d) does not limit assessed fees awarded under ORS 656.307(5) for services rendered in a "307" responsibility proceeding). Claimant is not entitled to an attorney fee award under ORS 656.307 for his counsel's services on review. See ORS 656.307(5); Lynda C. Prociw, 46 Van Natta 1875 (1994).

We note that claimant submitted a respondent's brief on review in which he argues that SAIF should be found responsible for his condition. It is undisputed that claimant would receive a higher rate of temporary total disability benefits under the SAIF claim than he would receive under the 1990 claim with RFI. (See Ex. 100). Thus, because compensability was not litigated at hearing and claimant's compensation is not at risk of reduction on review, claimant is not entitled to an attorney fee for his counsel's services on Board review. See ORS 656.382(2); Long v. Continental Can Co., 112 Or App 329 (1992); John H. Kirkpatrick, 47 Van Natta 2105 (1995); Rito N. Nunez, 45 Van Natta 25, 26 (1993). Finally, claimant's attorney is not entitled to a fee for services related to securing the attorney fee awards under ORS 656.386(1) and 656.307(5). See Allen T. Knight, 48 Van Natta 30 (1996); Ernest C. Richter, 44 Van Natta 101, on recon 44 Van Natta 118 (1992).

ORDER

The ALJ's order dated August 28, 1997 is modified in part and affirmed in part. In lieu of the ALJ's $1,000 attorney fee award under ORS 656.308(2)(d), claimant is awarded a $2,500 attorney fee under ORS 656.307(5), payable by RFI Electronics. Claimant is also awarded a $750 attorney fee under ORS 656.386(1) regarding SAIF's "pre-hearing" acceptance of claimant's left carpal tunnel syndrome claim, payable by the SAIF Corporation. Finally, claimant is awarded another $750 attorney fee under ORS 656.386(1) for SAIF's "pre-hearing" rescission of the compensability portion of its denial of claimant's left lateral epicondylitis condition, to be paid by SAIF. The remainder of the order is affirmed.

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February 27, 1998 Cite as 50 Van Natta 322 (1998)

In the Matter of the Compensation of
**TERRY R. TYLER, Claimant**
WCB Case No. 96-07138
ORDER OF ABATEMENT
Schneider, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

On January 30, 1998, we reversed an Administrative Law Judge's (ALJ's) order that had set aside the SAIF Corporation's denial of claimant's low back injury claim. Contending that we erroneously rejected the ALJ's demeanor-based finding that he was a credible witness and ignored the ALJ's implicit demeanor-based 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 further consider this matter, we withdraw our January 30, 1998 order. SAIF is granted an opportunity to respond. To be considered, that response must be filed within 14 days from the date of this order. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**CLYDE C. SLOAN, Claimant**
WCB Case No. 96-09656
ORDER ON REVIEW
Kasia Quillinan, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Michael Johnson's order that: (1) found that SAIF was precluded from denying claimant's current left knee condition; and (2) set aside SAIF's denial of the same condition. On review, the issues are preclusion and, potentially, compensability. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" except for those portions beginning with "Note to Reader."

## CONCLUSIONS OF LAW AND OPINION

### Preclusion/Scope of Acceptance

In the early 1960's, claimant sustained a nonwork-related left knee injury and underwent surgery. In July 1990, claimant again injured his left knee at work.

In September 1990, SAIF accepted a left lateral meniscus tear. (Ex. 6). At the same time, SAIF issued a denial of "post traumatic arthritis with chronic chondral damage left knee." In December 1990, SAIF notified claimant that it was "withdrawing" the denial. (Ex. 8A). In 1991, a Notice of Closure issued and was affirmed by an Order on Reconsideration.

In August 1991, claimant sustained an injury at work to his right knee.

In 1996, claimant again sought treatment for his left knee. SAIF issued a denial of claimant's "current care and treatment." (Ex. 20).

The ALJ first addressed the parties' disagreement as to whether SAIF in effect accepted the arthritic left knee condition when it withdrew its 1990 denial. Although agreeing with SAIF that the withdrawal did not constituted a "de facto" acceptance, the ALJ found that, under Deluxe Cabinet Works v. Messmer, 140 Or App 548, rev den 324 Or 305 (1996), SAIF was precluded from issuing its denial.

On review, SAIF contends that, because Messmer has been legislatively overruled, it is not precluded from denying the current left knee condition. Although acknowledging that Messmer was overruled, claimant continues to assert that, by withdrawing its denial, SAIF "de facto" accepted the left knee condition. According to claimant, the denial thus should be analyzed as a "back-up" denial.

Shortly before the ALJ's order issued, the 1997 Legislature amended ORS 656.262(10). Or Laws 1997, ch. 605, § 1. As amended, the statute now provides:

> "Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability, nor shall mere acceptance of such compensation be considered a waiver of the right to question the amount thereof. Payment of permanent disability benefits pursuant to a determination order, notice of closure, reconsideration order or litigation order or the failure to appeal or seek review of such an order or notice of closure shall not preclude an insurer or self-insured employer from subsequently contesting the compensability of the condition rated therein, unless the condition has been formally accepted." (Emphasis added).[1]

[1] Section 2 provides that the amendments to ORS 656.262 by section 1 of the Act "apply to all claims or causes of action existing or arising on or after the effective date of this Act, regardless of the date of injury or the date a claim is presented, and this Act is intended to be fully retroactive." Or Laws 1997, ch. 605, § 2. Thus, amended ORS 656.262(10) is fully retroactive and applies to this claim. See Bay Area Hospital v. Landers, 150 Or App 154, 157 (1997).

In Keith Topits, 49 Van Natta 1538 (1997), we concluded that the newly amended statute effectively overruled the Messmer decisions. Specifically, we held that a carrier's failure to appeal a prior Order on Reconsideration permanent disability award based on an unaccepted condition did not preclude the carrier from subsequently contesting the compensability of the condition. Consequently, whether or not the 1991 Notice of Closure awarded permanent disability for claimant's current left knee condition, SAIF is not precluded from now denying that condition. We turn to claimant's argument that SAIF "de facto" accepted the current left knee condition.

Whether an acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449, 452 (1992). Here, the record shows that SAIF expressly accepted only "left lateral meniscus tear." Claimant correctly asserts that he was diagnosed with "post traumatic arthritis with chronic chondral damage left knee" before the acceptance issued. That fact is not enough to show that SAIF accepted the arthritic condition, however, because SAIF officially accepted the meniscus tear. See Cecilia A. Wahl, 44 Van Natta 2505 (1992) (when an acceptance does not identify a specific condition, contemporaneous medical records are examined to determine the condition accepted).

We also reject claimant's assertion that SAIF's withdrawal of its denial of the arthritic condition constitutes an acceptance. The notice states only that SAIF was withdrawing its denial; there is no language indicating that SAIF was withdrawing its denial and accepting the condition. As discussed above, nothing else in the record shows that SAIF accepted the arthritic condition. Consequently, when SAIF withdrew its denial, SAIF put the arthritic condition in a status of neither being denied nor accepted.[2]

Thus, we conclude that SAIF is not precluded from denying claimant's current condition and that, because it did not previously accept the current condition, its denial does not constitute a "back-up" denial. We proceed to address the merits.

Compensability[3]

The record shows that claimant's "post traumatic arthritis" condition preexisted and combined with his 1990 injury. (Exs. 2, 5-4, 21-6, 22). Thus, in order to be compensable, claimant must show that the major contributing cause of his current need for treatment is the compensable 1990 injury. See ORS 656.005(7)(a)(B).

The physicians addressing this issue include claimant's treating orthopedic surgeon, Dr. Lewis, and examining orthopedic surgeon, Dr. James. Dr. James found that "the major contributing cause of [claimant's] current need for surgery on his left knee is the pre-existing condition secondary to his old" left knee surgery that occurred in the early 1960's. (Ex. 21-6). Dr. James further stated that the "1990 on-the-job injury perhaps related in a material contributing way, but not the major contributing way" and that claimant's subsequent work and "weight bearing on the knee" also materially contributed to his current condition. (Id.)

Dr. Lewis first indicated that claimant's current left knee condition "all relate[d] to his original industrial injury as the material contributing cause to his progressive degeneration and need for further" medical care. (Ex. 16). A subsequent report then stated that claimant "had a fairly benign knee through

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[2] In reaching this conclusion, we distinguish this situation from those presented in cases such as Sperry, Inc. v. Wells, 127 Or App 700 (1994), Harry L. Lyda, 46 Van Natta 478 (1994), and Eileen A. Edge, 45 Van Natta 2051 (1995). In each of those cases, the withdrawal or rescission of a carrier's denial was included within the parties' stipulation along with a provision requiring the carrier's acceptance and/or processing of the denied condition/claim. Here, unlike those situations, there was no such stipulation. In the absence of such an agreement, we are left with SAIF's withdrawal of its denial and the contemporaneous records to determine whether claimant's arthritic condition had been accepted. As explained above, our review of the withdrawal and the contemporaneous record does not establish that claimant's arthritic condition was accepted.

[3] The ALJ analyzed whether claimant's current left knee condition constituted a compensable worsening of the 1990 injury under ORS 656.273. Because claimant's aggravation rights expired in February 1996, the ALJ lacked jurisdiction to determine whether claimant suffered a worsening under ORS 656.273. ORS 656.273(4)(a). Rather, our review is limited to deciding whether or not claimant's current left knee condition is "causally related" to the compensable injury.

about July of 1990 at which time he had a fall and had a partial tear of the lateral meniscus and a partial tear of the medial collateral ligament, and a partial tear of the anterior cruciate ligament." (Ex. 22). Dr. Lewis further explained that, in 1990, claimant "had mild degenerative changes, but direct visualization of the cartilage [during surgery] showed the cartilage surface to be quite intact without problems, and no significant change in the medial joint space." (Id.) Because after the 1990 injury, claimant experienced "progressive knee problems and progressive degeneration of his knee," Dr. Lewis found it probable that the 1990 injury "caused his knee to deteriorate, probably from some degree of mild instability from the medial collateral and anterior cruciate ligament injuries, and that it progressed to severe arthritis by this time." (Id.)

We agree with SAIF that Dr. Lewis relied on an inaccurate history in rendering his opinion. Claimant did not sustain partial tears to the medial collateral and anterior cruciate ligaments during the July 1990 injury; rather, such injuries were sustained to claimant's right knee in August 1991. (Exs. 2, 9A). Because Dr. Lewis relied upon such injuries in explaining how the compensable injury caused claimant's current need for treatment in his left knee, we find persuasive reasons for not deferring to his opinion. See Weiland v. SAIF, 64 Or App 810 (1983).

We conclude that, lacking persuasive medical evidence that the 1990 compensable injury was the major contributing cause of claimant's current need for treatment, claimant failed to carry his burden of proof.

ORDER

The ALJ's order dated July 28, 1997 is reversed. The SAIF Corporation's denial of claimant's current left knee condition is reinstated and upheld. The ALJ's attorney fee award also is reversed.

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March 2, 1998 Cite as 50 Van Natta 325 (1998)

In the Matter of the Compensation of
**CLYDE C. SLOAN, Claimant**
Own Motion No. 96-0404M
OWN MOTION ORDER
Kasia Quillinan, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

The SAIF Corporation initially submitted claimant's request for temporary disability compensation for his compensable injury. Claimant's aggravation rights on that claim expired on February 6, 1996.

On August 29, 1996, SAIF denied medical benefits and responsibility for claimant's current condition diagnosed as loss of medial joint space with osteophyte formation, post-traumatic arthritis and medial wear. Claimant requested a hearing. (WCB Case No. 96-09656). The Board postponed action on the own motion matter pending resolution of that litigation.

By Opinion and Order dated July 28, 1997, Administrative Law Judge Michael Johnson (ALJ) set aside SAIF's August 29, 1996 denial. SAIF requested Board review of ALJ Johnson's order, and in an order issued on today's date, the Board reversed ALJ Johnson's order and reinstated and upheld SAIF's denial of claimant's current left knee condition.

Under ORS 656.278(1)(a), we may exercise our own motion authority to reopen a claim for additional temporary disability compensation when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization.

Here, the current condition and ensuing medical treatment for which claimant requests own motion relief, remains 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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In the Matter of the Compensation of
**CHARLES G. SWEET, Claimant**
WCB Case No. 97-00504
ORDER ON REVIEW
Robert J. Guarrasi, Claimant Attorney
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) McWilliams' order that: (1) upheld Liberty Northwest Insurance Corporation's (Liberty's) denial of her occupational disease claim for bilateral carpal tunnel syndrome, issued on behalf of Western Pneumatics Inc. (Western); and (2) declined to award penalties and attorney fees for allegedly unreasonable claim processing. On review, the issues are compensability, penalties and attorney fees. We affirm.

## FINDINGS OF FACT

Claimant sustained a compensable right wrist strain on April 4, 1994, while employed by Liberty's insured, Pierce Corporation. After claimant's employment with Pierce ended in May 1994, the claim was closed by Determination Order of December 1, 1994, which granted only temporary disability.

In the meantime, in October 1994, claimant began working as a welder for another Liberty insured, Western Pneumatics, Inc., as a temporary employee. Claimant became a permanent employee in February 1995.

In May 1995, claimant consulted his family physician, Dr. Larson, regarding upper back pain. Dr. Larson later referred claimant to a neurosurgeon, Dr. Goodwin, who evaluated complaints of bilateral hand numbness and tingling. Dr. Goodwin diagnosed bilateral carpal tunnel syndrome. (Ex. 65-2). In a July 11, 1995 chart note, Dr. Goodwin reported that claimant believed his condition was related to the prior work injury and that claimant desired to "reopen" the 1994 claim. The "pluses and minuses" of reopening the prior claim were discussed. (Ex. 70). Dr. Goodwin recommended a surgical release for claimant's right carpal tunnel condition. Id.

On July 20, 1995, Liberty accepted the bilateral carpal tunnel syndrome as part of the April 1994 Pierce claim. (Exs. 72, 73). After bilateral surgical releases were performed in August 1995, the Liberty/Pierce claim was closed on December 5, 1995 with an award of temporary disability. (Ex. 111).

In April 1996, Western laid off claimant. Dr. Larson filed an aggravation claim on claimant's behalf on May 6, 1996, after claimant once again began experiencing bilateral wrist symptoms. (Exs. 113, 119). Liberty accepted the aggravation claim on behalf of Pierce on May 15, 1996. (Ex. 125).

On August 23, 1996, claimant's counsel requested that claimant's bilateral hand condition be accepted as a "new claim" by reason of his employment with Western. (Ex. 145A). The aggravation claim accepted on behalf of Pierce was closed by Determination Order on December 3, 1996 with an award of 1 percent scheduled permanent disability for claimant's right wrist. (Ex. 157). Claimant requested reconsideration. (Ex. 158). On January 23, 1997, Liberty denied the new carpal tunnel claim on behalf of Western. (Ex. 155). Claimant requested a hearing.

## CONCLUSIONS OF LAW AND OPINION

The ALJ upheld Liberty/Western's denial,[1] finding that the August 1996 occupational disease claim was time-barred pursuant to ORS 656.807(1) because, based on his discussions with Dr. Goodwin in July 1995, claimant knew or should have known he was suffering from bilateral carpal tunnel

[1] The ALJ stated that Liberty's January 27, 1997 denial was at issue. However, the January 27, 1997 denial was of a neck and back claim issued on behalf of Pierce. (Ex. 161). Claimant specifically withdrew that claim at hearing. (Tr. 6, 7). The request for hearing against Pierce was dismissed by April 27, 1997 Order of Dismissal. Accordingly, the denial at issue and the denial the ALJ's order should have upheld was the January 23, 1997 denial of the carpal tunnel claim issued on behalf of Western. (Ex. 155).

syndrome at that time and, yet, did not file an occupational disease claim against Western until over a year had passed. Noting that the legislature in 1995 eliminated the requirement that a carrier prove prejudice as a result of untimely claim filling, see amended ORS 656.265(4), the ALJ also determined that Liberty/Western need not have proved prejudice as a result of claimant's untimely claim filing because claimant could not have had a viable claim against Liberty/Western until after the Pierce claim was closed in December 1996.

While we agree with the ALJ that Western's denial of a new occupational disease should be upheld, our reasoning differs from the ALJ's. That is, we need not determine whether the ALJ correctly concluded that the new occupational disease claim was time-barred, because we find that claimant was precluded from asserting a new occupational disease claim for bilateral carpal tunnel syndrome based on claimant's "pre-closure" work activities for Western. Because claimant failed to prove that he sustained a new occupational disease after that date, we agree with the ALJ that Liberty/Western's denial was proper. We reason as follows.

Claimant first sought compensation for his carpal tunnel condition as an occupational disease in August 1996, when his counsel filed a claim for bilateral carpal tunnel syndrome against Western. However, Liberty had accepted the carpal tunnel condition in July 1995 as part of the 1994 Pierce claim and, further, had accepted an aggravation claim on behalf of Pierce in May 1996. In December 1996, the "Liberty/Pierce" aggravation claim was closed by a Determination Order.

Although claimant requested reconsideration of the Determination Order, that closure became final by operation of law 180 days after the date of its mailing when the Department dismissed the reconsideration request.[2] Accordingly, claimant's contention that his bilateral carpal tunnel condition was improperly processed as part of the 1994 injury claim is barred by claim preclusion. See Drews v. EBI Companies, 310 Or 134, 149 (1990); Christopher H. Peppler, 44 Van Natta 856, 857 (1992); Chella M. Morton, 43 Van Natta 321, 323 (1991).

Nonetheless, claimant is entitled to file a new claim to establish that, after the December 1996 closure of the 1994 injury claim, he developed a new and different carpal tunnel condition related to his work activities at Western. See Proctor v. SAIF, 68 Or App 333 (1984); Irene Jensen, 42 Van Natta 2838 (1990). However, claimant left his employment with Western in April 1996. The medical record does not support a conclusion that claimant developed a new occupational disease after December 3, 1996. Thus, we find that claimant failed to establish a new occupational disease claim for which Liberty/Western was responsible. Therefore, we conclude that the ALJ properly upheld Liberty/Western's denial.[3]

## ORDER

The ALJ's order dated August 25, 1997 is affirmed.

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[2] We may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned," including agency orders. See Grace B. Simpson, 43 Van Natta 1276, 1277 (1991). Inasmuch as a Department's order is an agency order, we take administrative notice of the Department's April 18, 1997 Order of Dismissal, dismissing claimant's reconsideration request.

[3] We adopt and affirm the ALJ's reasoning and conclusions with respect to the penalty and attorney fee issues.

In the Matter of the Compensation of
**JUAN SERRANO, Claimant**
WCB Case No. 95-02746
ORDER ON REVIEW
Bruce D. Smith, Claimant Attorney
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Brazeau's order that: (1) upheld the self-insured employer's February 28, 1995 denial of his current cervical, left shoulder and back conditions; (2) upheld the employer's denial of his left shoulder impingement syndrome; and (3) found that his claim was not prematurely closed. On review, the issues are the procedural validity of the employer's February 28, 1995 denial, compensability and premature closure. We affirm in part and reverse in part.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

### February 28, 1995 Denial

On October 25, 1994, claimant slipped off a platform at work and fell about eight feet to the floor. On November 2, 1994, the employer accepted a cervical contusion and left shoulder, cervical/back strain. (Ex. 8). On February 28, 1995, before the claim was closed, the employer issued a denial that relied on a February 9, 1995 report from Dr. Dickerman. (Ex. 36). The employer explained:

> "It is [Dr. Dickerman's] opinion, and we agree, the conditions you received from your fall of October 25, 1994 are completely resolved and you are no longer in need of medical treatment. We must, therefore, deny ongoing medical treatment as not being related to your claim of October 25, 1994." (Id.)

At hearing, claimant argued that the employer's February 28, 1995 denial was an impermissible preclosure denial of medical treatment. The ALJ found no persuasive evidence that the employer had accepted either a "combined" or "consequential" condition on November 2, 1994. Nevertheless, the ALJ found that the conditions denied by the employer in February 1995 were psychologically-based and were not the same conditions as the physically-based conditions previously accepted. The ALJ concluded that the current condition denial was procedurally proper.

For the following reasons, we agree with claimant that the employer's preclosure denial is invalid. To begin, we disagree with the employer's argument that ORS 656.262(7)(b) applies to this case. The employer contends that, at the time of Dr. Dickerman's examination, claimant's condition became psychologically based and it was "required" to issue the current condition denial.

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."

ORS 656.262(7)(b) applies only if the accepted condition, whether voluntary or by litigation, was a "combined condition." Robin W. Spivey, 48 Van Natta 2363, 2365 (1996); Elizabeth B. Berntsen, 48 Van Natta 1219, 1221 (1996). Under ORS 656.005(7)(a)(B), a "combined condition" exists when a compensable injury combines with a preexisting condition to cause or prolong disability or a need for treatment. A "combined condition" is compensable "only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause" of the disability or need for treatment of the combined condition. Here, the employer accepted a cervical contusion and left shoulder, cervical/back strain. (Ex. 8). There is no evidence that the employer accepted a "combined condition." Therefore, ORS 656.262(7)(b) does not apply. See Spivey, 48 Van Natta at 2365; Berntsen, 48 Van Natta at 1221.

The employer contends that the record indicates that by February 1995, the psychological proponents of claimant's personality had taken over as the driving factor for his claim. The employer argues that claimant's psychological condition was not the same as the physically-based condition originally accepted. We disagree.

In Elizabeth B. Berntsen, 48 Van Natta at 1221-23, we concluded that a "preclosure" denial of a current condition is invalid when that condition is neither a "combined" nor a "consequential" condition, provided the condition is for the same condition previously accepted. Thus, we found that the rationale expressed in Roller v. Weyerhaeuser Co., 67 Or App 583, on reconsideration 68 Or App 743, rev den 297 Or 601 (1984), which precluded preclosure denials of a previously accepted condition, remained viable under these circumstances despite enactment of amended ORS 656.262(6)(c) and (7)(b). In Berntsen, we found that the claimant was seeking treatment for the same condition as her accepted condition. We concluded that, based on Roller, a carrier may not deny further responsibility for any condition arising from the accepted claim while the claim is in open status and before the extent of the accepted condition has been determined pursuant to the statutory procedures for claim closure. Since the claimant's current mid-back condition was the same condition as the accepted mid-back condition and her claim was not yet closed, we concluded that the carrier's partial denial with respect to claimant's mid-back condition was an invalid preclosure denial of an accepted condition and must be set aside. 48 Van Natta at 1223.

Here, the employer accepted a cervical contusion and left shoulder, cervical/back strain. (Ex. 8). On February 28, 1995, before the claim was closed, the employer denied claimant's current conditions on the basis that the conditions had "completely resolved" and he was no longer in need of medical treatment. (Ex. 36). The employer denied ongoing medical treatment as unrelated to the October 25, 1994 injury. Although the employer argues that psychological factors had taken over as the driving factor for claimant's claim, the employer's February 28, 1995 denial only mentions that claimant's accepted conditions had resolved. The denial makes no reference to any psychological factors affecting claimant's conditions.

The employer analogizes this case to Charles L. Wallace, 49 Van Natta 52, on recon 49 Van Natta 472 (1997), aff'd mem 152 Or App 566 (1998). In Wallace, the insurer denied the compensability of the claimant's low back claim on August 18, 1995. On October 12, 1995, the insurer issued another denial, which stated that it stood by its position that the original denial should be upheld, but that, as an "alternative" position, if the claimant did suffer a low back injury on July 3, 1995, the condition had "fully resolved" by August 21, 1995. The insurer then wrote that it denied the compensability of "any and all current conditions, physical or psychological, effective August 21, 1995, even if it is established that [claimant] had an actual injury incident on July 3, 1995." The insurer subsequently accepted a "low back strain" in October 1995.

On review, we held that the insurer's "preclosure" denial of the claimant's current condition was permissible because the denied condition was not the same as the previously accepted condition. We distinguished Elizabeth B. Berntsen on the basis that the claimant's current condition was psychologically based and was not related to the previously accepted low back strain. We found that portion of the insurer's denial invalid. 49 Van Natta at 54.

On reconsideration, however, we determined that part of the insurer's denial should be set aside as an invalid prospective denial because it denied "any and all current conditions, physical or psychological," prior to claim closure on the ground that the accepted condition had "resolved." 49 Van Natta at 473. See also Linda J. Miossec, 46 Van Natta 1730 (1994); Gary L. Best, 46 Van Natta 1694 (1994).

Unlike Wallace, the employer's denial in this case was issued after acceptance. The denial in Wallace was a prospective denial, rather than a preclosure denial. We found in Wallace that the claimant's current low back condition was not related to his accepted low back strain and was, instead, psychologically based. 49 Van Natta at 54. We relied in part on a medical report indicating that the claimant had severe chronic anxiety reaction status. Id. at 52.

Here, in contrast, we find that claimant's current conditions as of the February 28, 1995 denial were not separate from, or unrelated to, the conditions accepted by the employer in November 1994.

The employer relies on Dr. Dickerman's February 9, 1995 report to establish that claimant's conditions had become psychologically based. We are not persuaded by the employer's argument. Dr. Dickerman reported that claimant's compensable conditions were medically stationary and the claim should be closed. (Exs. 32-15, -16). He also noted that there were no objective findings to support claimant's subjective complaints and he had significant elements of positive embellishment. (Ex. 32-15). However, Dr. Dickerman did not diagnose a psychological condition. Unlike Wallace, there was no medical evidence at the time of the February 1995 denial that indicated claimant had been diagnosed with a psychological condition.

Furthermore, the medical evidence establishes that claimant's current conditions as of the February 1995 denial were not distinctly separate from, or unrelated to, the accepted cervical contusion and left shoulder, cervical/back strain. See Elizabeth B. Berntsen, 48 Van Natta at 1221-23; compare Zora A. Ransom, 46 Van Natta 1287 (1994) (where the medical evidence "unequivocally" indicated that the claimant's current condition was not related to the accepted condition, the preclosure denial was proper).

The employer accepted the claim on November 2, 1994. (Ex. 8). After acceptance, claimant continued to have chiropractic treatments for his neck, shoulder and back. (Exs. 10, 14, 16). On December 6, 1994, Dr. Dunn reported that claimant had pain in his low back, left sacroiliac area and interscapular area. (Ex. 18). He diagnosed claimant with a sacroiliac ligament strain secondary to injury and lumbar and cervical muscular strains secondary to injury. (Ex. 18-3). Dr. Dunn recommended that claimant engage in a sacroiliac and strain program for four weeks and remain on light duty. (Id.)

On December 8, 1994, Dr. Thomas treated claimant with osteopathic manipulation in the cervical, thoracic, lumbosacral and left shoulder girdle areas. (Ex. 19-2). On December 22, 1994, Dr. Thomas reported that claimant continued to have soreness in the cervical, thoracic and lumbosacral areas and he had not been able to get into physical therapy. (Ex. 22). Claimant continued to have chiropractic treatments at least until January 13, 1995. (Ex. 23). On January 17, 1995, Dr. Thomas reported that claimant had not been receiving physical therapy and was still symptomatic. (Ex. 24). He prescribed medication and said that claimant was not medically stationary and needed physical therapy, as well as an active stretching and strengthening exercise education. (Id.) On January 30, 1995, claimant began a four week physical therapy program. (Ex. 27).

After reviewing the record, we conclude that the medical evidence establishes that claimant's current conditions as of the February 1995 denial were not clearly separate or severable from the accepted cervical contusion and left shoulder, cervical/back strain. At the time the denial was issued, the claim was not yet closed. Under these circumstances, we conclude that the employer's partial denial with respect to claimant's current conditions was an invalid preclosure denial of accepted conditions and must be set aside. See Elizabeth B. Berntsen, 48 Van Natta at 1223.

Furthermore, we conclude that the employer's preclosure denial of claimant's conditions as "completely resolved" is an impermissible denial of future responsibility with respect to the compensable cervical contusion and left shoulder, cervical/back strain. As we discussed earlier, in Charles L. Wallace, we determined that part of the insurer's denial should be set aside as an invalid prospective denial because it denied "any and all current conditions, physical or psychological," prior to claim closure on the ground that the accepted condition had "resolved." 49 Van Natta at 473. We reach the same conclusion in this case. The effect of the employer's denial was to limit its acceptance to a "resolved" cervical contusion and left shoulder, cervical/back strain and to deny future medical treatment for those conditions.

In sum, we agree with claimant that the employer's February 28, 1995 denial was an impermissible preclosure denial of medical treatment.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review with respect to the propriety of the employer's February 28, 1995 "current condition" 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 regarding the February 1995 denial is $3,500, 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.

Left Shoulder Impingement Syndrome

We adopt and affirm the ALJ's reasoning and conclusion that claimant has not established compensability of his left shoulder impingement syndrome.

Premature Closure

We adopt and affirm the ALJ's reasoning and conclusion that claimant has not established that his claim was prematurely closed, with the following change. In the last paragraph beginning on page 5, we change the first sentence to read: "Claimant argues that the October 1995 Determination Order, which was affirmed by the April 1996 Order on Reconsideration, prematurely closed his claim."

ORDER

The ALJ's order dated May 28, 1997 is affirmed in part and reversed in part. That portion of the ALJ's order that upheld the self-insured employer's February 28, 1995 denial is set aside. The employer's denial is set aside and the claim is remanded to the employer for processing according to law. The remainder of the ALJ's order is affirmed. For services at hearing and on review concerning the February 28, 1995 denial, claimant's attorney is awarded an assessed fee of $3,500, payable by the self-insured employer.

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March 5, 1998 Cite as 50 Van Natta 331 (1998)

In the Matter of the Compensation of
**CARLA K. CHURCHILL, Claimant**
WCB Case No. 96-10322
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Thaddeus J. Hettle, Defense Attorney

Reviewed by Board Members Haynes and Bock.

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

FINDINGS OF FACT

In approximately 1989, claimant began working for the employer as a cashier/clerk at its retail store. In 1994, claimant injured her right shoulder and hip while at work. She filed a claim for that injury which was accepted by the employer. Her claim was closed by a October 27, 1994 Determination Order that awarded temporary disability benefits.

On June 8, 1996, claimant moved several boxes of stoneware dishes at work. Following completion of this task, claimant experienced neck and left shoulder pain. Claimant did not seek medical treatment at that time and continued to perform her work duties. On June 24, 1996, claimant sought treatment from Dr. Oskenholt, D.O., for complaints of neck pain, headaches, and nausea. Dr. Oskenholt's examination revealed no radicular pain and he diagnosed probable musculoskeletal pain with tension cephalgia.

On June 27, 1996, claimant filed an 801 Form alleging that she had injured her left spine as a result of moving the stoneware dishes on June 8, 1996. In an incident report filled out the same day, claimant indicated that her symptoms were located in her neck, upper back, shoulder, and upper arm.

Claimant was seen by Dr. Oskenholt on June 28, 1996 and again on July 17, 1996. On both occasions claimant noted symptoms in her neck. On August 1, 1996, claimant filled out an 827 Form indicating that she was injured while moving stoneware dishes. Also on that date, claimant underwent a cervical spine x-ray which showed disk space narrowing with degenerative changes at C5-6 and minimal anterior listhesis of C3 on 4 and C4 on 5. On August 5, 1996, claimant underwent physical therapy for cervical pain which she attributed to lifting boxes of stoneware dishes. Claimant continued with physical therapy throughout August 1996.

In late August 1996, claimant changed her treating physician to Dr. Soot, M. D. Dr. Soot recorded claimant's complaints as involving the neck. Dr. Soot specifically noted that claimant did not have radicular symptoms into her shoulders. On August 30, 1996, claimant was again seen by Dr. Oskenholt. On September 13, 1996, claimant was examined by Dr. Reimer, M.D., at the request of the employer. Dr. Reimer's report indicated that claimant's symptoms appeared following repeated lifting of stoneware dishes at work in early June 1996. In a pain diagram prepared prior to Dr. Reimer's examination, claimant indicated that her symptoms were in her neck and left shoulder.

By letter dated September 20, 1996, the employer denied claimant's claim.

On November 5, 1996, claimant underwent a cervical MRI scan which revealed an abnormality at C5-6 with intervertebral disk space narrowing and spurring with foraminal stenosis at C5-6. On January 7, 1997, claimant was examined by Dr. Brett, M.D., on referral from Dr. Oskenholt. Dr. Brett's report indicated that claimant had first experienced neck symptoms on June 7, 1996 after moving a counter at work. The report further indicated that two days later, claimant began experiencing radicular symptoms into her forearm following repetitive lifting at work. Dr. Brett diagnosed preexisting cervical spondylosis with a superimposed disk protrusion with referred left trapezious, scapular, and arm symptom. Dr. Brett recommended a cervical diskectomy and fusion at C5-6.

On January 20, 1997, Dr. Brett performed the recommended surgery. On February 20, 1997, claimant was examined by Dr. Rosenbaum, neurologist, at the request of the employer. Dr. Rosenbaum's report indicated that claimant had first experienced cervical symptoms following a work incident wherein she moved a wood counter to retrieve a customer's credit card.

## CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant had credibly testified concerning the counter moving incident at work. Further, finding that Drs. Brett and Rosenbaum had an accurate history regarding that incident, the ALJ concluded that claimant's cervical condition was compensable. We disagree.

The central issue in this case is accuracy and reliability of claimant's testimony regarding the counter moving incident, as well as the timing of her radicular complaints. The ALJ found that the substance of claimant's at-hearing testimony was credible. Although we generally defer to an ALJ's finding concerning credibility, when such finding is based on the substance of the record, we are as in a good a position as the ALJ to evaluate the credibility of a witness. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). 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 such material testimony is credible. See Gail A. Albro, 48 Van Natta 41, 42 (1996). Where a claimant's reporting is inconsistent or incomplete, a medical opinion based on the reporting is unpersuasive. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

Claimant testified that she had told Drs. Oskenholt, Reimer and Soot of the work incident where she lifted the wood counter to retrieve a customers' credit card. (Tr. 24, 30, 52). However, none of those physicians' contemporaneous medical reports contain any reference to such a work incident. (Exs. 29, 31,40, 45, 46, 51). Moreover, while Dr. Reimer indicated that claimant had told him about moving the stoneware dishes, he testified that claimant had not mentioned the wood counter incident. (Ex. 63-15). In addition, claimant testified that she informed her supervisors of the counter-moving incident. (Tr. 25, 56). Contrary to claimant's testimony, Carol Hamlin testified that claimant had not told her of the counter-moving incident. (Tr. 67). Finally, neither the 801 Form nor the incident report, both of which were completed by claimant, mention the counter-moving incident. (Exs. 27, 28).

Claimant also testified that she began experiencing radicular symptoms within days of allegedly moving the counter. (Tr. 34, 45, 49). Again, the contemporaneous medical evidence, including a symptom diagram completed by claimant, does not support claimant's testimony. (Exs. 29, 31, 40, 45, 46, 51) In this regard, Dr. Soot specifically reported that claimant had not had radicular symptoms at the time of the August 27, 1996 examination and opined that any injury to claimant's cervical disc must have occurred after that examination. (Ex. 59).

Based on the above, we find that claimant is not credible. Inasmuch as the medical opinions which support compensability are based on claimant's history, which we do not find credible, those opinions are not persuasive. Miller v. Granite Construction Company, 28 Or App at 476. Under these circumstances, claimant has failed to establish that her work activities were the major cause of her cervical condition. Consequently, the employer's denial must be upheld.

ORDER

The ALJ's order dated August 8, 1997 is reversed. The self-insured employer's denial, dated September 20, 1996, is reinstated and upheld. The ALJ's award of a $3,200 assessed attorney fee is reversed.

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March 5, 1998 Cite as 50 Van Natta 333 (1998)

In the Matter of the Compensation of
**DAVID W. DENT, JR., Claimant**
WCB Case No. 95-13843
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
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) Hoguet's order that set aside its denial of claimant's consequential condition claim for a psychological condition. Claimant cross-requests review of that portion of the ALJ's order that awarded an assessed fee of $3,000 pursuant to ORS 656.386(1). On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings Of Fact," with the exception of the "Ultimate Findings Of Fact."

CONCLUSIONS OF LAW AND OPINION

Claimant, a bus driver, sustained a compensable left shoulder strain injury on February 6, 1990. An orthopedic surgeon, Dr. Switlyk, subsequently performed left shoulder surgeries in September 1992, January 1993, and July 1993. Claimant received a total of 46 percent unscheduled permanent disability.

During the course of the claim, several psychological evaluations were performed. In March 1993, Dr. Yospe, a clinical psychologist, began counseling claimant. Dr. Yospe, who diagnosed an injury-related major depressive disorder and panic disorder with agoraphobia, counseled claimant nearly 80 times from March 1993 through October 26, 1995, when the employer denied the compensability of claimant's psychiatric care. (Ex. 243). Claimant requested a hearing from the denial.

In determining the compensability of claimant's psychological claim, the ALJ applied ORS 656.005(7)(a)(A).[1] The ALJ found that the opinion of Dr. Yospe, as supported by Drs. Klein, Gerson, and Switlyk, established that claimant's injury and related surgeries were the major contributing cause of claimant's psychological conditions. The ALJ then set aside the employer's denial and remanded the claim to the employer for acceptance of the above conditions.

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

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

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

On review, the employer contends that the ALJ should not have set aside its denial. It asserts that we should find the opinion of Dr. Klecan, an examining psychiatrist who opined that claimant has no injury-related psychological condition, more persuasive than Dr. Yospe's and reinstate its denial. For the following reasons, we agree.

Initially, we must determine which provisions of the Workers' Compensation Law are applicable. Hewlett-Packard Co. v. Renalds, 132 Or App 288 (1995) (quoting Dibrito v. SAIF, 319 Or 244, 248 (1994)); see also Michelle K. Dibrito, 47 Van Natta 970 (1995). After reviewing the medical opinions, we find that claimant's psychological condition should be analyzed under ORS 656.005(7)(a)(A) as a consequential condition claim allegedly related to his accepted left shoulder condition and subsequent surgeries. See SAIF v. Freeman, 130 Or App 81 (1994) (psychological condition remained compensable because the medical evidence established that the claimant became depressed and lost self esteem and confidence when his ability to work was diminished as a result of his compensable injury); Boeing v. Viltrakis, 112 Or App 396 (1992) (when a claimant merely seeks to recover benefits for the consequences of a compensable injury, but does not seek to establish independently the compensability of a mental disorder, the provisions of ORS 656.802 do not apply); see also Albert H. Olson, 46 Van Natta 1848 (1994) (psychological condition was compensable as a "consequential condition" under ORS 656.005(7)(a)(A) because the claimant's compensable low back injury was the major contributing cause of his psychological condition).

Considering the delayed onset of claimant's psychological condition and the disagreement among the medical experts regarding its etiology, we find that the causation issue is a complex medical question that requires expert evidence for its resolution. See Barnett v. SAIF, 122 Or App 279 (1993). We rely on those medical opinions which are well-reasoned and based on accurate and complete histories. See Somers v. SAIF, 77 Or App 259 (1986). In addition, we generally rely on the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983).

During the course of his treatment of claimant, Dr. Yospe noted symptoms of depression and panic. (Ex. 249). According to Dr. Yospe, the major etiological factor which contributed to claimant's psychiatric condition was claimant's slow realization that his injury would prevent him from returning to work as a bus driver. (Ex. 249-2). Dr. Yospe stated that this was devastating to claimant's entire identity and feeling of self-worth. Id. Dr. Yospe concluded that claimant's industrial injury was the major contributing cause of the depressive and panic disorders, although he acknowledged that his diagnostic impression was at variance with various examining physicians. (Ex. 249-3).

Dr. Klecan provided the primary medical evidence contrary to Dr. Yospe's assessment of the etiology of claimant's psychological condition. In his initial report of December 11, 1995, Dr. Klecan performed a comprehensive evaluation of claimant's psychological complaints. (Ex. 247). Except for a non-work related personality disorder with passive-dependent and passive-aggressive features, Dr. Klecan diagnosed no mental disorder. Asserting that claimant was not in need of further psychological or psychiatric treatment, Dr. Klecan noted that claimant had over two years of psychological counseling and other treatment modalities. Dr. Klecan concluded that further treatment would only "assist and enable" claimant in the maintenance of an open claim. (Ex. 247-15).

After Dr. Yospe submitted his causation report noted above, Dr. Klecan submitted a detailed and lengthy rebuttal, concluding that claimant's alleged mental disorder had been embellished for the purpose of maintaining the status quo with regard to disability status and passive income. (Ex. 250-9). In reaching this conclusion, Dr. Klecan detailed numerous criticisms of Dr. Yospe's analysis and provided an extensive defense of his own reasoning. Dr. Klecan included his view that Dr. Yospe's failure to improve claimant's psychological condition after two years of treatment indicated that Dr. Yospe's diagnosis and treatment approach were incorrect. (Ex. 250-2). In addition, Dr. Klecan asserted, among other contentions, that the delayed onset of claimant's alleged depressive disorder militated against a casual connection to the compensable injury, that Dr. Yospe did not afford sufficient significance to the influence of secondary gain, and that Dr. Yospe's explanation for claimant's inconsistent presentation on examination was implausible. (Ex. 250-5, 7, 9).

Dr. Klecan also testified at the hearing. After extensive cross-examination, Dr. Klecan maintained his position that claimant had no mental disorder apart from a non-work related personality disorder. (Trs. 76, 77). Dr. Klecan testified that he was aware that there was evidence in the record that suggested a diagnosis of depression, but that, based on the totality of the record, his assessment was correct. (Tr. 80).

Based on our de novo review of the medical evidence, we find that Dr. Klecan's opinion is most persuasive on this record. Specifically, we find Dr. Klecan's analysis to be thorough, well-reasoned and based on an accurate history. We are particularly persuaded by his detailed response to Dr. Yospe's causation opinion, which response included cogent criticism of Dr. Yospe's opinion.[2] Finally, we find Dr. Klecan's testimony credible and further strengthened by rigorous cross-examination.

Accordingly, we conclude that the persuasive medical evidence does not establish that claimant's compensable injury and related surgeries are the major contributing cause of an alleged psychological disorder. ORS 656.005(7)(a)(A). Therefore, we reverse.[3]

ORDER

The ALJ's order dated July 16, 1997 is reversed. The employer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

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[2] We recognize that two psychiatrists (Dr. Klein and Dr. Gerson) who briefly treated claimant diagnosed major depression. (Exs. 141-2, 239A). In addition, Dr. Switlyk, claimant's attending surgeon, authorized Dr. Yospe's psychological treatment. However, none of those physicians provided an in-depth analysis of claimant's psychological complaints or directly addressed the causation issue. Moreover, Dr. Klecan's opinion was supported by previous examining psychiatrists (Drs. Parvaresh and Glass), both of whom found no depressive or panic disorder. (Exs. 35, 66, 194).

[3] Given our disposition of the claim, we need not address claimant's contention that the ALJ's attorney fee award should be increased.

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In the Matter of the Compensation of
**KEITH M. HALE, Claimant**
WCB Case No. 97-02325
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Bock, Biehl and Moller.

The insurer requests review of Administrative Law Judge (ALJ) Brazeau's order that set aside its denial of claimant's injury claim for a right inguinal hernia condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,400, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by counsel's statement of services and claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated July 31, 1997 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,400, payable by the insurer.

**Board Member Moller dissenting.**

The majority affirms without opinion the ALJ's conclusion that claimant sustained his burden of proving a compensable hernia claim. Because I disagree with the ALJ's determination, I respectfully dissent.

Claimant, a timber faller, filed a claim for a right inguinal hernia allegedly the result of work activites on December 5, 1996. The ALJ upheld the insurer's denial under ORS 656.005(7)(a)(B),[1] reasoning that the medical evidence established that claimant's work activity was the major contributing cause of his need for medical treatment.

On review, the insurer contends that the ALJ erroneously determined that the hernia claim was compensable because the medical evidence only establishes that work activities were the "precipitating" rather than the "major contributing cause" of the disputed condition. In my view, the insurer's argument is well-taken.

The medical evidence is in agreement that claimant has a preexisting congenital predisposition to developing hernias. (Exs. 60, 67). The parties do not dispute, and I would find, that it is appropriate to analyze this claim under ORS 656.005(7)(a)(B) as an otherwise compensable injury combining with a preexisting condition to cause disability or a need for treatment. See ORS 656.005(24) (defining "preexisting condition" as including congenital abnormality that contributes or predisposes a worker to disability or a need for treatment).

In order to establish compensability under ORS 656.005(7)(a)(B), claimant must show that his work activities on or about December 5, 1996 were the major contributing cause of the disability or need for treatment of the combined condition. SAIF v. Nehl, 148 Or App 101, on recon 149 Or App 309 (1997); Gregory C. Noble, 49 Van Natta 764, 767 (1997). Determining the "major contributing cause" involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause. Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev dismissed 321 Or 416 (1995); Gregory C. Noble, 49 Van Natta at 765-66.

In Robinson v. SAIF, 147 Or App 157, 162 (1997), the court applied ORS 656.005(7)(a)(B) to an injury claim in which the claimant had a preexisting bilateral hernia condition. After a lifting incident at work, the claimant's "combined condition" was a symptomatic left inguinal hernia. The Robinson court held that, while the evidence showed that the claimant's work injury "precipitated" his need for treatment, we did not err in concluding that it did not establish that the claimant's work injury, when weighed against his preexisting condition, was the major cause of the claimant's need for treatment of his combined condition. 147 Or App at 163. The insurer argues that the result here should be same as in Robinson. Based on the state of the medical evidence in this case, I agree.

The medical causation issue boils down to primarily two medical opinions: that of Dr. Shortridge, claimant's surgeon, and that of Dr. Gross, who performed a records review on behalf of the insurer.[2] Dr. Gross opined that claimant's hernia may have been "precipitated" by his work activities, but that the "major underlying cause" was the presence of a preexisting congenital sac which predisposed the development of an indirect hernia. Dr. Gross explained that, if the congenital defect were not present, no amount of abdominal pressure (whether from lifting, coughing or straining) would produce an indirect hernia. (Ex. 60).

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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] Several other physicians expressed opinions on causation: Drs. Hartmann, Little and Eschelman. However, those opinions consisted of unexplained, "check-the-box" concurrences with reports from Drs. Gross and Shortridge, as well as a refusal to express an opinion and a brief concurrence letter. (Exs. 61, 63, 64, 71, 72). Because these reports contain little reasoning, I would not rely on them in deciding the causation issue. See Somers v. SAIF, 77 Or App 259 (1986).

Dr. Shortridge opined that, while claimant was predisposed to the formation of a hernia, the hernia itself was not congenital. According to Dr. Shortridge, it was a work event that "precipitated" the "acquisition" of claimant's hernia. (Ex. 67-1). Dr. Shortridge further explained that an episode of coughing or sneezing could have "precipitated" the formation of the hernia and that claimant could have been working at home when the hernia appeared. Dr. Shortridge concluded by again emphasizing that, while claimant had a congenital condition, "this congenital condition did not include an inguinal hernia and that the appearance of the hernia was precipitated by the lifting and dragging of logging chains." (Ex. 67-2, emphasis added).

In a final report dated April 11, 1997, after receiving clarification of the exact nature of the work activities that resulted in the appearance of claimant's hernia, Dr. Shortridge confirmed that his prior analysis still applied with the specific nature of the activity that "precipitated" the appearance of the hernia. (Ex. 69). In his final report of May 28, 1997, Dr. Gross reiterated his opinion that claimant's work activity "precipitated" the appearance of the hernia, but that the major contributing cause remained the preexisting congenital condition. (Ex. 73).

As previously noted, determination of major contributing cause involves evaluating the relative contribution of different causes of claimant's need for treatment of the combined condition (the right inguinal hernia and the preexisting congenital condition) and deciding which is the primary cause. Dietz v. Ramuda, 130 Or App at 401. Because of the multiple possible causes of claimant's disability or need for treatment, this issue presents a complex medical question that must be resolved on the basis of expert medical evidence. See Uris v. Compensation Dept., 247 Or 420 (1967); Barnett v. SAIF, 122 Or App 279 (1993).

Here, Dr. Shortridge did not state that the major cause of claimant's hernia was his work activity. Dr. Shortridge was only able to state that claimant's work activity "precipitated" the appearance of the hernia condition. However, as the court noted in Robinson, such evidence "does not ineluctably establish that claimant's work injury, when weighed against his preexisting condition, was the major cause of claimant's need for treatment of his combined condition." 147 Or App at 163. On this record, Dr. Shortridge's opinion fails to establish that claimant's work activity was the major contributing cause of his need for medical treatment of the "combined condition." Because Dr. Gross' opinion is that the preexisting congenital condition is the major contributing cause of the need for medical treatment, claimant failed to meet his burden of proof under ORS 656.005(7)(a)(B).

Because the majority and the ALJ concluded otherwise, I dissent.

In the Matter of the Compensation of
**JAMES L. MACK, Claimant**
WCB Case No. 97-02101
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board en banc.

The insurer requests review of Administrative Law Judge (ALJ) T. Lavere Johnson's order which determined that claimant's claim was prematurely closed. On review, the issue is premature claim closure. We reverse.

## FINDINGS OF FACT

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

## CONCLUSIONS OF LAW AND OPINION

Claimant sustained multiple physical injuries as a result of a compensable injury occurring on September 26, 1995. Dr. Zirschky, claimant's attending physician, later referred claimant to Dr. Nelson, a consulting doctor, for an evaluation of his compensable medical conditions. On March 11, 1996, Dr. Nelson noted that, at the end of the evaluation, claimant complained of symptoms "consistent with reactive depression." Dr. Nelson prescribed an anti-depressant drug. (Ex. 24-4).

On August 14, 1996, Dr. Zirschky declared claimant's physical conditions medically stationary. (Ex. 35). No reference was made to a psychological condition.

On October 7, 1996, a Determination Order closed the claim, finding claimant's conditions medically stationary on August 14, 1996. Claimant requested reconsideration, including a contention that the claim was prematurely closed. An Order on Reconsideration issued on February 10, 1997, which also found claimant's conditions medically stationary on August 14, 1996. A day later, on February 11, 1997, the insurer accepted multiple additional physical conditions, as well as claimant's reactive depression condition. (Ex. 47).[1] It later reopened the claim. (Ex. 52).

On February 14, 1997, claimant moved for abatement and reconsideration of the reconsideration order, alleging that some of the newly accepted conditions were not medically stationary. (Ex. 50). The insurer opposed the motion because the claim had been reopened based on claimant's vocational status and on the newly accepted conditions. (Ex. 52). Before the Department responded to the insurer's contentions, claimant filed a hearing request contesting the reconsideration order.

The ALJ determined that the claim was prematurely closed. The ALJ reasoned that a determination should have been made prior to claim closure about whether claimant's mental state was medically stationary. For the following reasons, we disagree with the ALJ's conclusion that the claim was prematurely closed.

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[1] ORS 656.283(7) provides in relevant part:

"Evidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing, and issues that were notraised by a party to the reconsideration may not be raised at hearing unless the issue arises out of the reconsideration order itself."

The record in this case contains a number of "post-reconsideration" exhibits, including the document accepting claimant's psychological condition. Because no party objected to the admission of this "post-reconsideration" evidence, we consider it on review. See Fister v. South Hills Health Care, 149 Or App 214, 218-19 (1997) (because the employer did not object to the claimant's testimony at hearing regarding the extent of her disability, the Board should not have entertained the employer's argument, first made to the Board, that the evidence was inadmissible under ORS 656.283(7)).

A claim for compensation shall not be closed if the worker's condition has not become medically stationary. ORS 656.268(1). The test for determining whether a worker is medically stationary is whether "further medical improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17).

The Court of Appeals has held that a claimant's injury-produced psychological problems should be considered in determining whether the claim should be closed. Utera v. Dept of General Services, 89 Or App 114, 116 (1987). Furthermore, "pre-closure" references to injury-related psychological problem have previously been held sufficient to require the consideration of whether that condition is medically stationary prior to claim closure. Beverly A. Martell, 45 Van Natta 985 (1993); Saura C. Stewart, 44 Van Natta 2595 (1992); Mary J. McKenzie, 44 Van Natta 2302 (1992).

Here, Dr. Nelson diagnosed reactive depression and prescribed medication for the condition. Under prior case law, such "pre-closure" references to an injury-related psychological condition would have been sufficient to require consideration of whether that condition was medically stationary. See Beverly A. Martell, 45 Van Natta at 986 (references to psychological problems in examining physicians' reports required consideration of whether that condition was medically stationary prior to claim closure).

However, 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 Bernard G. Hunt, 49 Van Natta 223 (1997). Therefore, in rating permanent disability, the focus is on accepted conditions at the time of the reconsideration order.

Of more importance, the legislature has amended ORS 656.262(7)(c) to provide that "if a condition has been found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition." HB 2971, 69th Leg., Reg. Sess., Sec. (July 25, 1997). In light of this statutory amendment, we conclude that a determination of whether a claim has been prematurely closed must focus only on those conditions accepted at the time of closure.[2] The evaluation of a "post-closure" accepted condition must await the reopening and processing of the claim for that new condition.

In this case, claimant's psychological condition was not an accepted condition at the time of claim closure. Therefore, the issue of whether this condition was medically stationary at the time of claim closure is not relevant to a determination of whether the claim was prematurely closed.[3]

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[2] We find further support for our conclusion elsewhere in amended ORS 656.262(7)(c), which also provides that "the insurer or self-insured employer shall issue at claim closure an updated notice of acceptance that specifies which conditions are compensable. * * * Any objection to the updated notice or appeal of denied conditions shall not delay claim closure pursuant to ORS 656.268." These provisions also indicate that the focus at claim closure is on accepted conditions. If a condition is subsequently "found" compensable after claim closure, as was true in this case, the statute provides for reopening for processing of the new condition. See Ronald D. Smith, Sr., 49 Van Natta 1807, 1808 n. 1 (1997) (no distinction between the situation where a carrier voluntarily finds a condition to be compensable after issuance of a reconsideration order and that in which a "post-reconsideration order" condition is found compensable via a litigation order).

[3] Claimant contends that confining our review to only those conditions that were accepted at the time of claim closure has the potential of limiting his 5-year aggravation rights because, unlike the "pre-HB 2971" claims subject to the Utera rationale, the acceptance of a "post-closure" condition will not automatically result in a premature closure finding and the re-initiation of a claimant's 5-year aggravation rights if the "premature" closure was the original claim closure. He further asserts that our analysis may prompt additional appeals once the "reopened" claim for the "post-closure" accepted conditions is later closed. As with all determinations regarding claim closures, we recognize that our decision may have an impact on the future processing of the claim. Nonetheless, because neither the "medically stationary" status nor disability (temporary or permanent) regarding claimant's "post-closure" accepted conditions is before us, it would be inappropriate to directly address such matters. Instead, we would merely comment that our decision should not be interpreted as a determination that claimant is precluded from receiving temporary disability benefits for his "post-closure" accepted conditions for a time period that precedes this initial closure of his claim.

Inasmuch as Dr. Zirschky declared claimant's accepted physical conditions medically stationary on August 14, 1996 (prior to claim closure), we conclude that the claim was not prematurely closed. Because the ALJ reached an opposite conclusion, we reverse. Finally, inasmuch as claimant presentd no argument, either at hearing or on review, seeking an increase in his permanent disability awards as granted by the Order on Reconsideration, we reinstate and affirm those awards.

ORDER

The ALJ's order dated July 24, 1997 is reversed. The October 7, 1996 Determination Order and the February 10, 1997 Order on Reconsideration are reinstated and affirmed. The ALJ's attorney fee award is also reversed.

**Board Members Hall and Biehl specially concurring.**

We concur with the majority's conclusion that, in accordance with the current statutory scheme, only accepted conditions at the time of claim closure may be considered when determining whether a claim has been prematurely closed. We further agree with the majority's observations that our decision should not be interpreted as a determination that claimant would be precluded from receiving temporary disability benefits for his "post-closure" accepted conditions for a time period that precedes this initial claim closure.

We write separately to further note that the "reopening" and processing of the later accepted conditions may impact the benefits and closure by the first Determination Order. However, such a determination is not for us to make in the first instance. Instead, in finding that this claim was not procedurally closed prematurely, we are not passing judgment on what, if any, impact the "reopening" and processing of new conditions will have on the original closure.

In the Matter of the Compensation of
**SAMUEL S. GARBER III, Claimant**
WCB Case Nos. 96-06257, 95-09850, 96-01910 & 95-13580
SECOND ORDER ON RECONSIDERATION
Philip H. Garrow, Claimant Attorney
VavRosky, et al, Defense Attorneys
James B. Northrop (Saif), Defense Attorney
Thaddeus J. Hettle, Defense Attorney
Meyers, Radler, et al, Defense Attorneys

TIG Insurance (TIG) requests reconsideration of our January 23, 1998 Order on Review and our February 6, 1998 Order on Reconsideration that found TIG solely responsible for claimant's right long trigger finger condition and affirmed the Administrative Law Judge's (ALJ's) attorney fee awards under ORS 656.307(5), 656.308(2)(d) and 656.386(1). Specifically, TIG argues that we incorrectly applied the last injurious exposure rule to assign responsibility.

First, TIG argues that we incorrectly assigned initial responsibility for claimant's long trigger finger condition to Willamette Industries. TIG argues that, at the time claimant sought treatment in 1987 while employed by Willamette Industries, his trigger finger condition was not yet compensable. TIG asserts that the trigger finger condition was not compensable until June 19, 1995. On that date, TIG argues, claimant sought treatment from Dr. Sulkosky for the compensable triggering of the right long finger. TIG asserts that claimant's employers on that date, SAIF/Advanced Plumbing and SAIF/Noe Plumbing should be assigned initial responsibility for claimant's trigger finger condition.

Even assuming, for the sake of argument, that SAIF/Advanced Plumbing or SAIF/Noe Plumbing should be assigned initial responsibility, we find that responsibility would still shift to TIG. TIG cites to Karen J. White, 48 Van Natta 1109 (1996) and Oregon Boiler Works v. Lott, 115 Or App 70 (1992), to argue that where there is no expert medical evidence that the claimant's employment with the later employer actually contributed to a pathological worsening of the claimant's underlying condition, responsibility does not shift forward to the later employer.[1] As we stated in our initial order, we find that Dr. Button's medical opinion establishes that claimant's employment with TIG actually contributed to a worsening of claimant's trigger finger condition. In this regard, Dr. Button opined that claimant's change of occupations to plumbing was the major contributing factor relative to the advancement of the trigger finger condition. As explained in our initial order, we interpreted Dr. Button's opinion to mean that the plumbing employments pathologically worsened the trigger finger condition.

Dr. Button also stated that he could not "fractionate" contributing components between the various plumbing firms. We interpret Dr. Button's opinion to mean that, although each of the plumbing employments contributed to the worsening of the trigger finger condition, Dr. Button could not determine the exact degree of contribution caused by each specific employment. Because the last injurious exposure rule only requires a determination of whether a specific employment actually contributed to a worsening of the condition, we do not find it necessary to know which employment contributed the most to the condition. It is enough to know that the plumbing employments all contributed to the "advancement" or worsening of the trigger finger condition.

Because we find that claimant's work activities while employed by TIG's Insured actually contributed to a worsening of claimant's right long trigger finger condition, we continue to find that responsibility shifts to TIG under the last injurious exposure rule. Lott, 115 Or App at 74-75. This is so regardless of which carrier is assigned initial responsibility.

Our January 23, 1998 and February 6, 1998 orders are withdrawn. As supplemented herein, we republish our January 23, 1998 and February 6, 1998 orders in their entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] We find White and Lott factually distinguishable. In both cases, there was no medical evidence that the later employment actually worsened the underlying disease. In contrast, in the present case, we find that Dr. Button's opinion establishes that each of the plumbing employments actually contributed to a worsening of the trigger finger condition.

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

Reviewed by Board Members Moller and Bock.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Spangler's order that set aside its denial of claimant's injury claim for a "clay shoveler's" fracture. On review, the issue is compensability. We reverse.

## FINDINGS OF FACT

On December 5, 1996, claimant felt pain in his right shoulder while planting trees for his employer, a nursery. Dr. Wagner provided claimant's initial treatment and diagnosed a mild rhomboid strain. (Ex. 3).

Claimant reaggravated the injury on January 15, 1997, while lifting and carrying tree branches at work. (Ex. 5). Dr. Owen, a chiropractor, began providing care for claimant and referred x-rays he took of the cervical and lumbosacral spine to Dr. Wei, a chiropractic radiologist, for interpretation. On January 22, 1997, Dr. Wei noted the possibility of an avulsion fracture at C7 and T1 (clay shoveler's fracture), but recommended a "Swimmer's" view because the spinous processes at C7 and T1 were obscured in the lateral view. (Ex. 7).

On February 17, 1997, Dr. Doughton, a medical doctor, became claimant's attending physician. Dr. Doughton initially diagnosed a cervical strain or sprain and a resolving thoracic sprain. (Ex. 12-1). The insurer then accepted the December 1996 claim as a disabling right rhomboid muscle strain. (Ex. 13).

In March 1997, an examining physician (Dr. Gambee) evaluated claimant's back condition. X-rays of the cervical and thoracic spine were obtained, including a "Swimmer's" view. (Ex. 14-5). Dr. Gambee interpreted the x-rays as not showing a clay shoveler's fracture. (Ex. 14-6).

Dr. Gambee and another medical doctor (Dr. Marble) reexamined claimant in May 1997, along with a chiropractor (Dr. Krein). Dr. Gambee and Dr. Marble reiterated that no clay shoveler's fracture was apparent in the March 1997 x-rays. (Ex. 19-6). Dr. Krein issued a separate report and also concluded that the "Swimmer's" view of March 1997 did not confirm any fracture. (Ex. 20-2).

On June 9, 1997, the insurer denied the alleged clay shoveler's fracture. (Ex. 24). Claimant requested a hearing from the denial.

## CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the insurer's denial, finding that claimant met his burden of proving a compensable clay shoveler's fracture at C7 and T1. In reaching this conclusion, the ALJ relied on the opinion of the attending physician,Dr. Doughton, as supported by Dr. Owen, that the December 5, 1996 work incident caused a clay shoveler's fracture at C7 and T1.[1] On review, the insurer contends that the ALJ should not have deferred to the opinions of Drs. Doughton and Owen. For the following reasons, we agree.

At the outset, we note that the compensability issue turns upon whether a clay shoveler's fracture exists. The insurer does not contend that, if such a fracture exists, it is not related to the compensable December 1996 injury. In evaluating the medical evidence, we rely on those opinions

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[1] The ALJ's order stated that Exhibits 1 through 26 were received into evidence. However, Exhibits 1 through 27 were admitted. (Tr. 7). Moreover, we note that proposed Exhibit 16A was not admitted into evidence. (Tr. 8).

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

As previously noted, on February 17, 1997, Dr. Doughton diagnosed cervical and thoracic sprains. However, a handwritten addendum to Dr. Doughton's February 17th chart note states that: "added later correct dx is fx of C7 clay shoveler's fracture." (Ex. 12-1). It is not clear when the addendum was added to the chart note. However, a subsequent chart note of March 3, 1997 states that, after a phone report from x-ray, claimant had a clay shoveler's fracture. (Ex. 13A).

Dr. Doughton later explained in an August 5, 1997 report the basis of his opinion that claimant had sustained a clay shoveler's fracture as result of the December 1996 incident. Dr. Doughton related that he made his diagnosis "clinically," based on the fact that he could feel avulsed muscle and possible bone from C7. (Ex. 26-1). Dr. Doughton also noted that he could reproduce a clicking sound or sensation at the bottom of claimant's neck each time that he examined claimant.

We do not find Dr. Doughton's opinion that claimant had a clay shoveler's fracture persuasive. First, Dr. Doughton made his diagnosis based on a clinical examination. Dr. Doughton's records do not establish that he ever actually examined the x-ray film of claimant's cervical and thoracic spine. (Exs 12, 13A, 16D, 17, 18A, 25, 26). Moreover, Dr. Doughton's observation that he detected a clicking at the top of claimant's thoracic spine or at the bottom of claimant's neck is not reflected in his chart notes until May 5, 1997, after April 1997, the point at which Dr. Doughton stated that the alleged avulsion fracture had healed. (Exs. 18A, 25).

In contrast to Dr. Doughton, Drs. Gambee, Marble and Krein examined the actual x-ray film of claimant's cervical and thoracic spine. (Exs. 14-5, 19-6, 20-2). They unequivocally concluded that the film, including the recommended "Swimmer's" view, did not reveal a clay shoveler's fracture at C7 and T1. Medical literature admitted into evidence stated that such a fracture can be readily confirmed radiographically. (Ex. 16B-3). Given this evidence, we are persuaded that, if a clay shoveler's fracture were present, the examining physicians would have detected it.[2]

Accordingly, we conclude that a preponderance of the medical evidence does not establish the presence of a clay shoveler's fracture. It follows that the insurer's denial was appropriate. Because the ALJ concluded otherwise, we reverse.

## ORDER

The ALJ's order dated October 7, 1997 is reversed. The insurer's June 9, 1997 denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

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[2] We recognize that Dr. Owen provided a report dated September 8, 1997 (one day prior to the September 9, 1997 hearing) in which he stated that he "retook" the January 22, 1997 x-rays that Dr. Wei determined were inconclusive regarding the presence of an avulsion fracture at C7 and T1. (Ex. 27). According to Dr. Owen, the x-rays showed definite fractures of the spinous processes at C7 and T1. However, we do not find Dr. Owen's opinion more persuasive than those of the examining physicians. Considering that Dr. Owen felt it necessary to refer his x-rays to Dr. Wei for interpretation, we are not convinced that he has more expertise in interpreting x-ray film than Drs. Gambee, Marble or Krein. Moreover, unlike those physicians, Dr. Owen apparently never examined the Swimmer's view that Dr. Wei recommended.

In the Matter of the Compensation of
**LARRY W. OGBURN, Claimant**
WCB Case No. 97-01779
ORDER ON REVIEW (REMANDING)
Welch, Bruun, et al, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that: (1) denied claimant's motion to postpone the hearing to present medical evidence from a new attending physician; and (2) upheld the self-insured employer's denial of claimant's aggravation claim for a low back condition. On review, the issues are the ALJ's procedural ruling and aggravation. We vacate the ALJ's order and remand.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following exception and supplementation. We do not adopt the ALJ's findings of ultimate fact.

On October 11, 1996, Dr. Wagner, claimant's attending physician, filed a Notice of Claim for Aggravation with no time loss authorized. In a January 2, 1997 chart note, Dr. Wagner found that claimant's recent MRI showed no problem that could be improved with surgery. (Ex. 29). Dr. Wagner noted that no further treatment was required, other than claimant continuing to do his home exercise program. He also found claimant medically stationary with no impairment. (Id.) Dr. Wagner would not agree to refer claimant to a specialist and did not support claimant's aggravation claim. (Tr. 15, 16-17). Claimant became dissatisfied with Dr. Wagner's treatment and thought that a specialist would be able to "fix [him]." (Tr. 15).

On January 9, 1997, the employer issued a denial denying claimant's aggravation claim. (Ex. 30). On February 26, 1997, claimant, through an attorney, requested a hearing on that denial. A hearing was scheduled for May 20, 1997, before ALJ Thye. Claimant was unable to make an appointment with that attorney until March 24, 1997, at which time he signed a retainer agreement. (Ex. 33-2-3, Tr. 14).

By letter dated March 25, 1997, claimant's attorney requested that the employer's attorney send him and claimant a copy of the employer's Managed Care Organization (MCO) list so that claimant might choose a different attending physician, if he wished. (Ex. 33-1).

In an April 8, 1997 letter to the employer's claims administrator, the employer's attorney noted that claimant's attorney had called him on that date asking whether a copy of the MCO approved doctor list had been sent to claimant, noting that claimant's attorney claimed not to have received a copy of the list. The employer's attorney requested that a new list be sent at the claims administrator's earliest convenience. (Ex. 34).

In an April 11, 1997 letter to claimant's attorney, the employer's attorney noted that he spoke with the claims administrator on April 10, 1997, and was told that claimant was mailed a copy of the MCO approved doctor list on the same day he and claimant's attorney had last spoke. (Ex. 35). The employer's attorney related that the claims administrator would provide claimant with another list, however, the list was being changed and would not be available for about a week. The employer's attorney asked that claimant's attorney let him know if this presented any problems. (Id.)

After receiving the updated MCO list, claimant contacted six or seven specialists on the list who refused to see him unless he was referred by another doctor on the list. (Tr. 15). A nurse in Dr. Wagner's office recommended Dr. Cole as a specialist. Dr. Cole was not on the MCO list. A "couple of weeks" before the scheduled hearing, claimant called Dr. Cole's office and was able to see Dr. Gambee, a physician in Dr. Cole's office. (Tr. 16). Dr. Gambee requested authorization for an MRI and advised claimant that he would notify him when the authorization was received. (Id.) As of the date of hearing, Dr. Gambee had not contacted claimant. (Id.)

By letter dated May 15, 1997, claimant's attorney requested that ALJ Thye postpone the May 20, 1997 hearing pursuant to claimant's request to allow claimant to seek additional medical assistance before proceeding to hearing. Claimant's attorney noted that the employer's attorney objected to a postponement. This letter had been placed in the hearings file and ALJ Thye did not see it until the day of the hearing. (Tr. 3).

In a May 19, 1997 conference call, Assistant Presiding Administrative Law Judge (APALJ) Bethlahmy heard the parties' arguments regarding claimant's request for postponement and denied the request. (Tr. 3, 7-8).

At hearing, claimant renewed his motion for postponement. (Tr. 3-4). The parties stipulated at hearing that, if postponement was denied, the record was insufficient to sustain claimant's burden of proving an actual worsening of his compensable condition. The ALJ denied claimant's motion for postponement and issued an order upholding the employer's aggravation denial based on the parties' stipulation.

## CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, claimant argues that the ALJ abused his discretion in refusing to continue the hearing. However, there is no evidence that claimant ever made a motion to continue the hearing. (Tr. 1-17). To the contrary, the only motion before the ALJ and the APALJ was claimant's motion to postpone the hearing. (Id.) Since no motion for continuance was ever made at hearing, we decline to address any arguments regarding a "denied" continuance.

Therefore, the issue is whether claimant's motion for postponement should be granted. Although denying claimant's motion for postponement, the ALJ did not address that issue in his order. Claimant requests that we remand this case to the ALJ so that the ALJ may provide his reasoning for denying claimant's motion for postponement.

We may remand to the ALJ if we find that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Under the circumstances of this case, we do not find it necessary to remand to the ALJ for determination of his reasoning regarding his denial of postponement. In this regard, claimant does not contend that the record is insufficiently developed to determine the postponement issue. In any event, such an argument would fail because the ALJ allowed the parties to develop the record regarding the postponement issue. Therefore, on de novo review, we are able to determine the issue without remanding to the ALJ for his reasoning.

OAR 438-006-0081, the postponement rule, provides that hearings "shall not be postponed except by order of [an ALJ] upon a finding of extraordinary circumstances beyond the control of the party . . . requesting the postponement." Subsection (4) of the same rule provides that "extraordinary circumstances" shall not include "[i]ncomplete case preparation, unless the [ALJ] finds that completion of the record could not be accomplished with due diligence." Thus, the postponement rule requires that a postponement motion based on incomplete case preparation be denied, unless there is a showing of due diligence by the moving party.

We find that "extraordinary circumstances" existed to justify postponement of the hearing before the ALJ. Claimant was dissatisfied with his current attending physician, Dr. Wagner, and wanted to change attending physicians. However, because claimant is enrolled in an MCO, he is required to treat with a physician who is a member of the employer's MCO. Furthermore, a referral from an MCO attending physician is required before treating with a specialist.

Claimant contacted an attorney in late February 1997, so that his request for hearing was timely. However, he could not get an appointment with the attorney until March 24, 1997. On March 25, 1997, through his attorney, claimant attempted to get a copy of the employer's MCO list of approved physicians so that he could change his attending physician. When claimant's attorney inquired further about the list, he was informed that it was in the process of being updated and would not be available for about a week from April 10, 1997. (Exs. 33, 34, 35). Therefore, it appears that claimant did not get a copy of the updated MCO list until about April 17, 1997, a little over a month before the date of the May 20, 1997 hearing.

Thereafter, claimant attempted to contact six or seven specialists on the MCO list, but none was willing to see him without a referral from an attending physician. A couple of weeks before the hearing, claimant contacted Dr. Gambee, who was willing to treat claimant and requested authorization for an MRI. However, by the date of hearing, claimant was still waiting to hear from Dr. Gambee as to whether that request had been approved.

Once claimant became dissatisfied with his attending physician, he could arguably have been more diligent in attempting to get a copy of the employer's MCO list and trying to get a new attending physician from among the physicians on the MCO list. In addition, we acknowledge that claimant's attorney could have notified the employer's attorney that the delay in obtaining an updated MCO list presented problems. (Ex. 35). However, even considering these factors, on the whole, the evidence supports a finding that claimant made several attempts to find a specialist and new attending physician before the scheduled hearing. His search was delayed, in part, by problems with getting an updated MCO list.

We find that the record supports a conclusion that extraordinary circumstances beyond claimant's control prevented completion of the record with due diligence. OAR 438-006-0081(4). Thus, we conclude that postponement of the hearing should have been granted.

As noted above, we may remand to the ALJ if we find that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Under these circumstances, we find that remand is appropriate. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986). Therefore, we remand to the ALJ with instructions to schedule a hearing in the ordinary course of business. At that hearing, the parties shall have the opportunity to present evidence regarding the issues raised by claimant's hearing request.

Accordingly, the ALJ's order dated January 9, 1997 is vacated. This matter is remanded to ALJ Thye for further proceedings consistent with this order. Following these further proceedings, the ALJ shall issue a final, appealable order.

IT IS SO ORDERED.

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March 9, 1998 Cite as 50 Van Natta 346 (1998)

In the Matter of the Compensation of
**GLENDA JENSEN, Claimant**
WCB Case No. 95-07344
ORDER ON REMAND
Ransom & Gilbertson, Claimant Attorneys
Lundeen, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Liberty Northwest Insurance Corporation v. Jensen, 150 Or App 548 (1997). The court has reversed our prior order that adopted and affirmed an Administrative Law Judge's (ALJ's) order that had held that the insurer improperly terminated claimant's temporary total disability (TTD) and assessed a penalty for unreasonable claim processing. Concluding that the insurer had complied with OAR 436-60-030(12)(c) (1996) prior to its termination of claimant's TTD benefits, the court has held that we erred in awarding such benefits and in imposing a penalty. Consequently, the court has remanded for reconsideration.

In accordance with the court's holding, we find that claimant is not entitled to the TTD benefits that she seeks. Likewise, we conclude that the insurer's termination of such benefits was not unreasonable.

Accordingly, on reconsideration of our prior order, the ALJ's order dated October 30, 1995 is reversed.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**CHRISTOPHER L. PHILLIPS, Claimant**
WCB Case No. TP-96004
THIRD PARTY DISTRIBUTION ORDER
Meyers, Radler, et al, Attorneys
Martin Bischoff, et al, Attorneys

Reviewed by Board Members Hall and Moller.

Oregon Insurance Guaranty Association (OIGA), the successor in interest to insurer Enterprise Insurance (Enterprise)[1] and paying agency, has petitioned the Board for resolution of a dispute concerning the amount of OIGA's recovery from a third party judgment. See ORS 656.593(1)(c). Specifically, OIGA seeks to recover the following sums: (1) $135,639.09 for future permanent total disability benefits;[2] and (2) $2,398,199 for the present value of its "reasonably to be expected future medical expenditures." Claimant, on the other hand, challenges the calculation of OIGA's expected future expenditures and asserts that: (1) his future permanent total disability benefit is $87,623;[3] and (2) the present value of his expected future medical costs is $222,674.

For the reasons set forth below, we conclude that OIGA is entitled to recover the following amounts from the third party judgment pursuant to ORS 656.593(1)(c): (1) $543,028.51 for actual claim costs incurred through February 28, 1997 (less the amounts previously paid by claimant); and (2) $895,596 (including $87,623 for claimant's future monthly permanent total disability benefits) as the present value of its reasonably to be expected future medical expenditures.[4]

## FINDINGS OF FACT

Claimant was compensably injured on June 6, 1985, when the truck he was driving went off a forest road and into a ravine.[5] He was rendered a quadriplegic as a result of the accident, two months before his 24th birthday.

In 1989, claimant brought suit in Idaho federal court against the United States Forest Service for negligence in constructing and maintaining the road. The employer filed a notice of workers' compensation lien in the action. (Ex. 4). After a bench trial, claimant was awarded $7,767,344. The judgment was entered July 31, 1992. (Ex. 1-33)

At trial, claimant called as a witness John Dahlberg, a rehabilitation consultant who had managed claimant's case since his injury. (Ex. 7). In May 1992, Mr. Dahlberg prepared a detailed report documenting claimant's anticipated future medical and rehabilitational expenses and testified regarding his findings. (Ex. 6). In preparing this report, Mr. Dahlberg relied on his extensive knowledge of claimant's needs as well as his consultations with claimant's treating physician, Dr. Stark.

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[1] Enterprise became insolvent in 1987 and OIGA became responsible for paying certain claims (including claimant's workers' compensation claim) pursuant to ORS 734.510 *et seq.* While this action was pending, claimant reimbursed Enterprise the amount of $207,452.13 for expenditures incurred by Enterprise prior to its insolvency.

[2] This amount is based on a remaining life expectancy of 39 years (as of August 1996) multiplied by a monthly payment of $738.56 reduced to present value using a 7 percent discount factor ($118, 939) plus the monthly benefits paid from September 23, 1994 through August 13, 1996 ($16,700.09).

[3] This amount is based on a monthly payment of $738.56 multiplied by a life expectancy of 16.75 years (from March 1, 1997) and using a net discount factor of 0 percent (based on the assumption that interest and inflation will equal each other over time).

[4] As explained herein, our determination of OIGA's lien for future expenses is calculated as of March 1, 1997.

[5] Although the accident occured in the State of Idaho, claimant, at the time an Oregon resident, was acting in the course and scope of his employment for Loomix, an Oregon employer.

In this 1992 report, Mr. Dahlberg concluded that claimant's future medical expenses for medications, medical supplies, durable medical equipment, treatment, attendant care and household assistance would total $65,381.22 annually. He opined that claimant had special housing needs and that modifications to his living quarters would cost $61,848. In addition, Mr. Dahlberg opined that claimant would likely need further medical and surgical procedures as a result of his quadriplegia, and that the cost of these procedures would total approximately $62,500. (Ex. 6).

The trial court found the figures put forth by Mr. Dahlberg to be "accurate and conservative." (Ex. 1-19). Based on Mr. Dahlberg's figures and the method for computing the present value of future expenses put forth by claimant's economist, Dr. Evenson, the trial court determined that claimant should recover $2,877,373 for future medical-related expenses. (Ex. 1-31). This figure was based on a life expectancy of 74.48 years. Id.

In May 1995, OIGA retained Richard B. Frank, a management consultant, to evaluate claimant's claim and determine the amount of claimant's reasonably to be expected future medical and permanent total disability payments. (Ex. 11). Assuming a life expectancy of claimant of 67 years (34 years from September 1994), an annual medical inflation rate of 9 percent, a present value rate of 7 percent and $64,226 in projected annual medical costs, Mr. Frank recommended a total lien reserve of $2,967,466.35. This amount consisted of $89,472 in permanent disability benefits,[6] $2,816,146.35 in medical benefits and $61,848 for a one time renovation of claimant's living quarters. (Ex. 11A-3).

At some point between May 1996 and February 1997, claimant moved to Boise, Idaho and purchased a home, which he had substantially modified to accommodate his unique needs. Claimant paid for the home and its renovation with his portion of the third party judgment proceeds, and has not sought reimbursement for any of these expenditures (or any home maintenance and upkeep costs) from OIGA. (Ex. B).

In February 1997, Mr. Dahlberg prepared a second detailed report at claimant's request which reassessed claimant's anticipated annual medical and rehabilitative expenses. (Ex. C). In preparing this second analysis, Mr. Dahlberg relied on his twelve year history with claimant's case, the case reserve projection of Mr. Frank,[7] reports from claimant's physician, Dr. Stark, and a cost itemization of claimant's actual expenses for the calendar year 1996.

In updating his 1992 projections, Mr. Dahlberg opined that claimant's future expenses for medications, medical supplies, durable medical equipment, treatment, attendant care, transportation and household assistance would total $52,948.75 annually. Mr. Dahlberg noted that since claimant had moved to Boise from Ontario, Oregon, he was able to have his annual spinal cord re-evaluations done on an outpatient basis at a local Boise hospital, rather than incurring the cost of traveling to Portland for this service.[8] Mr. Dahlberg again noted that claimant would likely need further medical and surgical procedures as a result of his quadriplegia, and that the cost of these procedures would be approximately $62,500 over claimant's lifetime. Mr. Dahlberg did not include any housing renovation costs in his 1997 based on the fact that claimant had already purchased a home and paid for the necessary modifications. (Ex. 6).

Claimant's attending physician, Dr. Stark, has opined that claimant's life expectancy is approximately 52 to 53 years of age. (Ex. D). In a February 1997 affidavit, Dr. Stark explained that his opinion regarding claimant's life expectancy was based on his familiarity with claimant's case (and the complications and risks that are unique to claimant's condition) as well as his professional experience with other patients with similar medical conditions and known statistics on the life expectancy of persons with spinal cord injuries similar to that sustained by claimant. Id.

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[6] In an August 1996 affidavit, Mr. Frank updated his calculation of future permanent total disability payments because claimant's monthly benefit increased on October 1, 1995. Mr. Frank reported that, assuming a life expectancy of 67 years and reducing the monthly payments to present value using a 7 percent discount factor, the total anticipated expenditure for permanent total disability payments would be $115,254. (Ex. 11-2).

[7] Mr. Dahlberg used Mr. Frank's report as a guide to eliminate noncompensable items from his previous report. (Ex. C).

[8] In his 1992 report, Mr. Dahlberg used the $10,149 cost of claimant's 1992 annual re-evaluation at a comprehensive spinal cord injury treatment center in Portland for projecting future costs. In the 1997 report, Mr. Dahlberg estimated that claimant's ongoing cost for such annual re-evaluations in Boise would only be $1,000. (See Exs. 6-10, C-9).

In a February 9, 1997 report, economist Dr. James Evenson analyzed the present value of claimant's future anticipated medical expenses based on the figures set forth in Mr. Dahlberg's 1997 report. Mr. Evenson calculated the present value of future anticipated medical expenses assuming three different life expectancies: (1) 16.75 years from March 1, 1997 (a life expectancy of 52.31 years); (2) 23.14 years from March 1, 1997 (a life expectancy of 58.70 years); and (3) 26.44 years from March 1, 1997 (a life expectancy of 62 years). Under these three different life expectancies, Mr. Evenson determined the total present value of claimant's future expected medical related expenses (including monthly permanent total disability benefits) to be $895,596, $1,152,612 and $1,275,208 respectively.

Meanwhile, in August 1996, OIGA petitioned the Board for a third party distribution order, seeking reimbursement for its expenditures for compensation and a determination of the present value of its expected future expenditures for compensation on claimant's claim. After several continuances in the briefing schedule (requested by the parties for purposes of settlement negotiations), claimant submitted his opposition to OIGA's petition in late February 1997. Following submission of OIGA's reply brief in mid-March 1997, the parties agreed to mediation and moved to abate the third party dispute. Thereafter, on May 16, 1997, the Board suspended its consideration of the matter.

Six months later, on November 12, 1997, OIGA advised the Board that the parties' mediation efforts had been unsuccessful and renewed its request that the third party distribution dispute be resolved by the Board. Pursuant to the Board's request, both parties submitted supplemental briefing.

Between February 1987 (when OIGA became responsible for the claim) and February 28, 1997, OIGA paid a total of $543,028.51 on claimant's claim.[9] (See Ex. 12). In July 1995, claimant and OIGA settled that portion of OIGA's lien representing expenditures for compensation through September 23, 1994 for the sum of $479,674.17.[10]

## CONCLUSIONS OF LAW AND OPINION

If a worker sustains a compensable injury due to the negligence or wrong of a third party not in the same employ, the worker shall elect whether to recover damages from the third party. ORS 656.578. The paying agency has a lien against the worker's cause of action, which is preferred to all claims except the cost of recovering such damages. ORS 656.580(2). Where, as here, the worker elects to bring an action against the third party and obtains a judgment for damages, the recovery is to be distributed pursuant to the statutory formula set forth in ORS 656.593(1).[11]

As set forth above, claimant recovered more than $7.7 million in damages against the third party. OIGA, as the paying agency, has a lien against the judgment proceeds, which must be distributed according to the specific statutory formula. Although the parties have, by mutual agreement, completed the first two steps of the statutory distribution formula, i.e., the payment of costs and attorney fees and at least 33-1/3 of the proceeds distributed to claimant, see ORS 656.593(1)(a) and (b), they cannot agree upon the amount of OIGA's lien.

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[9] Using OIGA's actual expenditures on the claim during this 10 year period, this amounts to an annual average claim cost for medical services of $54,302.85. In its supplemental brief, OIGA established that between September 24, 1994 and October 31, 1997, it has paid compensation totaling $197,656.03. (Kendall Affidavit). We have since been advised that claimant paid OIGA this amount in December 1997.

[10] This amount did not include the $207,452.13 incurred by Enterprise prior to its insolvency.

[11] On July 25, 1997, while the third party dispute was in abeyance, the Legislature enacted Senate Bill 484 which, among other things, added subsection (6) to ORS 656.593 See Or Laws 1997, ch. 639, sec. 4 (July 25, 1997). Pursuant to ORS 656.593(6), a worker (or the beneficiaries of a worker) who is entitled to payment from a third party judgment or settlement in the amount of $1 million or more may, if certain conditions are met, elect to "opt out" of the workers' compensation system by reimbursing the paying agency for costs incurred and releasing the carrier from all further liability on the claim, thereby cancelling the lien for reasonably expected future claim costs. In this case, however, claimant has yet to make such an election, so the new law does not impact our resolution of this third party dispute. (Unlike ORS 656.583, which empowers a paying agency to compel a worker's election to bring an action within a specific time period, ORS 656.593(6) has no provision for compelling a prompt "opt out" election by the worker or his or her beneficiaries. The new section provides, in pertinent part, "[p]rior to and instead of the distribution of proceeds described in subsection (1) of this section . . . the worker or the beneficiaries of the worker may elect ... ," but it does not set forth any specific time period for the election.)

In this regard, ORS 656.593(1)(c) provides as follows:

> "The paying agency shall be paid and retain the balance of the recovery, *but only to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under this chapter.* Such other costs include expenditures of the department from the Consumer and Business Services Fund, the Self-Insured Employer Adjustment Reserve and the Workers' Benefit Fund in reimbursement of the costs of the paying agency. Such other costs also include assessments for the Workers' Benefit Fund, and include any compensation which may become payable under ORS 656.273 or 656.278." (Emphasis added).

OIGA has the burden of establishing that it is reasonably certain it will incur the expenses in order to support its lien for anticipated future expenditures. Sharon K. Falsetto, 49 Van Natta 1202, on recon 49 Van Natta 1573 (1997); Mona R. Skelton, 47 Van Natta 882 (1995). After OIGA is reimbursed for its actual expenditures and paid the present value of its expected future expenses pursuant to ORS 656.593(1)(c), any remaining balance is retained by claimant. ORS 656.593(1)(d).

As noted at the outset, OIGA seeks to recover $135,639.09 for future permanent total disability benefits and $2,398,199.00 for future medical expenditures (based on a life expectancy for claimant of 74.48 years and the anticipated annual medical expenditures and rehabilitative costs set forth in Mr. Dahlberg's 1992 report). OIGA argues that these amounts have already been litigated and determined by the federal court in awarding claimant's damages in the third party action and may not be relitigated by the Board. Alternatively, OIGA seeks to recover $115,254.00 for future PTD benefits and $2,877,994.35 for future medical expenditures based on the projections of its expert, Mr. Frank.[12]

As explained below, we reject both approaches set forth by OIGA. Instead, we calculate OIGA's lien for reasonably to be expected *future* expenditures from February 28, 1997,[13] based on a life expectancy of 52.31 years (16.75 years from February 28, 1997) projected by Dr. Stark, a monthly PTD benefit of $738.56 and the anticipated compensable medical costs set forth in Mr. Dahlberg's February 1997 report. In reaching this determination, we rely on the approach for computing the present value for these future expenses offered by Mr. Evenson, in his February 9, 1997 report.

OIGA asserts that claimant is precluded from relitigating his life expectancy or the amount of his anticipated future medical expenses because the federal trial court already made the determination as part of his $7.7 million award.[14] We disagree.

A prior determination will have preclusive effect on subsequent litigation only if the issue was "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 (1994). In Nelson v. Emerald People's Utility Dist., 318 Or 99, 103 (1993), the Oregon Supreme Court held that issue preclusion may apply if five requirements are met: (1) The issue in the two proceedings is identical; (2) The issue was actually litigated and was essential to a final decision on the merits in the prior proceeding; (3) The party sought to be precluded has had a full and fair opportunity to be heard on that issue; (4) The party sought to be precluded was a party or was in privity with a party to the prior proceeding; (5) The prior proceeding was the type of proceeding to which the court will give preclusive effect.

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[12] Both of these approaches treat all expenses from September 24, 1994 as "future expenses" for purposes of calculating OIGA's lien for future expenditures. OIGA utilized this date because it has only been paid for its expenditures through September 23, 1994. (Ex. 9).

[13] We use this date because (1) relatively speaking, it is much closer in time to the date of our order; (2) OIGA has already determined the amount of actual expenditures it has incurred on this claim as of that date; and (3) it is essentially the same date used by Dr. Evenson to calculate the present value of claimant's anticipated future medical and permanent total disability costs. (See Exs. 12, A (attachment 3)).

[14] As noted above, the trial court allocated $2,877,373 for future medical related expenses based on a life expectancy of 74.48 years, the figures in Mr. Dahlberg's 1992 report and the present value computations of Mr. Evenson. (Ex. 1-19, 1-31).

Here, although claimant was a party to the federal trial and the prior proceeding was sufficiently formal and comprehensive for us to give it preclusive effect, we are unable to find that the issue is identical in the two proceedings or that (with regard to claimant's life expectancy) the issue was actually litigated and was essential to the final decision on the merits.

The issue before us is the amount of OIGA's expenditures for compensation and claimant's "reasonably to be expected future expenditures for compensation" under Oregon's workers' compensation laws. See ORS 656.593(1)(c) ("the paying agency shall be paid * * * for compensation and other costs of the worker's claim *under this chapter*") (emphasis added). While the federal court in Idaho determined among other things, the amount of claimant's future medical related expenses (in 1992 dollars), this determination was not based on damages compensable under Oregon law. Indeed, as the Frank Report details, there are costs and expenses included in the court's damage calculation which are not compensable as medical expenses under Oregon workers' compensation law. (Ex. 11A -6). Therefore, the "expected future expenditures" issue before us is not identical to the issue decided by the federal court.

Second, we are not persuaded that claimant's life expectancy was actually litigated and essential to the final decision in the federal trial court. Although the trial judge based his calculation of claimant's future medical expenses on a life expectancy of 74.48 years, he did not find as a matter of fact that claimant was expected to live to that age. Indeed, as claimant points out, no doctors were called to testify as to claimant's life expectancy and the economists for both sides calculated damages using a normal life expectancy without accounting for claimant's injury. The defense did not present any evidence on this issue. In fact, the only evidence presented at trial regarding claimant's life expectancy was Mr. Dahlberg's testimony that claimant could live to around 70 years old but that his life expectancy would "be reduced somewhat" because of his quadriplegia.[15] (Ex. 7-41). Because the record before us does not indicate how or why the federal court used a life expectancy of 74.48 years to calculate claimant's damages, we conclude the issue of claimant's post-injury life expectancy was not actually litigated in the prior proceeding.

Consequently, we conclude that the federal court's determination concerning claimant's future medical related expenses has no preclusive effect in this workers' compensation proceeding to determine the amount of OIGA's lien for future expenditures for compensation.

As an alternative to relying on Mr. Dahlberg's 1992 figures and the federal court determination, OIGA asks us to order distribution of claimant's third-party judgment based on the amounts set forth in the Frank Report. (Ex. 11A). As noted above, Mr. Frank calculated OIGA's projected lien from September 1994 and recommended a reserve ($2,967,466.35) based on a life expectancy of 67.5 years and projected annual medical costs of $64,226 annually (in 1994 dollars) using an annual inflation rate of 9 percent and a present value discount rate of 7 percent. Id.

We find that claimant's challenges to the accuracy and reliability of the Frank Report are well taken. First, in projecting claimant's life expectancy (34 years from September 1994), the Frank Report relies on statistics (the "Frankel" formula, which projects a 91.4 percent compromised life expectancy due to the injury) and does not consider the life expectancy projection of claimant's long-term treating physician, Dr. Stark. Dr. Stark opined that claimant's life expectancy has been significantly reduced as a result of his accident and that claimant would only survive an additional 17 or 18 years (to age 52 or 53). Considering Dr. Stark's medical expertise and personal familiarity with claimant's unique circumstances, we find his opinion as to claimant's life expectancy more persuasive than the generalized statistics (which do not take into account gender and special circumstances or complications) utilized by the Frank Report. See generally Weiland v. SAIF, 64 Or App 810, 814 (1983) (absent persuasive reasons to do otherwise, we generally give greater weight to the opinion of the attending physician because of his or her opportunity to observe the claimant over an extended period of time).

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[15] OIGA asserts that claimant's position in this proceeding is inconsistent with his position in the federal trial and that the doctrine of "judicial estoppel" operates to preclude his assertion that his life expectancy is reduced as a result of his injuries. We disagree. Although claimant benefited from the federal court's use of a near normal life expectancy, we do not find his position before the Board to be inconsistent with his position in the prior proceeding. Indeed, neither claimant nor the defense took a position concerning claimant's life expectancy at the federal trial.

In addition, the Frank Report calculates "future" expenditures from September 1994 (without considering the actual expenses incurred since that time) and relies on questionable growth and discount rates in determining present value. Claimant's economist, Dr. Evenson, specifically challenges the Frank Report's use of a 9 percent "annual medical inflation rate" (or growth factor) for all medical related expenses because that rate is significantly higher than the historic growth rates for medical goods and services (which historically averages approximately 4 to 6.5 percent, depending on the category of the medical related expense).[16] We are also persuaded by the expert opinions of economists Dr. Evenson and Cornelius Hofman that the Frank Report's use of a net discount rate of + 2 percent (9 percent growth less 7 percent interest) is outside the range of rates currently used by economists to calculate present value.[17] (See Exs. A (Attachment 3) and E).

Finally, the Frank Report includes "future" costs that are noncompensable or have already been paid for by claimant. For example, although the Frank Report includes $61,848 for a one-time house renovation, claimant has already purchased a new home and modified it to suit his special needs with his own funds. Therefore, this is not an expense reasonably certain to be incurred by OIGA in the future.[18] Consequently, for the reasons set forth above, we do not rely on the Frank Report in calculating the present value of OIGA's lien for future expected compensable medical expenses.

Although claimant urges us to rely on Dr. Stark's opinion of his life expectancy, Mr. Dahlberg's 1997 assessment of his anticipated costs[19] and Dr. Evenson's method of calculating present value, he nevertheless challenges the compensability of certain expected expenses and seeks to omit them from the calculation of OIGA's lien. Specifically, claimant asserts that the annual expected costs for his attendant care and miscellaneous help ($36,163, according to the Dahlberg report) and his customized van ($1,578, according to the 1997 Dahlberg report) are not compensable medical services under ORS 656.245(1), and therefore not reasonably to be expected future expenditures under ORS 656.593(1)(c). We decline to exclude these costs for the reasons that follow.

Claimant asserts that his 24-hour attendant care is not compensable because he does not use trained medical providers to render care. He also contends that only about 30 percent of the attendants' time is spent providing "hands on" services and that the remainder of their time is spent providing housekeeping, transportation and other services. Finally, claimant argues that the attendants do not provide compensable "medical services" under ORS 656.245(1) and OAR 436-010-0050 because their treatment is not rendered under a physician's direct control or supervision. In response, OIGA

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[16] As set forth in Dr. Evenson's report, the various categories of medical related expenses call for different growth factors. The cost of medications, medical supplies and medical procedures has grown an average of 6.38 percent between 1954 and 1994, whereas the cost of durable medical equipment and transportation has grown an average of 4.36 percent. The cost of other services, such as home attendant care, psychological counseling and accounting services has grown with the average rate of growth in wages (5 percent per year between 1959 and 1994). (Ex. A (Attachment 3)).

[17] Cornelius A. Hofman, an economist and economic consultant, has averred that "when calculating present value the net discount rates currently used by economists generally range from 0 to negative three percent" and also that "use of a positive net discount rate is highly unusual and causes the present value calculation of future amounts to be much larger than appropriate." (Ex. F).

[18] We recognize that certain modifications to claimant's home necessary to accommodate his quadriplegia may be compensable as other related services under ORS 656.245(1). See, e.g., Jack H. Glubrecht, 1 WCSR 558 (1996). In this case, however, claimant has already paid for his new home and its modifications out of his share of the proceeds and has represented to this forum that he will not seek reimbursement for these costs from OIGA. (See Ex. B). Although OIGA has a continuing duty to provide compensation for claimant's future medical services and expenditures under ORS 656.245(1), see SAIF v. Parker, 61 Or App 47 (1982) (unless, of course, claimant elects to release OIGA from the further liability on the claim pursuant to amended ORS 656.593(6)), we conclude, based on his representations to this forum, that claimant would be judicially estopped from seeking reimbursement for the (already incurred) costs of his home modification.

[19] We rely on the 1997 Dahlberg report because it is a more current evaluation of claimant's anticipated medical expenses. We note that, where the 1997 projected annual cost of a treatment or service differs substantially from that set forth in his earlier report, the 1997 report generally provides an explanation for the cost change. For example, as noted above, the 1997 report explains that claimant's annual medical revaluation cost was significantly reduced (from $10,149.62 to $1,000) by having his re-evaluation done an outpatient basis at a local Boise hospital.

contends that claimant's 24-hour attendant care is compensable because he is unable to attend to his daily needs without assistance. OIGA also notes that it has paid for claimant's attendant care since his injury at a rate of approximately $30,000 per year and has never contested the compensability of this service.

Home health care is a compensable service under Oregon law. See, e.g. Robert P. Holloway, 45 Van Natta 2036 (1993) (compensable services included assisting the claimant with personal hygiene, housekeeping, changing bandages, taking medication, use of physical therapy/mobility devices, and transportation to medical appointments). Although mere housekeeping services are not reimbursable medical expenses under ORS 656.245(1), see Baar v. Fairview Training Center, 139 Or App 196 (1996), other related services, designed to prevent the worsening of compensable conditions, are compensable. See Pamela J. Panek, 47 Van Natta 313, 314 (1995) (on remand) (home health care services which included housekeeping, shopping for food, meal preparation, and personal hygiene assistance were not mere housekeeping, because, without such services, claimant's compensable conditions would worsen).

In this case, although claimant apparently does not use licensed home health care providers or attendants under the direct control and supervision of his attending physician, his compensable condition renders him unable to care for himself without assistance. He needs attendant care available on a 24-hour basis for his personal care and hygiene, as well as to assist him in managing his household. (Ex. C, see also Ex. 1-10). Because the record establishes that claimant's compensable condition requires that he have full time attendant care available, OIGA has been and will be (unless claimant elects to release the carrier from this obligation pursuant to amended ORS 656.593(6)) obligated to pay for attendant care for the remainder of claimant's life. Recognizing this obligation, OIGA has paid for such care since claimant's injury and has not contested the compensability of this significant expense nor claimant's decision to hire attendants lacking in formal medical training.[20] Under these circumstances, we decline to exclude claimant's attendant care expenses from the calculation of OIGA's lien.

Claimant also argues that his customized van is not compensable. OIGA responds that it considers the van a compensable prosthetic device and has established that it paid $21,900 for claimant's van in 1993. (Ex. 16) OIGA has also represented to this forum that (unless released from its liability on the claim), it will continue to pay for the maintenance and replacement of the van for claimant's transportation needs. Considering OIGA's concession that the van and related maintenance costs are compensable medical services, we also decline to exclude the anticipated future expenses from the calculation of its lien.

Finally, claimant argues that, to the extent the Dahlberg report notes that claimant is "at risk for" certain medical problems and recommends setting aside a fund of $62,500 (apart from the projected annual expenses) to cover other, nonperiodic expenses, OIGA has not established that it is reasonably certain that he will need such additional medical and/or surgical procedures in the future as a result of his compensable injury. We disagree.

As noted above, OIGA must establish that it is reasonably certain that it will incur such expenses to support a lien for anticipated future costs. See Sharon K. Falsetto, 49 Van Natta 1202, on recon 49 Van Natta 1573 (1997). In this case, Dr. Stark has opined that claimant's quadriplegia places him at greater risk for certain conditions, diseases and infections (including urinary tract problems, bedsores and ulcerations, cardiovascular disease and pulmonary infections), and that it is more than likely that claimant will suffer these complications due to his paralytic state. (Ex. D). In addition, the Dahlberg reports refer to specific medical procedures as "eventualities." (Exs. 6-14, C-12). In the federal trial, Mr. Dalhberg testified that although certain procedures set forth in his report (such as the tracheostomy revision and Baclofen pump) were only possibilities and/or elective procedures,[21] other procedures, including a rhizotomy, Drez procedure and decubitis ulcer repair would probably be necessary. (Ex. 7, pp. 77-79). Mr. Dalhberg further noted that the expected cost for surgical repair and

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[20] As set forth in Exhibits 12 and 15, claimant continues to bill OIGA for his attendant care on a monthly basis, and OIGA pays approximately $2,500 a month for such services.

[21] Insofar as the record establishes that certain procedures are a possibility, but not necessarily a probability, the carrier is not entitled to recover for the cost for these surgeries. See, e.g., Mona R. Skelton, 47 Van Natta 882 (1995).

hospitalization for a decubitus ulcer is approximately $30,000, the cost of a rhizotomy is between $10,000 and $15,000 and the cost of a Drez procedure is about $25,000. Id. Consequently, on this record, we are persuaded that it is reasonably certain OIGA will incur at least $62,500 in nonperiodic medical expenses over the course of claimant's life. We therefore include the $62,500 fund recommended by the Dahlberg report in calculating OIGA's lien.

In conclusion, based on the total projected annual cost for medical expenses set forth in Mr. Dahlberg's 1997 report ($52,948.75) a life expectancy for claimant of 16.75 years from February 28, 1997 (per Dr. Stark's opinion), and Dr. Evenson's calculations of present value, we conclude that the total present value of claimant's reasonably to be expected future medical costs (including future monthly permanent total disability benefits) as of March 1, 1997 is $895,596. (See Ex. A, Attachment 3, Table A). Accordingly, claimant is directed to pay OIGA this amount out of the proceeds of the third party judgment. In addition, claimant is directed to pay OIGA the sum of $543,028.51 (less the amounts paid in July 1995 and December 1997) for actual claim costs incurred through February 28, 1997.

IT IS SO ORDERED.

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March 9, 1998 Cite as 50 Van Natta 354 (1998)

In the Matter of the Compensation of
**MARTY R. BENTON, Claimant**
WCB Case Nos. 96-09863, 96-09862, 96-09861 & 96-02712
ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney
Mannix, Nielsen, et al, Defense Attorneys
Lundeen, et al, Defense Attorneys

Liberty, on behalf of employer CBI Logging, requests reconsideration and clarification of that portion of our February 12, 1998 order that neglected to specify which entity was responsible for the assessed attorney fee. Specifically, Liberty/CBI Logging asserts that because our order affirmed the Administrative Law Judge's (ALJ's) decision to uphold its denial of claimant's current low back condition, it should not be responsible for any portion of the assessed attorney fee. We agree.

Our February 12, 1998 order affirmed the ALJ's order that: (1) set aside Liberty/J.R. Turner denial of claimant's May 21, 1996 low back injury; (2) set aside Liberty/Independent Thinning, Inc.'s denial of claimant's September 4, 1995 low back injury; and (3) upheld the denials of SAIF Corporation and Liberty/CBL Logging, Inc. of claimant's current low back condition. Our order further assessed a $1,200 attorney fee against Liberty, without specifying which Liberty-insured employer.

On reconsideration, we find that claimant's attorney is entitled to an assessed fee for services on review under ORS 656.382(2), that a reasonable fee for claimant's attorney's services on review is $1,200, and that the fee is payable in equal portions by Liberty/J.R. Turner and Liberty/Independent Thinning, Inc.[1]

Accordingly, we withdraw our February 12, 1998 order. On reconsideration, as supplemented and modified 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.

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[1] Even though Liberty/Independent Thinning did not initiate the appeal, it did challenge the compensability of claimant's September 5, 1995 injury in its respondent's brief.

In the Matter of the Compensation of
**CHRISTOPHER L. CAMARA, Claimant**
Own Motion No. 97-0489M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Schneider Hooton, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests review of the insurer's November 18, 1997 Notice of Closure which closed his claim with an award of temporary disability compensation from July 1, 1997 through September 15, 1997. The insurer declared claimant medically stationary as of September 15, 1997. Claimant does not contend that he was not medically stationary when his claim was closed. Rather, claimant contends that he is entitled to temporary partial disability benefits from June 9, 1997 through September 15, 1997. Claimant further requests a penalty for the insurer's allegedly "unreasonable delay in the payment of his compensation."

Entitlement to Temporary Disability Benefits

Claimant contends that he is entitled to additional temporary disability benefits because his timeloss should be calculated from June 9, 1997, the date Dr. Puziss, claimant's treating physician, "specifically stated that [claimant] was precluded from all but sedentary work until such time as surgery was authorized and could be performed." Claimant underwent surgery on July 1, 1997. The Board is authorized to award temporary disability compensation to claimants whose compensable conditions have worsened requiring surgery or inpatient hospitalization. ORS 656.278(1)(a). This temporary disability compensation begins as of the date of actual surgery or hospitalization. Id. Inasmuch as we are not authorized to award temporary disability compensation prior to the date of surgery, we find that claimant is not entitled to additional temporary disability compensation.

Penalty

Claimant contends that his temporary disability compensation was due 14 days from the date of our October 28, 1997 Own Motion Order.[1] This would make the timeloss payment due on or before November 12, 1997.[2] The insurer paid temporary disability from July 1, 1997 through September 15, 1997, the medically stationary date, on November 13, 1997 when it closed the claim.

The insurer is required to make the first payment of temporary disability compensation within 14 days from the date of an order reopening the claim. OAR 438-012-0035. However, we have previously made the distinction between "prospective" and "retroactive" temporary disability for the purposes of establishing penalty guidelines when a carrier does not make timely payment of benefits. Lee R. Parker, 48 Van Natta 2473 (1996); Larry P. Karr, 48 Van Natta 2183 (1996); Jeffrey T. Knudson, 48 Van Natta 1708 (1996).

Because OAR 438-012-0035 does not make the distinction between "prospective" and "retroactive" temporary disability, we rely on OAR 436-060-0150(5)(h) which provides that timely payment of temporary disability means that payment has been made no later than 14 days from the date of any order which authorizes "retroactive" temporary disability becomes final; i.e., within 44 days from the date of its issuance. The rule further provides that temporary disability accruing from the date of the order ("prospective" TTD) shall begin no later than 14 days from the date of the order.

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[1] Claimant requested reconsideration of our October 28, 1997 order. On November 18, 1997, an Own Motion Order on Reconsideration was issued which withdrew the prior order, republished the order as supplemented, and granted appeal rights to run from the date of the order on reconsideration.

[2] November 11, 1997 is the actual 14th day counting from October 28, 1997. However, pursuant to OAR 436-060-0150(1) payments falling due on a weekend or legal holiday pursuant to ORS 187.010 and ORS 187.020 may be paid on the last working date prior to or the first working day following the weekend or legal holiday. Thus, counting from October 28, 1997, payment would be due on or before November 12, 1997 based on claimant's contention.

Here, claimant contends that his temporary disability benefits was due 14 days from the October 28, 1997 order.[3] However, on November 18, 1997, the October 28, 1997 Own Motion Order was withdrawn and reconsidered. Therefore, under such circumstances, payment would not be due until 44 days from the November 18, 1997 order on reconsideration. Inasmuch as the insurer paid claimant's temporary disability benefits on November 13, 1997, we do not find that the insurer unreasonably delayed payment of claimant's compensation. Therefore, a penalty is not warranted.

Accordingly, we affirm the insurer's November 13, 1997 Notice of Closure in its entirety.

IT IS SO ORDERED.

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[3] Because the temporary disability benefits accrued prior to our October 28, 1997 order, "retroactive" TTD would become due 14 days after the order became final. See OAR 436-060-150(5)(h).

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In the Matter of the Compensation of
**GAYLE A. WINK, Claimant**
WCB Case No. 97-00275
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order that upheld the insurer's denial of her low back 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 her low back condition is compensable as an accidental injury under ORS 656.005(7)(a). Claimant argues that her low back condition occurred during a short, discrete period, rather than over a long period of time. The employer, however, argues that the case is correctly analyzed as an occupational disease because there was no specific injury and the doctors who supported compensability reported that claimant's condition was due to repetitive activities. See 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).

We conclude, however, that it is not necessary to determine whether the "major"or "material" contributing cause standard applies in this case. For the reasons set forth in the ALJ's order, we find that, under either standard, claimant's claim for her low back condition is not compensable.

ORDER

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

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

On January 9, 1998, we abated our December 11, 1997 order that: (1) reversed that portion of the Administrative Law Judge's (ALJ's) order reducing claimant's scheduled permanent disability for loss of use or function of the left arm from 5 percent (9.6 degrees) to zero; (2) declined to award a penalty and attorney fee for allegedly unreasonable "de facto" denials; and (3) awarded an attorney fee. We abated our order to consider the self-insured employer's motion for reconsideration. Having received claimant's cross-request for reconsideration, claimant's response to the employer's request for reconsideration, and the employer's response/cross-reply, we proceed with our reconsideration.

Claimant has an accepted claim for "left elbow contusion." An Order on Reconsideration found that an epicondylitis condition was a "sequela" of the accepted condition and awarded 5 percent scheduled permanent disability based on impairment from the epicondylitis condition. The ALJ reasoned that, because epicondylitis was not an accepted condition, the award was "in error." The ALJ concluded that, in the absence of evidence showing impairment due to the accepted left elbow contusion condition, claimant failed to prove entitlement to scheduled permanent disability.

After reviewing the medical evidence, we found that the epicondylitis condition was a "direct medical sequela" of the original accepted condition. We further found that, based on impairment from the epicondylitis condition and ORS 656.268(16),[1] claimant was entitled to 5 percent scheduled permanent disability. We also awarded an "out-of-compensation" attorney fee and an assessed attorney fee for services at hearing concerning the scheduled permanent disability award.

In moving for reconsideration, the employer argues that, in order for claimant to be entitled to impairment based on the epicondylitis condition, he needed to first satisfy ORS 656.262(6)(d). The employer also challenges our finding that epicondylitis qualified as a "direct medical sequela" of the accepted condition.

Subsequent to our order on review, we issued Julio C. Garcia-Caro, 50 Van Natta 160 (1998), where 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 t he 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.

Here, we find that the preponderance of medical evidence shows that claimant's epicondylitis condition may be a "direct medical sequela" of the accidental injury, but the epicondylitis condition is not a "direct medical sequela" of the accepted condition of left elbow contusion. As discussed in our first order, this opinion was expressed by Dr. Browning and Dr. Tesar. Dr. Peterson, whose opinion we found persuasive in our first order, did state that the epicondylitis condition "arises from the accepted condition of left elbow contusion[.]" (Ex. 35C-B). Her report, however, does not distinguish between sequela of the accepted condition and the accidental injury. Furthermore, based on Dr. Browning's extensive contact with claimant as the treating physician, we find her opinion concerning this issue more persuasive than that of Dr. Peterson, who saw claimant one time.

Thus, having found that claimant failed to show that the epicondylitis condition is a "direct medical sequela" of the accepted left elbow contusion condition, we conclude that he is not entitled to impairment based on the epicondylitis condition. See ORS 656.268(16); Julio C. Garcia-Caro, 50 Van

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[1] ORS 656.268(16) provides: "Conditions that are direct medical sequelae to the original accepted condition shall be included in rating permanent disability of the claim unless they have been specifically denied."

Natta at 163.[2] Finally, we need not address the employer's contention concerning the attorney fee award because, having concluded that claimant is not entitled to scheduled permanent disability, claimant also is not entitled to an "out-of-compensation" attorney fee or assessed attorney fee for services at hearing.

We turn to claimant's cross-request for reconsideration. In his motion, claimant objects to that portion of our order that declined to assess a penalty. As he did on review, claimant contends that the employer was unreasonable in failing to accept or deny the conditions of bursitis and epicondylitis. Our order adequately addresses this argument and we see no need to further supplement our reasoning.

On reconsideration, we affirm the ALJ's May 9, 1997 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[2] In support of its motion for reconsideration, the employer offers several "post-hearing" documents, including a June 24, 1997 request from claimant's attorney to accept the epicondylitis condition, a July 28, 1997 Notice of Acceptance including epicondylitis, and an August 7, 1997 Notice of Closure awarding 5 percent scheduled permanent disability for the left arm. Generally, we consider submissions on review of "post-hearing" documents as a motion to remand. Because we agree with the employer, however, that claimant is not entitled to scheduled permanent disability in this proceeding, we need not consider whether remand is warranted.

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In the Matter of the Compensation of
**GLORIA HALL-LEFFLER, Claimant**
Own Motion No. 97-0300M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Industrial Indemnity, Insurance Carrier

Claimant requests review of the insurer's January 9, 1998 Notice of Closure which closed her claim with an award of temporary disability compensation from July 22, 1997 through December 23, 1997. The insurer declared claimant medically stationary as of December 23, 1997.

In her request for review, claimant goes into detail regarding her medical condition and requests that we "please review my claim and let me know how to proceed, in contesting the notice of closuer. [sic]" We assume that claimant is contending that she was not medically stationary at claim closure.

A claim may not be closed unless the claimant's condition is medically stationary. See OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he/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 9, 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).

In a January 27, 1998 letter, we requested the parties to submit copies of materials considered in closing the claim. Upon submission of these materials, claimant was allowed 15 days to submit additional materials. The insurer submitted its response on January 27, 1998, however, no further response has been received from claimant. Therefore, we will proceed with our review.

Claimant, contends that she has continued pain and cannot walk without the use of special shoes and a cane. Further, claimant contends that she will need "one or two more surgeries, to remive [sic] the screws and to fuse the mid-section of my foot. My other option is amputation." Claimant relies on these contentions to support her position that she was not medically stationary at the time of claim closure. The term "medically stationary" does not mean that there is no longer a need for continuing medical care. Maarefi v. SAIF, 69 Or App 527, 531 (1984). Rather, claimant bears the

burden of proving that there is a reasonable expectation that further or ongoing medical treatment would "materially improve" her compensable condition at claim closure. Lois Brimblecom, 48 Van Natta 2312 (1996).

Dr. Woll's, claimant's treating physician, prognosis of claimant's condition is determinative. In his December 23, 1997 chart note, Dr. Woll assessed that:

> "... I have advised her that she should go as long as possible with symptomatic treatment for this, show modifications, anti-inflammatories, possible occasional use of pain medication. ... I will see her back in 3-4 months to check her progress with that. Otherwise, at this point, the next step would be a transverse tarsal joint arthrodesis creating a pantalar fusion. She has been informed of the poor function of that. She was informed that at some point she may even want to consider an amputation. Certainly she is not ready for that at this point, ...".

Dr. Woll goes on to opine that "I do not believe that she [claimant] will be able to return to her previous employment, although she is medically stationary." Further, in a letter dated December 23, 1997, Dr. Woll, reasserts that: "She [claimant] is at a point where I would declare her medically stationary. If she has an exacerbation, her claim would need to be reopened and we could possibly schedule her for a fusion of the transverse tarsal joint." These opinions are unrebutted.

Based on the uncontroverted medical evidence, we find that claimant has not met her burden of proving that she was not medically stationary on the date her claim was closed.[1] Therefore, we conclude that the insurer's closure was proper.

Accordingly, we affirm the insurer's January 9, 1998 Notice of Closure in its entirety.

IT IS SO ORDERED.

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[1] Should claimant's compensable condition subsequently worsen 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).

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March 12, 1998 Cite as 50 Van Natta 359 (1998)

In the Matter of the Compensation of
**MICHAEL C. LEGGETT, Claimant**
WCB Case No. 96-07715
ORDER OF ABATEMENT
Popick & Merkel, Claimant Attorneys
VavRosky, et al, Defense Attorneys

On February 11, 1998, we 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. Contending that our reconsideration of a companion case, Michael C. Leggett, WCB No. 96-04719, 50 Van Natta 151, 264 (1998) which was abated at the employer's request, is likely to affect our deliberations concerning the claim closure in this case, claimant seeks abatement and reconsideration of our February 11, 1998 order.

In order to further consider this matter, we withdraw our February 11, 1998 order. Following the issuance of our Order on Reconsideration in WCB Case No. 96-04719, the following supplemental briefing schedule shall be implemented. Claimant's opening supplemental brief must be filed within 14 days from the date of our Order on Reconsideration in WCB Case No. 96-04719. The self-insured employer's supplemental response must be filed within 14 days from the date of mailing of claimant's brief. Claimant's supplemental reply must be filed within 14 days from the date of mailing of the employer's response. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
**BLAINE P. HOSEY, Claimant**
WCB Case No. 97-01164
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board en banc.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) affirmed the temporary disability rate calculated by the SAIF Corporation; and (2) declined to assess a penalty for SAIF's allegedly unreasonable claim processing. On review, the issues are jurisdiction, rate of temporary disability, and penalties. We modify.

## FINDINGS OF FACT

Claimant was employed at Donna Avery Company during the month of October 1994. On October 28, 1994, claimant sustained a compensable, disabling injury to his left knee. Time loss benefits were paid.

Claimant's time loss benefits were originally calculated and paid based upon a 3.8 week work period wherein claimant earned $12.51 per hour for certain work; $10.00 per hour for other work; a subsistence allowance of $18.00 per day; and an $.89 per hour fringe benefit. Time loss benefits were calculated on a wage of $626.00 per week.

Claimant actually worked four weeks in October 1994 (Tr. 16), earning gross wages of $1,249.49 for the period October 3-14, based on $998.29 for hourly work, plus $180 subsistence, plus $71.20 fringe benefits (Ex. 38), and $1,289.45 for the period October 17-31, based on $988.25 for hourly work, plus $180 subsistence, plus $71.20 fringe benefits (Ex. A). Claimant's total gross wages for the month of October 1994 were $2,488.94.

A Notice of Closure issued September 26, 1996, awarding periods of temporary disability (November 1, 1994 through March 6, 1996 and May 15, 1996 through August 20, 1996), as well as scheduled permanent disability for the left knee. (Ex. 27-1). The Notice of Closure did not indicate the rate at which temporary disability would be paid. However, it included a statement authorizing deduction of overpaid disability benefits.

Subsequent to claim closure, a claim audit determined that claimant had been paid wages amounting to a total of $818.29 for the time he was employed by this employer. A recalculation of time loss benefits based upon the $818.29 wage resulted in an overpayment of some $23,000.00.

On October 23, 1996, claimant was notified of SAIF's determination of the amount of overpayment, as well as what SAIF believed to be the correct time loss rate. (Exs. 32, 33 at 1-2). Claimant's attorney was also advised of the amount of overpayment SAIF intended to recover. (Ex. 33 at 1-2).

On October 30, 1996, claimant, through his counsel, requested reconsideration of the Notice of Closure. (Ex. 35). Claimant identified an issue regarding the dates of temporary disability, but did not specifically identify an issue regarding the rate of temporary disability. (Id.).

An Order on Reconsideration issued January 6, 1997, awarding additional days of temporary disability (October 29 through October 31, 1994), as well as additional scheduled permanent disability. (Ex. 40).

On February 4, 1997, SAIF notified claimant of the amount of overpayment that would be recouped from the permanent disability award, resulting in no additional payment to claimant. (Ex. 41).

On February 5, 1997, claimant requested a hearing, raising the issues of rate of temporary disability and amount of overpayment. (See Administrative Record; see also Tr. 2-3).

## CONCLUSIONS OF LAW AND OPINION

### Jurisdiction

Both parties contend that the ALJ lacked jurisdiction to address the temporary disability rate issue because the issue was not raised on reconsideration. We disagree.

We have previously held that when a temporary disability rate issue arises out of claim closure, the rate issue cannot be addressed at hearing if it was not first raised on reconsideration. See William T. Masters, 48 Van Natta 1788 (1996). In subsequent decisions, we have held that when the rate of disability, whether temporary or permanent, has been manifest in the closure document, the rate issue cannot be raised at hearing unless it was first raised on reconsideration. See Benjamin G. Santos, 49 Van Natta 1429 (1997); Ferral C. Crowder, 48 Van Natta 2322 (1996) (In both cases, PPD rate was manifest in DO; therefore, PPD rate must be raised at reconsideration to preserve the issue for hearing). However, where the rate issue arises out of the reconsideration process itself, there is no statutory preclusion to raising the rate issue at hearing. Jose L. Villegas, 49 Van Natta 1128, on recon 49 Van Natta 1571 (1997).

Here, the temporary disability rate was not manifest in the Notice of Closure. SAIF merely awarded certain dates of temporary disability and indicated that deduction of overpaid disability benefits was allowed. (Ex. 27). However, the September 26, 1996 Notice of Closure did not indicate that temporary disability would be paid at any different rate from that previously paid. Rather, the rate issue arose in the course of an audit SAIF conducted separate from and following closure. Claimant and his attorney received notice of the recalculated rate by separate letters dated October 23, 1996. (Exs. 32, 33). Under such circumstances, we find that the temporary disability rate issue did not arise out of the Notice of Closure.[1] Therefore, we find that it was not necessary to raise the temporary disability rate issue at reconsideration in order to preserve the issue at hearing. See ORS 656.283(7).[2] Accordingly, we conclude that the ALJ had jurisdiction to address the temporary disability rate issue.

To the extent our holding is inconsistent with our decision in William T. Masters, we disavow our holding in Masters. We hold, instead, consistent with our decisions in Santos and Crowder, that a rate issue must be raised on reconsideration only when the rate is apparent from the closure document itself. On the other hand, where, as here, the temporary disability rate issue is not apparent in the closure document itself, the rate issue need not be raised on reconsideration in order to preserve the right to request a hearing on that issue.

### Rate of Temporary Disability

The ALJ held that SAIF had correctly recalculated claimant's time loss rate. Claimant contends that SAIF's initial calculation was correct or, alternatively, that claimant is entitled to time loss based on an average weekly wage of $622.24.

Pursuant to ORS 656.210(5)(c), the Director may prescribe rules for establishing a worker's weekly wage when a worker's remuneration is not based solely on daily or weekly wages. Workers who sustain an injury are entitled to benefits based on the worker's wage at the time of injury. ORS 656.210(2)(b)(A); former OAR 436-60-025(1). The Director's rule in effect at the time of claimant's injury provided, in material part:

> "The rate of compensation for workers regularly employed, but paid on other than a daily or weekly basis * * * shall be computed on the wages determined by this rule. * * *.

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[1] Because the rate issue arose out of a separate audit following claim closure, we do not find that the rate issue arose out of the reconsideration process itself. Therefore, our decision in Jose L. Villegas does not govern our decision in this case.

[2] 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).

> "(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. * * *. 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." Former OAR 436-60-025(5).

A worker's wage is defined as follows:

> "Wages means the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident, including reasonable value of board, rent, housing, lodging or similar advantage received from the employer[.]" ORS 656.005(29).

Here, claimant worked four weeks for the employer, from Monday, October 3, 1994 through Friday, October 28, 1994. (Tr. 16). There is no evidence that claimant worked any additional weeks for this employer during the 52 weeks preceding claimant's injury. Therefore, temporary disability benefits are to be based on the actual weeks of employment with the employer at injury in October 1994. Consequently, claimant's temporary disability benefits are to be based on his wage during October 1994.

According to the employer, claimant earned a total of $818.29 gross wages for the month of October 1994. (Ex. 34). Claimant contends that his gross wages for the month of October 1994 totaled $2,488.94; therefore, his average weekly wage for the four weeks worked is $622.24. We agree with claimant.

We find claimant's evidence regarding his wages more persuasive than the employer's evidence. Claimant relied on his employer's handwritten summary of wages for the period October 3-14, and a "timecard" prepared by the employer documenting wages earned for the period October 17-31, 1994. (Exs. 38, A; Tr. 18, 47). The documented information is consistent with claimant's explanation that he earned $12.51 per hour to run certain equipment and $10 per hour for mechanic work, plus $18 per day "subsistence" for the inconvenience of living in the woods, plus 89 cents per hour fringe benefits. (Tr. 11-12). It is also consistent with the wage information the employer initially reported on the 801 form. (Ex. 3).

On the other hand, the wage information SAIF relies on consists solely of the employer's handwritten note, dated October 27, 1996, indicating that claimant's gross wage for the month of October 1994 was $818.29. The employer provided no supporting documentation for this letter, nor was the employer available for cross-examination regarding the contents of the letter. Furthermore, the employer's October 27, 1996 letter is inconsistent with its earlier statements regarding claimant's wage. (Compare Exs. 3, 38). Finally, the employer's letter appears to be internally inconsistent as well. The employer acknowledges that claimant earned $12.51 per hour for operating a hoe and $10 per hour for mechanic work. (Ex. 34). Thus, claimant's gross wage of $818.29 would represent only 65-80 hours of work for the month of October 1994. However, there is no evidence that claimant worked less than 40 hours per week, or that he worked less than four weeks prior to his injury. (See Tr. 14, 21). Under such circumstances, we find the documentation claimant relies on to be more persuasive than the documentation SAIF relies on.

Accordingly, we find that the persuasive evidence establishes that claimant was paid gross wages of $1,249.49[3] for the period October 3-14, 1994, and $1,239.45[4] for the period October 17-31, 1994, for a total gross wage of $2,488.94[5] for the month of October 1994. (See Exs. A, 38). Since

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[3] Claimant's gross wage is calculated as follows: $998.29 for hourly work, plus $180 subsistence ($18 per day x 10 days), plus $71.20 fringe benefits ($.89 per hour x 80 hours). (Ex. 38).

[4] Claimant's gross wage is calculated as follows: $988.25 for hourly work, plus $180 subsistence, plus $71.20 fringe benefits. (Ex. A).

[5] We include claimant's "subsistence" payments in his wage because we find that, in this case, the subsistence payments represent the reasonable value of housing "or similar advantage received from the employer." ORS 656.005(29). (See Tr. 14-15).

claimant actually worked four weeks during this period, the average weekly wage is $622.24 ($2,488.94 divided by 4). Therefore, SAIF is directed to calculate claimant's temporary disability benefits based on an average weekly wage of $622.24, rather that the $626 average weekly wage it had initially calculated. Thus, SAIF has established an overpayment in the aforementioned amount, which it may recover from claimant's current and future compensation awards in the manner prescribed in ORS 656.268(13) and (15).

Penalties

Claimant seeks a penalty for SAIF's allegedly unreasonable claims processing for continuing to insist upon a reduced temporary disability rate after receiving information from claimant regarding his wages.

The carrier shall be liable for penalties when it "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(11)(a). Deciding if a carrier acted unreasonably depends on whether, in light of all the evidence available to it, the carrier had a legitimate doubt as to its liability. Brown v. Argonaut Ins. Co., 93 Or App 588, 590 (1988).

Here, although SAIF may have received information from claimant regarding his wages during the period in question, SAIF also had information from the employer that indicated that claimant's temporary disability benefits should be calculated on the basis of a gross wage of $818.29 for the month of October 1994. Because SAIF had conflicting information, it had a legitimate doubt as to its liability regarding claimant's temporary disability rate. See Brown, 93 Or App at 592 (continued denial becomes unreasonable only if new evidence destroys any legitimate doubt about liability). Accordingly, we conclude that claimant is not entitled to a penalty.

Attorney Fees

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

ORDER

The ALJ's order dated May 9, 1997 is modified. Claimant is awarded temporary disability benefits based on an average weekly wage of $622.24. To the extent this order creates an overpayment, offset is authorized. Claimant's counsel is awarded an out-of-compensation attorney fee equal to 25 percent of the increased compensation created by this order, if any; the attorney fee is not to exceed $3,800.

**Board Member Moller concurring in part and dissenting in part.**

I agree with the majority opinion to the extent that the opinion finds that we have jurisdiction to review the issue of rate of temporary disability benefits. However, I do not agree with the majority's resolution of that issue.

The majority found that there was no evidence that claimant worked less than 40 hours per week, or that he worked less than four weeks prior to his injury. First, such a finding impermissibly shifts the burden of proof. Moreover, the record does show that claimant worked less than a 40 hour week. Specifically, claimant testified that he "came up" to the job on Monday morning, which required a four hour drive from his home. Tr. 12, 13. Claimant further testified that "most of the day Tuesday I didn't work" because he "had to go back home because [he] had meetings [he] was going to." He then drove the four hours back up again on Wednesday. Finally, claimant testified that they quit at noon on Fridays and did not work on Saturday and Sunday. Tr. 12.

Under the circumstances, because the record shows that claimant most likely worked a full day on Thursdays only, I disagree with the majority's conclusion that claimant worked a 40 hour week. Claimant's testimony, therefore, supports the calculation documents submitted by SAIF. (Exs. 34, 42).

Finally, the majority relies on Ex. 38 to find that claimant was paid wages for a two week period in Ocotber 1994. However, at hearing, the claims auditor testified that Ex. 38 reflected that the employer "plugged all of the monies (claimant) earned into this two-week period....". Tr. 32. Accordingly, Ex. 38 shows payment for the entire period of time claimant worked, rather than just payment for two weeks out of four. This is consistent with the Oregon Employment Department wage statement included in the record as Exhibit 42.

In sum, I do not disagree with the majority's finding regarding inclusion of claimant's fringe benefits, subsistence pay and fuel reimbursement, see ORS 656.005(29) in calculating claimant's temporary disability benefits. Nevertheless, I believe that the majority errs in departing from the tax-reported wages in the record and for that reason, I respectfully dissent from the majority's decision on the merits of this case.

**Board Member Haynes dissenting.**

ORS 656.283(7) provides that issues not raised by a party to the reconsideration may not be raised at hearing unless the issue arises out of the reconsideration order itself. Therefore, the issue in this case is whether SAIF's alleged overpayment, which resulted from its recalculation of claimant's temporary disability rate, is "an issue regarding a notice of closure."

I disagree with the majority's conclusion that we have jurisdiction over this case. The majority holds that a rate issue must be raised on reconsideration only when the rate is apparent from the closure document itself. The majority also finds that there was no need to raise the issue on reconsideration in this case, because the rate issue was not apparent in the closure document.

I believe that the majority's conclusion is inconsistent with our prior holdings in cases involving the rate of permanent disability awards. For example, in Ferral C. Crowder, 48 Van Natta 2322 (1996), we held that, because the claimant had not challenged the rate of his unscheduled permanent disability award (granted by Determination Order) during the reconsideration proceeding, he was precluded from raising the issue at hearing. In Crowder, we concluded that the Determination Order specified a dollar amount that was equivalent to a rate of $100 per degree. Consequently, because it was apparent that the claimant's unscheduled award had been calculated at a certain rate, we held that it was incumbent on the claimant to have raised his objection during the reconsideration proceeding. Also see Benjamin G. Santos, 49 Van Natta 1429 (1997).

Here, a September 26, 1996 Notice of Closure provided that, "[d]eduction of overpaid disability benefits (whether from changes in rate or duration of temporary disability or from permanent disability) is allowed." (Ex. 27-1)(emphasis supplied). In addition, pursuant to two October 23, 1996 letters, SAIF notified claimant that it had incorrectly calculated his time-loss rate at $442.21 per week, whereas the correct rate had been determined to be $152.12. SAIF further explained that this rate was based on a weekly wage of $215.34. In the event that he disagreed with these calculations, claimant was requested to contact SAIF as soon as possible. (Ex. 32). Additionally, the second letter sent to claimant refered to the September 1996 NOC and provided that there had been an overpayment of time loss benefits, and such amounts already received had been deducted from the balance due. (Ex. 33).

There is no contention that claimant neither received SAIF's letter announcing its recalculations nor its letter notifying claimant of its overpayment. (Ex. 33). To the contrary, on November 4, 1996, SAIF sent a letter to claimant's attorney regarding the basis for its calculations of claimant's average weekly wage which was expressly in response to claimant's attorney's "October 29, 1996 request."

On October 30, 1996, one day after the "October 29, 1996" request, claimant's attorney signed a Request for Reconsideration, which was filed with the Department on October 31, 1996. Although requested to identify "specific disagreements with the claim closure," claimant did not register any objection to the rate of his temporary total disability benefits. Instead, he checked the box on the "reconsideration" form that disagreed with the "temporary total disability dates" shown on the Notice of Closure.

Inasmuch as claimant's attorney's "October 29, 1996 request" to SAIF preceded the October 30, 1996 reconsideration request to the Department, it is apparent that claimant was aware of SAIF's TTD rate re-calculation and its intention to offset this "overpayment" against his present and future compensation awards before he filed his request for reconsideration. In the absence of this "pre-reconsideration" correspondence regarding the calculation of his TTD rate, I may well have concurred

with the majority's conclusion that the "TTD rate" issue was not raisable during the reconsideration proceeding. Nonetheless, because the record establishes that claimant was notified of SAIF's re-calculation prior to the filing of his reconsideration request, it was incumbent on claimant to have raised his objection during the reconsideration proceeding. Because claimant neglected to do so, I would find that he was barred from challenging the rate issue at hearing. Consequently, I respectfully dissent from the majority opinion.

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March 11, 1998 Cite as 50 Van Natta 365 (1998)

In the Matter of the Compensation of
**GLENN E. McKELVY, Claimant**
WCB Case Nos. 96-07933 & 96-03745
ORDER ON REVIEW
Robert E. Nelson, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Aetna Casualty Co., on behalf of its insured, Americo Inc., requests review of that portion of Administrative Law Judge (ALJ) Mills' order that set aside its denial of claimant's injury claim for lumbar stenosis. Claimant cross-requests review of that portion of the ALJ's order which upheld the SAIF Corporation's denial of her injury claim for upper and lower back conditions on behalf of Reach Community Development. On review, the issues are compensability and (potentially) responsibility. We affirm in part and reverse in part.

## FINDINGS OF FACT

We adopt the ALJ's "findings of fact" with the following addition. The March 3, 1996 motor vehicle accident that occurred during the course of claimant's employment for SAIF's insured was the major contributing cause of claimant's disability and need for treatment for cervical, thoracic and lumbar strains.

## CONCLUSIONS OF LAW AND OPINION

### Aetna's Denial

On June 24, 1981, claimant sustained a compensable left foot injury when he fell off a ladder. Claimant subsequently underwent multiple surgeries and developed an altered gait. This later resulted in middle and low back pain. Aetna denied the mid and low back conditions, which prompted claimant to request a hearing.

In September 1988, a hearing was held to determine the compensability of claimant's back conditions. By Opinion and Order of October 19, 1988, a prior ALJ found that claimant's low back condition, diagnosed as a postural low back pain (Ex. 19), was compensable. However, the ALJ determined that claimant's mid back condition, including degenerative disc disease, was not compensable. (Ex. 21).

In January 1989, Dr. Grewe, a neurosurgeon, became claimant's attending physician. Although Dr. Grewe proposed surgery in 1990, claimant continued to receive conservative treatment. In October 1995, Dr. Grewe again requested authorization for surgery after a myelogram and CT scan revealed a disc herniation at L4-5 and spinal stenosis. Aetna denied the stenosis condition and related surgery on March 14, 1996. (Ex. 60). Claimant requested a hearing.

After determining that the Hearings Division retained jurisdiction to decide the compensability issue, see SAIF v. Shipley, 147 Or App 26 (1997),[1] the ALJ set aside Aetna's denial, finding that claimant's underlying back condition continued to be a compensable claim against Aetna. On review,

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[1] No party contests the ALJ's finding that the Hearings Division had jurisdiction over Aetna's denial. In any event, the ALJ was authorized to resolve the dispute regarding the compensability of the underlying claim. See Jacqueline Rossi, 49 Van Natta 1184, on recon 49 Van Natta 1844 (1997).

Aetna contends that claimant's lumbar stenosis was never a part of the compensable 1981 injury claim. Aetna asserts that it was only responsible for a postural low back condition as a result of the 1988 litigation and that claimant failed to prove that the lumbar stenosis condition is a compensable consequence of the 1981 injury under ORS 656.005(7)(a)(A).

We need not determine the scope of Aetna's acceptance. That is, even assuming Aetna's acceptance of the 1981 injury claim did not encompass the stenosis, we agree with the ALJ's reasoning that Dr. Grewe's opinion established that claimant's 1981 injury is the major contributing of the stenosis condition. Thus, we conclude that the stenosis condition is a compensable consequential condition under ORS 656.005(7)(a)(A).

SAIF's Denial

On March 3, 1996, claimant was involved in a motor vehicle accident (MVA) in the course of his employment with SAIF's insured. On May 3, 1996, claimant sought treatment from an emergency room physician, Dr. Laub, who diagnosed a lumbosacral strain following the MVA. (Ex. 63 AB). Dr. Grewe diagnosed a sprain/strain of the cervical, mid-thoracic and lumbar spine superimposed upon disc prominence and facet arthritis at L4-5 and L5-S1. (Ex. 63AC). Claimant filed a workers' compensation claim with SAIF based on the MVA. (Ex. 63AF). SAIF denied the claim on the ground that claimant's work activity was not the major contributing cause of a "lumbar sprain/strain." (Ex. 66). Claimant was advised to file separate claims against other potentially responsible employers or insurers. Id. Claimant requested a hearing regarding SAIF's denial. The matter was consolidated with the Aetna claim.

At the hearing, SAIF's counsel orally amended the denial to include the "upper back." (Tr. 2). Neither Aetna nor claimant objected to the amendment.

The ALJ found that claimant did not sustain a new injury as a result of the MVA. Although finding that the MVA had combined with a "preexisting condition," the ALJ concluded that the medical evidence did not establish that the MVA was the major contributing cause of claimant's disability or need for treatment. See ORS 656.005(7)(a)(B). In reaching this conclusion, the ALJ determined that Dr. Grewe's medical opinion only established that the MVA was the "precipitating" factor in claimant's disability and need for treatment for the MVA.

On review, claimant contends that the ALJ improperly allowed SAIF to orally expand its denial to include the upper back. Claimant also asserts that the ALJ should have set aside SAIF's denial because the MVA was the major contributing cause of treatment and disability for a "combined condition" for seven or eight months after the accident. For the following reasons, we find that claimant did establish a new injury claim as a result of the MVA.[2]

First, we agree with the ALJ that the medical evidence establishes that claimant's injury resulting from the MVA combined with preexisting degenerative disease and claimant's prior back condition to cause or prolong disability. (Exs. 68-3, 69-15). Therefore, we also agree that compensability is determined under ORS 656.005(7)(a)(B).[3] However, unlike the ALJ, we conclude that a preponderance of the medical evidence proves that the injuries from the March 1996 MVA were the major contributing cause of claimant's disability or need for treatment for the combined condition.

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[2] We reject claimant's contention that the ALJ improperly allowed SAIF to expand its denial to include the "upper back." Because claimant's counsel did not object to SAIF's oral amendment of its denial to include the upper back, we find that claimant implicitly agreed to litigate an issue outside the express terms of the denial. See Alan T. Spaeth, 48 Van Natta 1585, 1588 n. 1 (1996) (Given the lack of objection to a carrier's attempt to raise a compensability defense, an implied agreement existed to try a compensability issue); Michael A. Beall, 48 Van Natta 487, 487 (1996) (where the parties tried the issue of whether the claimant's injury occurred in the course of his employment by implicit agreement, i.e., without objection, the issue was properly before the ALJ).

[3] ORS 656.005(7)(a)(B) provides:

"If an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or 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."

Dr. Grewe is claimant's attending physician. He opined in June 1996 that claimant's temporary disability and increase in medication usage was the result of the MVA. (Ex. 65-1). Dr. Grewe was subsequently deposed. There, Dr. Grewe opined that, while pathology that preexisted the March 1996 MVA was primarily the major contributing cause of claimant's disability and need for treatment, this was not true for seven or eight months after the MVA. (Ex. 69- 16, 21). Finding no persuasive reasons not to rely on Dr. Grewe's medical opinion, we find that it establishes that claimant sustained a new compensable injury as a result of the March 1996 MVA.[4] See Weiland v. SAIF, 64 Or App 810 (1983).

Claimant's attorney is entitled to an assessed fee for services at hearing and on review regarding SAIF's denial. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review regarding SAIF's denial is $3,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to SAIF's denial (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's attorney is also entitled to an assessed fee for services on review regarding the compensability of his lumbar stenosis. 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 lumbar stenosis issue is $1,500, payable by Aetna. 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 June 16, 1997 is reversed in part and affirmed in part. That portion that upheld SAIF's denial of claimant's upper and low back conditions is reversed. SAIF's 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 $3,000, to be paid by SAIF. The remainder of the ALJ's order is affirmed. For services on review regarding the lumbar stenosis issue, claimant's counsel is awarded an assessed fee of $1,500, to be paid by Aetna.

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[4] We find additional support for this conclusion in Dr. Laub's opinion that claimant sustained a lumbosacral strain after the MVA. (Ex. 63AB). Moreover, Dr. Zivin, an examining physician, also opined that claimant sustained a low back strain as a result of the MVA. (Ex. 68-3). While Dr. Zivin believed that the strain was never the major contributing cause of the need for treatment or disability, we find his opinion to be conclusory. Id. Under such circumstances, we find no reason to prefer Dr. Zivin's opinion over that of the attending physician, Dr. Grewe. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980) (conclusory and unexplained medical opinion rejected). Finally, unlike the case SAIF cites, Anselmo Perez, 48 Van Natta 71 (1996), where we found that the claimant did not sustain his burden of proof under ORS 656.005(7)(a)(B), we find that, in this case, claimant has proved the compensability of his "combined condition" because a preponderance of the medical evidence establishes that the MVA was the major contributing cause of that condition during the "post-MVA" recovery period.

In the Matter of the Compensation of
**AMY L. MELQUIST, Claimant**
WCB Case No. 96-02930
ORDER ON REVIEW
Hollander, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that upheld the self-insured employer's denial of her left chest, arm and shoulder injury claim. The employer cross-requests review and requests that sanctions be granted for claimant's allegedly frivolous appeal. On review, the issues are compensability and sanctions.

We adopt and affirm the ALJ's order with the following supplementation regarding the insurer's request for sanctions on review.

On review, the employer notes that the ALJ found claimant not credible based on her demeanor. The employer argues that, since the Board generally defers to an ALJ's credibility findings, particularly those based on demeanor, it follows that claimant did not have a reasonable prospect of prevailing on the merits of her appeal. Therefore, the employer argues that the Board should find claimant's request for review frivolous and award sanctions pursuant to ORS 656.390. We disagree.

ORS 656.390(1) allows the Board to impose an appropriate sanction against an attorney who files a frivolous request for or review. "'[F]rivolous' means the matter is not supported by substantial evidence or the matter is initiated without reasonable prospect of prevailing." ORS 656.390(2); see Westfall v. Rust International, 314 Or 553, 559 (1992) (defining "frivolous" under former ORS 656.390).

Here, claimant's request for review was not frivolous. We find that her request raised arguments that were sufficiently developed so as to create a reasonable prospect of prevailing. See Gerard R. Schiller, 48 Van Natta 854 (1996). We agree that, when the ALJ makes specific findings on credibility based upon attitude, appearance and demeanor, great weight and deference should be given to the ALJ. Bush v. SAIF, 68 Or App 230, 233 (1984). However, we are not statutorily mandated to accept the ALJ's credibility findings. Erck v. Brown Oldsmobile, 311 Or 519, 526 (1991).

Thus, while we generally defer to demeanor based credibility findings, we are not compelled to do so. In this regard, we have de novo review in this matter. Here, after our review of the entire record and consideration of the parties' arguments, we agree with the ALJ's findings and conclusions. On the other hand, claimant made colorable arguments on the evidence regarding compensability of her injury claim. Under these circumstances, we deny the employer's request for sanctions based on claimant's request for review.

ORDER

The ALJ's order dated June 27, 1997 is affirmed. The self-insured employer's request for sanctions on review is denied.

In the Matter of the Compensation of
**MARGARET A. REDINGER, Claimant**
WCB Case Nos. 97-03730 & 97-03729
ORDER ON REVIEW
Mannix, Nielsen, et al, Claimant Attorneys

Reviewed by Board Members Hall and Moller.

Claimant, pro se, requests review of those portions of Administrative Law Judge (ALJ) Brazeau's order that: (1) upheld the self-insured employer's denial of her consequential condition claim for a left shoulder condition; (2) upheld the employer's denial of her current right shoulder condition; and (3) upheld the employer's denial of her left shoulder injury claim. With her "brief," claimant has attached a copy of a September 15, 1997 written statement by a co-worker, a November 21, 1997 "post-hearing" medical report from Dr. Stewart, and a facsimile cover sheet and medical release. We treat such submissions as a motion to remand to the ALJ for the introduction of additional evidence. See ORS 656.295(5); Judy A. Britton, 37 Van Natta 1262 (1985); Ellen G. Johnson, 49 Van Natta 1360 (1997). On review, the issues are remand and compensability.

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

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

Here, claimant has offered no reason why the submitted materials were unobtainable with due diligence at the time of the September 15, 1997 hearing. Furthermore, we are not persuaded that the proffered evidence would likely affect the outcome of the case. That is, even if we considered the documents that claimant submitted, we would still agree with the ALJ that claimant failed to establish the compensability of bilateral shoulder conditions. Therefore, we conclude that the record was not improperly, incompletely, or otherwise insufficiently developed or heard by the ALJ and, therefore, we decline to remand the case to the ALJ for additional proceedings.

ORDER

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

In the Matter of the Compensation of
**RICHARD A. REGEHR, Claimant**
Own Motion No. 98-0063M
OWN MOTION ORDER

The self-insured employer has submitted claimant's request for temporary disability compensation for claimant's compensable fractured pelvis, contusion right hip and left acetabular fracture injury. Claimant's aggravation rights expired on July 18, 1993. The employer 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).

The employer contends that claimant was not in the work force at the time of the current disability. Claimant has not responded to the employer's contention.[1] 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] On February 9 and March 6, 1998, we requested work force information from both the employer and the claimant. The employer responded by letter dated March 5, 1998. To date, no response has been received from the claimant.

In the Matter of the Compensation of
**STEVEN L. THOMAS, Claimant**
WCB Case No. 97-00490
ORDER ON REVIEW
Mitchell & Associates, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Hall and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Neal's order that upheld the self-insured employer's denial of his right wrist injury claim. Claimant also requests that this matter be remanded to the ALJ for the taking of additional evidence. On review, the issues are remand and compensability. We reverse.

## FINDINGS OF FACT

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

Claimant struck his right wrist against a wood chipper at work on September 13, 1996. That accident was at least a material contributing cause of claimant's right wrist injury, variously diagnosed as internal derangement or triangular fibrocartilage complex injury, and the resultant need for treatment.

## CONCLUSIONS OF LAW AND OPINION

The ALJ held that claimant did not carry the burden of proving his injury claim for a right wrist condition diagnosed as internal derangement. In particular, the ALJ found that claimant was not a credible witness, and concluded that Dr. Gritzka's opinion, which supported the claim, was unpersuasive because it was based on claimant's unreliable history. On review, claimant challenges the ALJ's credibility finding and contends that he carried his burden of proof. We agree and reverse.[1]

We generally defer to the ALJ's determination of credibility, when it is based on the ALJ's opportunity to observe the witness; however, when the ALJ's credibility determination is based not on demeanor, but on an objective evaluation of the substance of the witness' testimony, we may reach our own independent determination of credibility. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987). Here, the ALJ's credibility determination was based on alleged inconsistencies involving the substance of claimant's testimony. Therefore, the ALJ's determination is not entitled to deference and we may reach our own determination based on the record.

After reviewing the record, we disagree with the ALJ's evaluation of the substance of claimant's testimony. The ALJ incorrectly stated that claimant denied having some snapping and popping in the right wrist prior to the alleged September 13, 1996 incident. (O&O, p. 2). Claimant in fact testified that his right wrist snapped and popped prior to September 1996, though not as much as it did after the alleged September 13 incident. (Tr. 17-18).

The ALJ also stated that claimant's testimony denying problems with his left wrist was inconsistent with his documented complaint of bilateral wrist pain to Dr. Reilly in December 1996. (O&O, p. 2). However, claimant explained that, after he complained to Dr. Reilly of bilateral wrist pain in December 1996, the left wrist pain "went away." (Tr. 19). He testified that his left wrist was "fine" at the time of hearing. (Tr. 18). Thus, claimant's testimony is consistent with the medical records showing that he had left wrist pain in December 1996, but that it had subsequently subsided.

The ALJ next stated that claimant testified that he had reported the September 13, 1996 accident to his foreman, but that claimant's testimony was contradicted by his foreman's testimony that claimant had not reported any work accident. However, claimant testified that he did not report the September 13 accident to his foreman because he thought that the right wrist pain was "no big thing" and would not require a doctor's attention. (Tr. 20). Claimant testified that he simply told his foreman: "I hurt

[1] We ordinarily would address a motion to remand before reaching the merits of the claim. However, given our ultimate conclusion that claimant's claim is compensable based on the current evidentiary record, we do not need to address claimant's motion to remand this matter for further supplementation of the record.

it." (Id.) The foreman, Mr. Johnson, testified that when he saw claimant with a right wrist brace and asked him what happened, claimant said: "I hurt it." (Tr. 6). Thus, claimant's testimony in this regard was entirely consistent with, and corroborated by, the testimony of his foreman.

The ALJ further stated that claimant's testimony that he had reported a work-related injury involving his right wrist to Dr. Ekholm on September 16, 1996, was contradicted by Dr. Ekholm's chart note which does not mention any wrist complaint or work injury. (O&O, pp. 2-3). We find a reasonable explanation for the discrepancy between claimant's testimony and Dr. Ekholm's chart note. Claimant testified that he saw Dr. Ekholm specifically for an ear infection. (Tr. 11). He further testified that when the doctor asked about his right wrist brace, he told the doctor that he hurt it at work. (Tr. 12). He also testified, however, that he told the doctor that he was not seeking treatment for the wrist, and that he fully anticipated that his wrist condition would improve with the passage of time. (Tr. 12-13). It appears, therefore, that claimant downplayed the seriousness of his wrist condition to Dr. Ekholm and declined medical attention for the wrist. Under these circumstances, we conclude that it was reasonable for the doctor not to mention the wrist condition or the reported work accident in the chart note. Furthermore, because there is no evidence in the record directly refuting claimant's testimony that he reported his wrist injury to Dr. Ekholm on September 16, 1996, we conclude that his testimony on this point is persuasive.

As additional support for her credibility finding, the ALJ noted the absence of any documented report of a work accident or injury occurring on September 13, 1996 until claimant saw Dr. Reilly on November 25, 1996, (Ex. 2), a few weeks after he was laid off from his job. We are persuaded, however, that claimant provided a reasonable explanation for the reporting delay. He explained that he did not believe his wrist condition was serious enough to require a doctor's attention and that he self-treated the wrist (with tape, gauze, and wrist brace) with the expectation that it would resolve over time. (Tr. 12-13). He added that he does not go to a doctor unless he absolutely has to go. (Id.) Moreover, claimant's delay in seeking treatment does not negate evidence which was corroborated by the foreman, that claimant was self-treating the wrist prior to his job termination.

The combination of claimant underestimating the seriousness of his wrist condition and his general reluctance to seek medical attention reasonably explains why he did not promptly seek medical attention or report the wrist injury to the employer. It also reasonably explains why, after September 13, 1996, claimant continued to sign work time sheets that contained the pre-printed statement: "I worked an accident free week." (Ex. 10). The record shows that claimant simply did not believe that his wrist injury was serious enough to report. (Tr. 20).

Therefore, based on our review of the record, we find that claimant was a credible witness. We also find that, after claimant realized the seriousness of his wrist condition and sought medical attention, he reported to his doctors a consistent history of the September 13, 1996 accident. He told both Drs. Reilly and Gritzka that he had the onset of right wrist pain after striking the wrist against a wood chipper at work on September 13, 1996. (Exs. 2-1, 9-1). That is essentially the same history to which he testified at hearing. (Tr. 11). Based on this record, we find that claimant was a credible and reliable historian.

We now turn to the expert medical evidence. Claimant's attending osteopathic physician, Dr. Reilly, examined claimant on four occasions during the period from November 25 through December 18, 1996. (Exs. 2, 3, 5, 6). Dr. Reilly did not detect any objective findings of an injury to the right wrist. (Ex. 11A-1).

On March 20, 1997, claimant was examined by Dr. Gritzka, orthopedic surgeon, who diagnosed internal derangement in the right wrist based on the objective finding of crepitus ("sharp click") originating from the triangular fibrocartilage complex. Reasoning that the mechanism of claimant's September 13, 1996 injury was "classic" for producing an internal derangement of the wrist, Dr. Gritzka opined that the work injury caused claimant's right wrist condition.[2] (Ex. 9, pp. 6-7).

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[2] The ALJ discounted Dr. Gritzka's opinion based in part on the doctor's written notation that claimant had worked on pipelines in 1996, whereas claimant actually worked on pipelines in 1997, just prior to Dr. Gritzka's examination. (O&O, p. 2; Ex. 9-2). However, it appears that the aforementioned reference to "1996" is a typographical error. Based on the chronological sequence by which claimant's history is arranged in Dr. Gritzka's report, it appears that the doctor actually intended to report that claimant's pipeline work occurred in 1997, not 1996. Therefore, the typographical error is not a persuasive basis for discounting Dr. Gritzka's opinion.

Subsequently, Dr. Reilly wrote that the objective findings identified by Dr. Gritzka were not present during his earlier examinations of claimant. Dr. Reilly stated that Dr. Gritzka's findings might have resulted from an overuse or injury sustained between Reilly's last examination (on December 18, 1996) and Gritzka's examination in March 1997. (Ex. 11). Later, in his deposition, Dr. Reilly clarified that his statement regarding an intervening injury "could only be speculation" and was based entirely on the absence of objective findings of injury during his examinations. (Ex. 13, pp. 12-13).

Dr. Gritzka reviewed Dr. Reilly's report regarding the absence of objective findings and responded that claimant's wrist injury (i.e., triangular fibrocartilage complex injury) is an "exotic" type of injury that has only recently been recognized by the medical community. (Ex. 14-2). He stated that the physical findings of the injury would not be recognized by a physician who did not have a high index of suspicion for the injury. (Id.) He also stated:

> "[I]f the [medical] examiner does not grasp or clasp the injured wrist with his own hand like a bracelet while the person being examined moves the wrist, crepitus is likely likely to be missed. Also, an examiner should seek tenderness specifically in the interval between the distal radius and ulna with [sic] the triangular fibrocartilage complex is. Unless Dr. Riley [sic] did these specific provocative and focused tests when he saw [claimant]. . ., he may have not recognized the diagnosis." (Ex. 14, pp. 2-3).

Subsequently, Dr. Reilly wrote a description of his "usual and customary" examination for the wrist, which included active and passive motion testing and lightly grasping around the wrist to palpate for crepitation within the wrist/carpal structures. (Ex. 15).

After reviewing the medical record, we conclude that Dr. Gritzka's opinion is well reasoned and based on complete information. Although he diagnosed claimant's right wrist injury after Dr. Reilly's multiple examinations failed to yield any objective findings, he offered a reasonable explanation for this discrepancy. He explained that the triangular fibrocartilage complex injury claimant suffered is somewhat "exotic" and could have been overlooked by a physician not looking for that particular injury. He set forth the specific testing that would detect the injury: (1) grasping the wrist during motion testing to elicit any crepitus; and (2) palpation for tenderness in the interval between the distal radius and ulna where the triangular fibrocartilage complex is located.[3]

The record does not contain any response by Dr. Reilly to Dr. Gritzka's statement that claimant's wrist injury could have been easily overlooked. More importantly, Dr. Reilly did not indicate whether he actually looked for the type of injury detected by Dr. Gritzka. Dr. Reilly's "usual and customary exam" description indicates that he grasps around the wrist during motion testing to detect crepitus, but it does not indicate whether he palpates the specific area of the wrist where the triangular fibrocartilage complex is located. Because there is insufficient evidence to establish whether Dr. Reilly performed the testing necessary to detect the injury ultimately diagnosed by Dr. Gritzka, we are not persuaded that Dr. Reilly's opinion was based on complete information. We therefore discount its probative value.

By contrast, Dr. Gritzka described and performed the specific testing necessary to detect claimant's wrist injury. Furthermore, he had claimant's credible and reliable history of the September 13, 1996 accident and observed that its mechanism was consistent with the diagnosed injury. Based on Dr. Gritzka's thorough and well-reasoned opinion, see Somers v. SAIF, 77 Or App 259, 263 (1986), we conclude that claimant carried his burden of proving by a preponderance of the evidence that the September 13, 1996 work accident was at least a material contributing cause of the right wrist injury and resultant need for treatment. See ORS 656.005(7)(a). We further conclude that Dr. Gritzka's finding of crepitus was sufficiently reproducible to be an objective finding of injury. See ORS 656.005(19). Accordingly, the right wrist injury claim is compensable and the employer's denial shall be set aside.

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[3] On review, the employer argues that Dr. Gritzka's diagnosis is unreliable because claimant testified that his right wrist is now feeling "okay," (Tr. 14), in contrast to Gritzka's expectation of possible surgery for the injury. However, Dr. Gritzka did not indicate that surgery was inevitable; he merely stated that there was a "substantial chance" that surgery will be required. (Ex. 9-7). That statement, in our view, left open the possibility that claimant would not require surgery. Therefore, we find no inconsistency.

Claimant's attorney is entitled to an assessed fee for prevailing over the 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 $4,400, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue(s), the value of the interest involved, and the risk that claimant's attorney's services may go uncompensated.

ORDER

The ALJ's order dated October 1, 1997 is reversed. The self-insured employer's denial of claimant's right wrist injury claim is set aside and the claim is remanded to the employer for processing according to law. Claimant's attorney is awarded an assessed fee of $4,400, payable by the employer.

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In the Matter of the Compensation of
**KAREN STEAN, Claimant**
WCB Case No. 97-00389
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) Thye's order that dismissed claimant's request for hearing for lack of jurisdiction. On review, the issues are jurisdiction and attorney fees.

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

Claimant's claim was accepted as nondisabling. Through her attorney, she requested reclassification of the claim from the Department of Consumer and Business Services. On January 2, 1997, the Department issued a Determination Order reclassifying the claim as disabling. Thereafter, claimant requested a hearing seeking an attorney fee for her attorney's efforts in obtaining reclassification. Prior to hearing, the parties submitted a stipulation, in which the attorney for the employer agreed to pay a 25 percent "out-of-compensation" attorney fee out of any temporary disability and any permanent disability paid, allowed or awarded on the claim up to the maximum allowed by the administrative rules. The ALJ dismissed claimant's request for hearing and declined to approve the stipulation, finding that claimant's counsel was not entitled to an approved fee.

On review, claimant maintains that her counsel is entitled to an approved fee under ORS 656.386(2) based upon the Determination Order reclassifying the claim as disabling. We conclude, as we did in Larry D. Simmons, 50 Van Natta 107 (1998), that the Hearings Division and the Board lack the authority to approve an attorney fee under the circumstances of this case.

In Larry D. Simmons, as here, the claimant requested a hearing seeking an attorney fee arising out of a Determination Order finding that his nondisabling injury had become disabling. We explained that, pursuant to ORS 656.385(5), neither the ALJ nor the Board may award penalties or attorneys fees for matters arising under the review jurisdiction of the Director and that, under ORS 656.277(1), reclassification is initially a matter within the Director's original jurisdiction. We found that where the "increased compensation" arose from the Department's classification decision (i.e., the unchallenged Determination Order) rather than an ALJ's order finding the claim disabling, the ALJ had no authority to award an approved attorney fee under ORS 656.386(2).

The same is true in this case. Because the ALJ lacked the authority to approve an "out-of-compensation" attorney fee award arising from the Determination Order, dismissal of claimant's request for hearing was appropriate.

ORDER

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

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In the Matter of the Compensation of
**CHARLES V. BURKHART, Claimant**
WCB Case No. 97-03144
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Baker's order that set aside its denial of claimant's current low back 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

In 1993, while working, claimant slipped and fell. The insurer eventually accepted a low back strain, a right shoulder strain and a cervical strain. (Ex. 99-2). After a June 1995 Determination Order awarded unscheduled permanent disability, claimant entered into a Claim Disposition Agreement (CDA) in October 1995, and released all rights, except medical services, relating to the claim and any compensable consequence. (Id. at 3).[1] Dr. Belza, neurosurgeon, has been claimant's treating physician throughout the claim.

In November 1996, claimant experienced an acute exacerbation of his low back condition when he stooped to lift a garden hose at home. (Exs. 109, 110). When claimant's symptoms did not subside, Dr. Belza requested authorization for a lumbar microdiscectomy on the left at L4-5. (Ex. 115).

The ALJ decided that Dr. Belza provided the most reliable opinion and, based on that opinion, claimant proved that the 1993 compensable injury was the major contributing cause of the need for treatment and disability of his current low back condition. The insurer challenges this conclusion, asserting that Dr. Belza's causation opinion is conclusory and inconsistent with his prior reports. We agree with the insurer.

Dr. Belza's opinion is contained in a report drafted by claimant's attorney to which Dr. Belza concurred. The report stated that claimant's "herniated nucleus pulposus at L4-5 combined with a mechanical instability of the lower lumbar spine." (Ex. 121-1). The report further stated that "this is the same condition from which [claimant] suffered since the original on-the-job injury." (Id. at 2). Furthermore, the report explained that a 1993 MRI scan "revealed osteoarthritis and discogenic changes at L4-5 which preexisted" claimant's injury and the "on-the-job injury combined with these preexisting changes to produce [claimant's] need for treatment from the injury date to the present." (Id.) Finally, the report stated that the 1993 injury was the major contributing cause of the combined condition in part because claimant "had no prior history of problems of the low back, no limitations or medical treatment to his lumbar spine" in contrast to "his consistent and evolving problems since" the injury. (Id. at 2-3).

Examining orthopedic surgeon, Dr. Plotkin, reported that his examination was "controlled" by claimant and Dr. Plotkin found a "great deal of symptom magnification and some contradiction[.]" (Ex. 118-5). Dr. Plotkin also noted "much functional overlay in regards to" claimant's back. (Id. at 6).

Dr. Plotkin submitted a follow-up report stating that "there is a lack of clinical evidence that the work injury * * * resulted in a disc condition at L4-L5." (Ex. 122-1). Dr. Plotkin noted that an MRI performed after the injury "did not demonstrate clinically significant L4-L5 findings" and no "further lumbar radiographic studies were deemed necessary until 34 months after the injury." (Id.) Instead,

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[1] The parties agreed at hearing that, as a result of the October 1995 CDA, the only benefits at issue in this case are medical services. (Tr. 5).

Dr. Plotkin thought that the "studies and supplied history are consistent with a separate and new pathologic process, a process that was characterized as 'acute' resulting from a bending injury of November 6, 1996[.]" (Id.) The report further found that this conclusion was supported by a November 1996 study showing "more prominent" findings in comparison to an August 1996 study. (Id.) Finally, Dr. Plotkin stated that there were no "clinically significant findings" at the time of the injury showing a herniated disc and that the lumbar x-rays and MRI also did not reveal a herniated disc. (Id. at 2).

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 persuasive reasons not to defer to Dr. Belza's opinion. First, although stating that the herniated disc was present since the time of the 1993 injury, Dr. Belza does not explain why that condition was not diagnosed until years after the injury. As noted by Dr. Plotkin, a MRI taken about a month after the accident failed to show a herniated disc; Dr. Belza also interpreted a February 1994 mylogram as showing no acute disc rupture and a March 1994 bone scan was negative and normal.

In the same vein, Dr. Belza also failed to respond to Dr. Plotkin's opinion that claimant's herniated disc was the result of a separate and new pathologic process. Prior to the exacerbation in November 1996, claimant for the most part had symptoms on the right side; symptoms consistently were reported on the left side beginning in November 1996. Consistent with this history, in November 1996, Dr. Belza stated that claimant "has a history of a Workmen's [sic] Compensation injury with low back pain radiating to the right lower extremity, but this particular injury presents with new symptomatology down the left lower extremity." (Ex. 113; emphasis supplied). In indicating that claimant herniated his disc during the 1993 accident, Dr. Belza does not explain why claimant's symptoms were predominantly on the right and, following a particular incident in November 1996, his symptoms relocated to the left side.

In short, by failing to address the points discussed above, we find Dr. Belza's opinion conclusory and lacking in persuasive reasoning for its conclusion. At best, the medical opinions are in equipoise. Consequently, because claimant did not prove by a preponderance of evidence that the compensable injury is the major contributing cause of his low back need for treatment and disability, we conclude that he failed to establish compensability. See ORS 656.005(7)(a)(B).

## ORDER

The ALJ's order dated September 29, 1997 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

In the Matter of the Compensation of
**MARK E. ESPELL, Claimant**
WCB Case No. 97-03474
ORDER ON REVIEW
Richard F. McGinty, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Myzak's order that set aside its denial of claimant's aggravation claim for his current left knee condition. On review, the issues are compensability and aggravation. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact. We summarize the relevant finding as follows.

In April 1991, claimant compensably injured his left knee while working for an out-of-state employer. In June 1991, he underwent debridement for an osteochondral defect of the medial femoral condyle. By late August 1991, claimant had fully recovered without disability and returned to regular work.

On June 13, 1994, claimant fell eight or nine feet off a ladder landing on his left knee on a concrete surface. He sought medical treatment with Dr. Tongue in late June 1994. The condition was diagnosed as left knee contusion and strain and SAIF accepted claimant's claim for these conditions. X-rays at that time revealed mild degenerative joint disease of both knees, right greater than left.

Claimant continued to have left knee pain after the June 1994 injury. By 1996, his left knee pain and symptoms had gradually progressively worsened. In September 1996, Dr. Ayers performed an arthroscopy of claimant's left knee with debridement of the left medial femoral condyle.

Claimant filed a claim for an aggravation of the 1994 compensable injury. On April 22, 1997, SAIF denied that claimant's accepted condition had worsened and that claimant's current left knee condition was compensably related to the accepted claim. Claimant requested a hearing from the denial.

## CONCLUSIONS OF LAW AND OPINION

Relying on the medical opinion of Dr. Stringham, the ALJ found claimant's current left knee condition compensable under ORS 656.005(7)(a)(B). On review, SAIF argues that the medical evidence does not establish that claimant's current left knee condition remains related to the June 1994 compensable injury. Claimant relies on the first opinion of Dr. Ayers and the opinion of Dr. Stringham to argue that his June 1994 compensable injury remains the major contributing cause of his current left knee condition.

Given the passage of time since the June 1994 compensable injury, claimant's prior left knee injury and surgery and the presence of preexisting degenerative joint disease, the causation of claimant's current left knee condition is a complex medical question requiring expert medical evidence. Uris v. Compensation Department, 247 Or 420, 427 (1967). Four physicians address the cause of claimant's left knee condition.

Dr. Tongue, an orthopedic surgeon, treated claimant for the June 1994 compensable injury. At that time, Dr. Tongue reported that "Prognosis with respect to his left knee history is excellent, although the preexisting problems will persist and may progress separately in the future." X-rays taken in June 1994 revealed mild degenerative joint disease in both knees, right greater than left. By July 25, 1994, Dr. Tongue reported that claimant's left knee strain and/or contusion of June 13, 1994 had resolved and was medically stationary without impairment.

Claimant returned to Dr. Tongue in June 1996 reporting progressive pain in his left knee which had been bothering him significantly for the past two months. Dr. Tongue opined that the June 1994 injury was "not clearly the major-contributing factor to his current problem of left knee symptoms of two months duration."

Dr. Mayhall, an orthopedic surgeon, who examined claimant on behalf of SAIF, opined that the major contributing cause of the left knee condition and need for treatment was the natural progression of the degenerative changes in the medial femoral condyle which existed in 1991. Dr. Mayhall indicated that while it was possible that the 1994 injury had some contribution, there was no objective evidence that the 1994 injury caused or materially worsened that process.

Claimant was treated for the 1996 worsened left knee symptoms by Dr. Ayers, an orthopedist. Dr. Ayers took a history that claimant had been complaining of pain in his left knee for about two years. The pain had gradually been getting worse. Dr. Ayers performed arthroscopy surgery in September 1996 on claimant's left knee. Dr. Ayers opined that there was a reasonable medical probability that the major contributing cause of claimant left knee condition was the June 1994 compensable injury.

After reviewing Dr. Mayhall's report, however, Dr. Ayers indicated that he agreed with Dr. Mayhall's findings and conclusions. Dr. Ayers also agreed that the major contributing cause of claimant's current left knee condition, need for treatment and disability, was the preexisting osteochondral defect rather than the June 1994 compensable injury.

Claimant was also treated by Dr. Stringham for his current left knee condition. Dr. Stringham opined that he was more persuaded by the opinion of Dr. Ayers that the June 1994 injury was the major contributing factor in claimant's current left knee condition. However, Dr. Stringham also stated:

> "However, I do wish to emphasize that differences of opinion expressed by the three orthopedists clearly suggests that the causality of the patient's current left knee condition and need for treatment is reasonably debatable. As I noted above, I do feel Dr. Mayhall provides some reasonable rational (sic) for his opinion based on natural history of the defect found in 1991 and progression of degenerative changes. Based on my review of the record and my medical knowledge, I can only say the patient's pre-existing left knee condition is a significant material contributing cause to patient's current knee condition and that his injury of 6/13/94 is also a significant material contributing cause of his current left knee condition. I am inclined to think that a jump or fall of some 9 feet as described by the patient and occurring on 6/13/94 could cause an impact on his left knee, which would lead to the findings of surgery on 9/96. Furthermore, there is no question that patient had a pre-existing medial-femoral condyle condition. However, the event of 6/13/94 may well have become the major contributing cause for his subsequent condition. Therefore, I do not agree with Dr. Mayhall when he states that the pre-existing condition is the major contributing cause. I am more inclined to agree with Dr. Ayers that the 6/13/94 event is the major contributing cause of the patient's current knee condition and need for treatment. However, I admit to some degree of uncertainty as discussed above as to major contributing cause."

After reviewing the medical evidence in this record, we do not agree with the ALJ's assessment that claimant has carried his burden of proof. In this regard, the ALJ relied primarily on Dr. Stringham. Dr. Stringham indicated he was "more persuaded" by the opinion of Dr. Ayers over the opinion of Dr. Mayhall. However, on review of Dr. Stringham's full opinion, we note that he is equivocal regarding the major contributing cause of claimant's condition. In this regard, he admits to uncertainty regarding the major contributing cause of the left knee condition. In addition, he states that the June 1994 injury "may well have become" the major contributing cause for claimant's subsequent left knee condition. Such an opinion does not rise to the level of reasonable medical probability required to establish compensability. See Gormley v. SAIF, 52 Or App 1055 (1981). In short, Dr. Stringham seems willing to state without qualification that the 1994 compensable injury was a material contributing cause of claimant's current left knee condition; however, he is equivocal and uncertain regarding the major contributing cause of that condition. Under such circumstances, his opinion is not sufficient to carry claimant's burden of proof.

The ALJ also found that Dr. Ayers had changed his opinion based on an incorrect history in Dr. Mayhall's report that claimant's left knee symptoms began two months, rather than two years prior to his first seeking treatment for the worsened left knee symptoms. Based on our examination of Exhibit 24, it is unclear what caused the change in Dr. Ayers' opinion. The record contains no explanation of Dr. Ayers' changed opinion. In any case, we find both of Dr. Ayers' opinions regarding causation to be unpersuasive because both opinions are conclusory and lacking in explanation and medical analysis. See Moe v. Ceiling Systems, 44 Or App 429 (1980).

The remaining medical opinions in the record do not support the compensability of claimant's current left knee condition. Accordingly, on this record, claimant has not established compensability of that condition.

ORDER

The ALJ's order dated August 27, 1997 is reversed. SAIF's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

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March 12, 1998 Cite as 50 Van Natta 379 (1998)

In the Matter of the Compensation of
**JOHN KIRWIN, Claimant**
WCB Case No. 97-04699
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that declined to award an approved attorney fee for his counsel's efforts in obtaining a Proposed and Final Contested Case Hearing Order declaring him to be a subject worker. On review, the issue is attorney fees.

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

Claimant allegedly injured his low back in September 1995 while working for Anthony Wilcox. Following an investigation, the Department of Consumer and Business Services determined that claimant was not a subject worker of a subject employer. Claimant challenged the Department's determination and a contested case hearing was held before ALJ Hazelett, as the Director's designee. On May 30, 1997, ALJ Hazelett issued a Proposed and Final Contested Case Hearing Order finding that claimant was a subject worker, that Wilcox was a subject employer and that claimant was a subject worker of a subject employer.[1]

Claimant then requested a hearing before the Workers' Compensation Board Hearings Division seeking an "out-of-compensation" fee pursuant to ORS 656.386(2) for his counsel's services before the Director's designee in setting aside the denial of subjectivity. Relying on Julie A. Johnson, 48 Van Natta 29 (1996) and Joseph M. Lewis, 47 Van Natta 381, on recon, 47 Van Natta 616 (1995), ALJ Thye declined to award such a fee. Specifically, the ALJ found that the Board and Hearings Division lack the authority to award an attorney fee unless compensation flows directly from the order awarding the fee.

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[1] Although the record does not reflect the status of the proposed order, we take official notice of the fact that the Director did not issue a final order and that the proposed order became final by operation of law after 30 days from the date of mailing. See ORS 183.464; OAR 436-001-0275; see also Rodney J. Thurman, 44 Van Natta 1572 (1992) (Board may take official notice of any fact that is "capable of accurate and ready determination by resort to sources whose accuracy cannot readily be questioned").

On review, claimant maintains that the ALJ had the authority to award an attorney fee under ORS 656.386(2). We disagree, for the reasons stated in the ALJ's order. In addition, subsequent to the ALJ's order, we held in Larry D. Simmons, 50 Van Natta 107 (1998), that neither an ALJ nor the Board has jurisdiction to award an approved attorney fee under ORS 656.386(2) in a matter in which the increased compensation, if any, arises from an order of the Director. In that case, the claimant requested a hearing seeking an attorney fee for his counsel's efforts in obtaining a Determination Order reclassifying his injury claim as disabling. We explained that, pursuant to ORS 656.385(5), neither the ALJ or the Board may award penalties or attorneys fees for matters arising under the review jurisdiction of the Director and that, under ORS 656.277(1), reclassification is initially a matter within the Director's original jurisdiction. We found that where the "increased compensation" arose from the Department's classification decision (i.e., the unchallenged Determination Order) and not an ALJ's order finding the claim disabling, the ALJ had no authority to award an approved attorney fee under ORS 656.386(2).

In this case, the subjectivity matter arises under the review jurisdiction of the Director, not the Board. See Lankford v. Copeland, 141 Or App 138 (1996).[2] Furthermore, although compensation may ultimately arise from the order finding claimant to be a subject worker, no increased compensation flows directly from the Director's designee's proposed and final order. Therefore, neither the ALJ nor the Board has jurisdiction to award an approved attorney fee based on that order.

## ORDER

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

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[2] Prior to Lankford, Board precedent authorized the ALJ to award an "out-of-compensation" fee for a claimant's counsel's successful efforts in overturning a Department determination that the claimant was not a subject worker. See, e.g., Stephen M. Olefson, 46 Van Natta 1762 (1994). In light of the Lankford decision (and the Director's subsequent rules, Chapter 436, Division 80), however, the authority to award an attorney fee, if any, in this situation rests exclusively with the Director.

In the Matter of the Compensation of
**GREGORY D. DE NOBLE, Claimant**
WCB Case Nos. 95-09931 & 95-06051
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
Lundeen, et al, Defense Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that: (1) admitted a medical report from an insurer-arranged medical examiner; (2) admitted a deposition from another insurer-arranged medical examiner in its entirety; and (3) upheld denials of claimant's lumbar disc condition issued by Liberty Northwest Insurance Corporation (Liberty) and the SAIF Corporation. On review, the issues are the ALJ's evidentiary rulings, compensability, and, potentially, responsibility.

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

On review, claimant renews his argument that the record was frozen as of November 28, 1995, with limited exceptions that included Dr. Mawk's opinion at Exhibit 89 and Dr. Fuller's deposition at Exhibit 91 from pages one through four only. Therefore, claimant argues, the ALJ erred in admitting the disputed exhibits. We need not address this evidentiary issue because, even without considering the disputed exhibits, we find that claimant has not met his burden of proof.

Claimant has worked over 25 years for the same employer as a long-haul truck driver and, at times, as a foreman. In November 1988, claimant sustained a work-related lumbosacral strain while Liberty was on the risk. In March 1989 Liberty accepted a strain of the lower back. No medical evidence relates claimant's current low back condition to that November 1988 back injury.

After that injury, in 1988 and 1989, claimant underwent several radiographic tests that revealed degenerative changes at L3-4 and L4-5, including degenerative disc disease, with L3-4 disc-space loss with degenerative osteophytosis and minimal spondylolisthetic displacement, but no evidence of nerve root displacement. (Exs. 2, 15, 18). Claimant also had L3-4 disc degeneration and circumferential disc bulging without focal herniated nucleus pulposus. (Ex. 19). At L4-5, claimant had circumferential disc bulging, left paracentral in prominence without focal herniation or nerve root impingement. (Id.)

On December 20, 1994, while securing a crane to a truck trailer, claimant jumped off the trailer and suffered low back pain with radiation into the buttocks bilaterally. (Exs. 61, 66). SAIF was on the risk at that time. Claimant filed a claim with both SAIF and Liberty. Liberty denied responsibility and SAIF denied compensability and responsibility. (Exs. 61, 74, 77). Claimant began treating with Dr. Jura, M.D., who authorized chiropractic treatment. (Exs. 63, 64). Claimant continued working and experienced waxing and waning of symptoms. In August 1995, claimant worked in Boise, Idaho, without any particular injurious event. While returning from Boise, claimant's back pain became severe. On August 18, 1995, claimant had radiating pain into the leg to the foot and an MRI revealed a large central herniation of L4-5 with a left-sided fragment. On August 21, 1995, claimant underwent a lumbar laminectomy and bilateral discectomy at L4-5 performed by Dr. Mawk, neurosurgeon.

It is undisputed that claimant had preexisting degenerative disc disease at L3-4 and L4-5 with spondylolisthesis at L3-4. Furthermore, as the ALJ found, the persuasive medical evidence establishes that claimant's preexisting degenerative low back conditions combined with the December 20, 1994 work incident. (Exs. 73, 75). No medical evidence relates claimant's current low back condition to an occupational disease. Instead, the focus is on the December 20, 1994 work incident. Therefore, it is appropriate to analyze this claim under ORS 656.005(7)(a)(B). Claimant does not dispute that ORS 656.005(7)(a)(B) applies to his claim and contends that he has met his burden of proof under that statute.

Pursuant to ORS 656.005(7)(a)(B), the record must establish that the December 20, 1994 work injury was the major contributing cause of the disability or need for treatment of the combined condition. ORS 656.266; Hutcheson v. Weyerhaeuser, 288 Or 51, 55-56 (1979); SAIF v. Nehl, 148 Or App 101, on recon 149 Or App 309 (1997); Gregory C. Noble, 49 Van Natta 764, 767 (1997). Determining the "major contributing cause" involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause. Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev dismissed 321 Or 416 (1995); Gregory C. Noble, 49 Van Natta at 765-66.

We generally defer to the opinion of the treating physician unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, only the opinions of Drs. Jura and Mawk might support compensability of claimant's lumbar disc condition. However, there are persuasive reasons not to defer to these opinions.

Dr. Jura had an inaccurate history in that he considered claimant's spondylolisthesis to be a new condition, not present before the December 1994 work incident. (Ex. 72). Furthermore, he explicitly based his opinion on this understanding. Id. However, the spondylolisthesis condition was present as early as 1989. (Exs. 2, 15, 18). In addition, Dr. Jura did not consider the contribution of claimant's degenerative disc disease, nor did he render any opinion after claimant's worsened condition requiring surgery. (Ex. 76). Because Dr. Jura's opinion is lacking in explanation and analysis and is based on a questionable history, we give it little weight. See Moe v. Ceiling Systems, 44 Or App 429 (1980) (rejecting conclusory medical opinion); Miller v. Granite Construction Co., 28 Or App 473, 478 (1977) (doctors' opinions based on an inaccurate history entitled to little or no weight).

Dr. Mawk first opined that, although claimant previously had been told he had "some modest disc bulging at the L4-5 level, the actual herniation of the disc undoubtedly occurred on December 20, 1994, when he jumped down from a tractor-trailer rig." (Ex. 87). Therefore, Dr. Mawk opined that the major contributing cause of claimant's current condition and need for treatment was the work incident. Id.. Later, Dr. Mawk opined that:

> "[claimant] views the inflection point of his disease as 20 December 1994, at which time he developed his syndrome, which was progressive thereafter. I think it is medically probable that his work on 20 December 1994 indeed led to his substantial L4-5 disc herniation. Progression of symptoms after such an injury is quite common." (Ex. 89-1).

There are several problems with Dr. Mawk's opinions. First, he does not explain his change of opinion from stating that the disc actually herniated on December 20, 1994, to stating that the herniation occurred as a progressive condition after that date. Since Dr. Mawk offers no explanation for his change of opinion, we attach little probative weight to his conclusions. See Kelso v. City of Salem, 87 Or App 630 (1987) (unexplained change of opinion renders physician's opinion unpersuasive).

Second, Dr. Mawk's opinions do not evaluate the relative causes of claimant's condition and determine the primary cause, as required by Dietz v. Ramuda, 130 Or App at 401-02. Dr. Mawk states only that claimant has been told he had a "modest disc bulge at the L4-5 level;" Dr. Mawk does not address the relative contribution of that preexisting condition. It is not apparent that Dr. Mawk is aware of the findings in 1989 regarding claimant's L4-5 disc bulge. (Ex. 19). Although, as the physician performing claimant's surgery, Dr. Mawk was in a good position to observe claimant's low back condition, he offered no opinion based on any such surgical observation. Instead, he offered conclusory opinions, which he changed without explanation. For these reasons, we agree with the ALJ that Dr. Mawk's opinions do not meet claimant's burden of proof.

## ORDER

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

In the Matter of the Compensation of
**PAMELA A. ELLER, Claimant**
WCB Case No. 96-11442
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Bock and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) McWilliams' order that upheld the SAIF Corporation's denial of claimant's claim for a psychological condition. On review, the issue is compensability. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact. We do not adopt the ALJ's second finding of ultimate fact.

We summarize the relevant facts as follows.

Claimant has bilateral carpal tunnel syndrome and left elbow lateral epicondylitis as a result of repetitive work activities embossing, folding and boxing greeting cards. SAIF accepted the claim for these conditions in October 1995. Claimant's employment with the employer had ended on July 21, 1995, when she was restricted to light duty. Claimant was treated by Dr. Butters for surgical correction of her bilateral carpal tunnel syndrome in November 1995. Claimant also saw Dr. Birskovich in October 1995 for enthesopathy of her left corporal brachialis muscle.

Following her surgery, claimant continued to experience symptoms. Dr. Lockfeld conducted repeat electrical studies in September 1996. Claimant also resumed treatment with Dr. Witkin for complaints of persistent pain, increased depression and sleep disturbance.

A bone scan was carried out to investigate claimant's continued physical complaints when stellate blocks failed to alleviate her pain. The study was interpreted as showing subtle signs of Reflex Sympathetic Dystrophy.

Claimant began treating with Dr. Brown, a psychiatrist, in September 1996. On November 15, 1996, a formal claim for depression was made on claimant's behalf.

Claimant continued receiving treatment for physical problems, which included myofascial pain syndrome/fibromyalgia by Drs. Butters and Witkin.

Claimant underwent an insurer-arranged medical examination in November 1996, which included a psychiatric examination by Dr. Klecan.

SAIF denied the claim for depression with psychosomatic symptoms on December 19, 1996. On the same date, the accepted claim was closed by Notice of Closure that awarded temporary disability only.

Claimant was examined, on behalf of SAIF, by Dr. Heck, a psychiatrist, on March 11, 1997.

## CONCLUSIONS OF LAW AND OPINION

The ALJ relied on the opinion of claimant's treating physician, Dr. Brown, to conclude that claimant did not suffer from a preexisting mental condition. However, finding that Dr. Brown had changed his opinion regarding causation without explanation, the ALJ found that claimant failed to satisfy her burden of proof under ORS 656.005(7)(a)(A) to establish compensability of her mental condition as a consequence of the compensable injury.

Three physicians address the nature and cause of claimant's mental condition. Dr. Klecan, a psychiatrist, examined claimant on behalf of SAIF. Dr. Klecan opined that claimant has probably had a chronic depression disorder since at least 1994, evidenced by vague symptoms of fibromyalgia for which no physical disease process can account. Dr. Klecan diagnosed dysthymic disorder, chronic, versus

chronic major depression disorder in partial remission. Dr. Klecan opined that claimant's current psychological condition is a continuation of her preexisting depression condition. Dr. Klecan further opined that the major contributing cause of claimant's psychological condition is a combination of constitutional factors and developmental stresses arising in childhood and adolescence to which secondary gains had been added.

Claimant was also examined by Dr. Heck, psychiatrist, on behalf of SAIF. Dr. Heck diagnosed dysthymic disorder (chronic depression). Based on his review of the medical record, Dr. Heck believed that claimant's symptoms represented a relapse of claimant's preexisting depressive disorder. Dr. Heck opined that the major contributing cause of claimant's current condition was a combination of her preexisting dysthymia and somatoform pain disorder as well as her underlying motivations to maintain a disabled role.

Dr. Brown, a psychiatrist, treated claimant for her mental condition, which he diagnosed as adjustment disorder, depressed and anxious type. Dr. Brown initially indicated that he could not demonstrate clearly that the workplace and claimant's industrial injury caused her current psychiatric disorder. However, Dr. Brown indicated that claimant's industrial injury and the way she was treated in the workplace were the major contributing factors with a weight of over 50 percent in terms of the continuation of her adjustment disorder.

In response to a letter from claimant's attorney, and after review of Dr. Heck's opinion, Dr. Brown gave an additional opinion that, based on his treatment over time with claimant, her industrial injury by itself was the primary contributing cause of the adjustment disorder with anxiety and depression.

When medical evidence is divided, we tend to give greater weight to the claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Here, after reviewing the medical evidence, we find no persuasive reason not to defer to Dr. Brown, claimant's treating psychiatrist. In reaching this conclusion, we disagree with the ALJ's conclusion that Dr. Brown changed his opinion without explanation.

The ALJ found that, although Dr. Brown had not "reversed himself," he had "refined his opinion to the level required to satisfy the standard of proof. He has done so without explanation, having previously been unable to do so. That change in position in such a manner undermines the persuasiveness of Dr. Brown's opinion." We disagree with the ALJ's analysis for the following reason.

In his initial opinion, Dr. Brown indicated that the injury and the way claimant was treated at the workplace were the major contributing cause of the continuation of her adjustment disorder. In his second opinion, he focused on whether the injury, by itself, excluding claimant's treatment at work, was the major contributing cause of the adjustment disorder. We do not read Dr. Brown's second opinion as being inconsistent with his earlier opinion. He has merely focused on whether the injury alone was the major contributing cause of the condition. For this reason, we do not find that Dr. Brown's second response is inconsistent with, or detracts from the persuasiveness of his opinion. Thus, based on Dr. Brown's persuasive opinion, we find that claimant's claim is properly analyzed as a consequential condition under ORS 656.005(7)(a)(A) and that claimant has esablished that her work injury is the major contributing cause of the consequential psychological 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 $5,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

## ORDER

The ALJ's order dated August 10, 1997 is reversed. SAIF's denial is set aside and the claim remanded to SAIF for processing according to law. For services at hearing and on review, claimant's attorney is awarded $5,000, payable by SAIF.

In the Matter of the Compensation of
**DONALD R. ESCH, Claimant**
WCB Case Nos. 96-10094 & 96-09091
ORDER ON REVIEW
Gatti, et al, Claimant Attorneys
Garrett, Hemann, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Baker's order that: (1) upheld the self-insured employer's denial of his injury/occupational disease claim for a lumbar strain condition; and (2) declined to assess penalties and attorney fees for the employer's allegedly unreasonable denial. On review, the issues are compensability, penalties and attorney fees. We affirm.

## FINDINGS OF FACT

Claimant, a firefighter, has worked for the employer since 1981. (Tr. 4). For the last 10 years, he has worked as an equipment operator, which involves heavy physical labor. (Tr. 4-8). His job requires him to maintain a high level of physical fitness and he works out at least one hour every day. (Tr. 27-28).

In March 1994, claimant filed an "801" form for an upper back strain. (Ex. 3). X-rays revealed two thoracic compression fractures and claimant was diagnosed with osteoporosis. (Ex. 8). The claim was resolved by disputed claim settlement. (Ex. 8A).

Claimant testified that, before 1995, he had experienced only minor occasional aches and pains in his low back. (Tr. 9). On August 6, 1995, claimant stepped off where he thought there was a curb and experienced a sharp pain in his lower back. (Tr. 10). He continued to work. The next morning his back felt better and he never sought medical treatment. (Tr. 11). Claimant testified that his symptoms lasted two to three weeks and resolved completely. (Tr. 12).

On November 21, 1995, claimant stepped into a ditch and jarred his lower back. (Tr. 13). He experienced sharp pain, but he continued to work. A supervisor's report of injury was completed the next day, which referred to "slight discomfort to lower back." (Ex. 8B). Claimant testified that he did not seek treatment immediately after the November 1995 incident because he felt the injury would clear up. (Tr. 14, 34).

On March 4, 1996, claimant was examined by Dr. Cook, his primary care physician. Dr. Cook reported that claimant "has had vague and nondisabling low back pain at times in the past, but over the last month has had increase in low back pain with normal activity." (Ex. 9). For the last week and a half, claimant had experienced full-time left leg numbness and pain in his buttocks. Dr. Cook noted that claimant did not recall a specific injury that caused the symptoms and he did a lot of physical activity at home and could not be sure that it was job-related. (Id.) Dr. Cook diagnosed low back pain with apparent sciatica.

On March 20, 1996, claimant signed an "801" form listing a date of injury of August 6, 1995 and stating that he had jarred his lower back when he stepped off a curb. (Ex. 10). On March 21, 1996, he signed an "801" form listing a date of injury of November 21, 1995 and stating that he felt sharp pain in his lower back when stepping into a ditch. (Ex. 11A).

Claimant returned to Dr. Cook on March 27, 1996 regarding his low back pain. Dr. Cook reported:

> "[Claimant] has done a lot of thinking about the etiology of this pain and does remember two specific incidents he had. On 11-21-95, while he was crossing a ditch, landed on uneven ground and feeling pain in his low back and then on 8-6-95, had to step off the truck awkwardly and landed hard with shooting pain up into his lumbar spine. He does not really remember any other activity at home or at work that may have precipitated his pain and he is assuming that it has been an accumulative effect eventuating in what sounds like radicular symptoms on the left." (Ex. 11).

The employer denied the claim on October 21, 1996. (Ex. 16). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Compensability

The ALJ concluded that there was no well-explained expert opinion that was based on a complete and accurate history that the "jarring" incidents or the accumulation of work activities were the major contributing cause of the lumbar strain. Claimant contends that he has established two compensable accidental injuries on August 6, 1995 and November 21, 1995, or alternatively, he claims an occupational disease arising out of cumulative trauma to his low back.

For the reasons that follow, we agree with the ALJ that claimant has not established compensability under either an accidental injury or an occupational disease theory. ORS 656.005(7)(a) defines a "compensable injury" as "an accidental injury * * * arising out of and in the course of employment requiring medical services or resulting in disability or death[.]" An injurious event that does not produce disability or a need for treatment does not give rise to a compensable claim. Judith W. Hall, 47 Van Natta 929, 930 (1995); Donald M. Hughes, 46 Van Natta 2281, 2284 (1994).

Here, there is no evidence that claimant's August 6, 1995 work incident required medical services or resulted in disability. Claimant testified that, by the morning after the August 6, 1995 incident, his back felt better and he never sought medical treatment. (Tr. 11). He testified that his symptoms lasted two to three weeks and resolved completely. (Tr. 12). Accordingly, on this record, claimant has not established a compensable low back injury resulting from the August 6, 1995 incident.[1] See ORS 656.005(7)(a).

Claimant argues that he experienced a second industrial accident on November 21, 1995, which led to his need for treatment in March 1996. Although claimant did not seek medical treatment shortly after the November 21, 1995 incident and did not file a claim, an incident report was completed, which stated that the incident caused "slight discomfort to lower back." (Ex. 8B). Claimant testified that the low back injury on November 21, 1995 persisted and kept getting worse until he sought medical treatment from Dr. Cook on March 4, 1996. (Tr. 14, 15).

In light of the passage of time between the November 21, 1995 injury and claimant's medical treatment, as well as the number of potential causes of claimant's need for treatment, this issue presents a complex medical question, which requires expert medical opinion. Uris v. Compensation Dept., 247 Or 420 (1967); Barnett v. SAIF, 122 Or App 279 (1993).

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

The medical evidence establishes that claimant had preexisting osteoporosis and degenerative disc disease in the lumbar spine. In 1994, claimant was diagnosed with bone density loss in the lumbar spine in the form of osteoporosis. (Exs. 6, 7, 8). On December 6, 1996, claimant's treating physician, Dr. Cook, reported that claimant likely had osteopenia, if not osteoporosis. (Ex. 18). Dr. Cook felt that claimant's low back pain had a musculoligamentous origin and, although he was not sure how

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[1] In any event, we find no evidence that the August 1995 incident was the major contributing cause of claimant's disability or need for treatment of his current low back condition. Although claimant relies on the opinions of Dr. Fuller and his treating physician, Dr. Cook, to establish compensability, neither of those opinions support compensability of the August 1995 incident. Dr. Cook said that he was "not sure how significant the two specific dates [August 6, 1995 and November 21, 1995] he described are, and I wonder if they have become a matter of contention simply because it is felt necessary to isolate a specific date where an injury occurred." (Ex. 18). Dr. Cook felt that claimant's lumbosacral pain was due to work in general, not a specific incident. (Id.) In addition, Dr. Fuller's opinion does not support compensability of the August 1995 incident. He reported that the incident in August 1995 "was negligible and resolved without medical treatment." (Ex. 14-6). Dr. Fuller said that whether or not the industrial injury makes any contribution depends entirely on claimant's personal history. (Id.) As we have discussed, claimant testified that his symptoms after the August 1995 incident resolved completely. (Tr. 12).

important the osteopenia was, he felt it was indicative of a general vulnerability to injury. (Id.) Dr. Parthasarathy concluded that claimant likely suffered from preexisting degenerative changes or Scheuermann's disease, which predisposed claimant to back pain and made him vulnerable to back injuries. (Ex. 12B). Dr. Dordevich referred to claimant's history of osteoporosis and also identified degenerative disc disease as a preexisting condition. (Ex. 21). Dr. White recognized the contributory effect of osteoporosis (Ex. 23), and joined Dr. Becker in acknowledging the significant contribution of preexisting degenerative disc disease. (Ex. 24). Dr. Moore also acknowledged the likely presence of preexisting degenerative disc disease. (Ex. 25).

In determining whether ORS 656.005(7)(a)(B) applies, we must determine whether claimant's preexisting conditions "combined" with the November 1995 incident to cause disability or a need for medical treatment.

Claimant relies on Dr. Fuller's opinion to argue that the neither of the work incidents combined with any preexisting conditions to cause the need for treatment. Although Dr. Fuller acknowledged claimant's preexisting osteoporosis, he concluded that there was no evidence of a preexisting problem with the lumbar spine and he found no preexisting conditions that made any contribution to claimant's low back strain diagnosis. (Exs 14-6, -7). Dr. Fuller's conclusions, however, are inconsistent with other portions of his report. Earlier in Dr. Fuller's report, he stated that "[s]ubsequently an MRI was performed on 3/28/96 which confirmed degenerative disc disease at L5-S1 with mild disc bulge but no herniation or pinched nerve." (Ex. 14-3). In another part of his report, Dr. Fuller referred to the imaging studies taken on March 4, 1996 and said there was a "suggestion of increased sclerosis at L5-S1[.]" (Ex. 14-5). In light of these inconsistencies, we are not persuaded by Dr. Fuller's conclusion that there were no preexisting conditions that made any contribution to claimant's low back strain.

The preponderance of medical opinion establishes that claimant's preexisting conditions combined with the November 1995 incident to cause the need for treatment. Dr. Cook concluded that claimant's physically demanding job in conjunction with some preexisting degenerative disease in his low back produced his need for treatment. (Ex. 18-2). Dr. Parthasarathy reported that claimant had preexisting degenerative spine abnormalities that contributed to his need for treatment. (Exs. 12B, 13). Dr. Dordevich felt that claimant's back strains had resolved and his current complaints were due to degenerative arthritis in his low back. (Ex. 21). Drs. White and Becker agreed with Dr. Dordevich's conclusions. (Ex. 24-2).

To establish compensability under ORS 656.005(7)(a)(B), claimant must establish that the November 1995 work injury was the major contributing cause of the disability or need for treatment of the combined condition. There are no medical opinions that support claimant's position.[2]

Dr. Cook, claimant's treating physician, did not believe the two specific injury dates (8/6/95 and 11/21/95) that claimant had described were significant. (Ex. 18). Dr. Parthasarathy felt that the November 1995 incident was a relatively minor event because it did not result in more timely medical attention and claimant was able to continue working regular duty. (Exs. 12B, 13). Dr. Fuller felt that the November 1995 incident was "pretty minimal" because he did not seek medical treatment. (Ex. 14-6). He noted that it was unlikely claimant would have been able to continue his duties if he was back was bothering him between November 1995 and March 1996. (Id.) Drs. Becker and White reported that the incidents of August 6, 1995 and November 21, 1995 would not, by themselves, have caused a need for treatment nearly four months later. (Ex. 24-1). Dr. Dordevich opined that claimant's injuries in August 1995 and November 1995 were "relatively minor" and had completely resolved without residuals. (Ex. 21-4). He felt that claimant's current complaints were due to preexisting degenerative arthritis, rather than an injury. (Id.) Dr. Moore did not believe the August 1995 and November 1995 incidents were severe enough to have been the major cause of his complaints in March 1996. (Ex. 25-1). He felt that it was impossible to attribute claimant's need for treatment to any specific etiology. (Ex. 25-2).

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[2] Claimant argues that Dr. Parthasarathy's May 31, 1996 report establishes that the November 21, 1995 injury materially contributed to his symptoms and need for medical treatment. (Ex. 12-4). Claimant's reliance on that report is misplaced. Dr. Parthasarathy subsequently reviewed additional medical reports and changed his view on causation. (Exs. 12B, 13). On June 25, 1996, Dr. Parthasarathy reported that it was speculative whether claimant's need for treatment in March 1996 was a result of his preexisting condition and degenerative spine abnormalities or whether it was due to the November 1995 incident. (Ex. 12B). On July 5, 1996, Dr. Parthasarathy reported that he had not been aware that claimant did not seek medical treatment for the November 1995 incident until March 1996. (Ex. 13). He concluded that the November 1995 incident was a relatively minor event, because it did not result in more timely medical attention. (Id.)

Because there are no medical opinions that establish that claimant's November 1995 work injury was the major contributing cause of his disability or need for treatment, he has not sustained his burden of proof under an accidental injury theory. See ORS 656.005(7)(a)(B).

Alternatively, claimant contends that he has established an occupational disease arising out of cumulative trauma. He relies on the opinion of his treating physician, Dr. Cook.

We generally defer to the medical opinion of an attending physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983). Here, we find persuasive reasons not to defer to Dr. Cook's opinion.

On December 6, 1996, Dr. Cook reported that the etiology of claimant's back pain was "multifactorial." (Ex. 18). He felt that claimant's lumbosacral pain was due to cumulative trauma primarily due to his work. Dr. Cook felt that a physically demanding job in conjunction with some preexisting degenerative disease in his low back produced claimant's need for treatment, although he felt that the job was the major reason for treatment. (Id.)

Dr. Cook's December 6, 1996 report is inconsistent with his subsequent concurrence with Dr. Fuller's September 1996 and October 1996 reports. (Ex. 19A). Unlike Dr. Cook, Dr. Fuller did not attribute claimant's need for treatment to cumulative trauma due to work. When Dr. Fuller was asked whether claimant's employment activity, when compared to all other contributing causes, was the major contributing cause of any new condition, he replied: "Probably not, since he had a 4 month interval of normal activity presumably including fire fighting with full equipment." (Ex 14-7). Dr. Fuller reported that claimant's type of lumbar strain could have occurred secondary to almost any event or could have occurred on an idiopathic basis, not related to any event. (Ex. 14-5).

Dr. Cook's subsequent concurrence with Dr. Fuller's reports is inconsistent with his December 6, 1996 report, which stated that claimant's work was the major contributing cause for his treatment. Because Dr. Cook did not explain his apparent change of opinion regarding causation of claimant's condition, we attach little probative weight to his conclusions. See Kelso v. City of Salem, 87 Or App 630 (1987). Furthermore, we are not persuaded by Dr. Cook's opinion because it is conclusory and lacking in explanation and analysis.

The other medical opinions do not support claimant's position that he has established an occupational disease arising out of cumulative trauma. Dr. White disagreed with Dr. Cook's conclusion that claimant was suffering from "muscular" pain, explaining that it was impossible to state that claimant was suffering from muscular pain rather than the spine discomfort associated with osteoporosis. (Ex. 23-2). Dr. White felt that the osteoporosis process was the major contributing cause of claimant's need for treatment in early 1996. (Id.) Drs. Becker and White were unable to relate claimant's March 1996 symptoms to his work. (Ex. 24-2). Dr. Dordevich opined that claimant's need for treatment was due to degenerative arthritis of the lumbar spine. (Ex. 21-6). Dr. Moore felt that it was impossible to definitively diagnose the cause of claimant's recurrent back complaints. (Ex. 25-3).

In sum, we conclude that claimant has failed to sustain his burden of proving a compensable accidental injury or occupational disease.

Penalties

Claimant seeks penalties and attorney fees for the employer's allegedly unreasonable denial of his claim. Because claimant's condition is not compensable, there are no "amounts then due" upon which to base a penalty and no unreasonable resistance to the payment of compensation to support an award of a penalty-related attorney fee. See Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991); Randall v. Liberty Northwest Insurance Corp., 107 Or App 599 (1991). Accordingly, claimant is not entitled to a penalty.

ORDER

The ALJ's order dated November 5, 1997 is affirmed.

In the Matter of the Compensation of
**DANIEL A. MELLO, Claimant**
WCB Case No. 97-04054
ORDER ON REVIEW
Darris K. Rowell, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Spangler's order that upheld the insurer's denial of his claim for a left knee injury. On review, the issue is compensability.

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

Claimant contends that his left knee condition is compensable on the basis that he was injured while participating in physical therapy prescribed for his accepted cervical condition. We disagree.

In Barrett Business Services v. Hames, 130 Or App 190, rev den 320 Or 492 (1994), the court held that when 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)." There, the claimant sustained an injury to his right ulnar nerve during physical therapy prescribed to treat his compensable shoulder dislocation injury, and the court found that the ulnar nerve injury was a direct consequence of appropriate treatment for the shoulder injury.

More recently, in Rogers v. Cascade Pacific Ind., 152 Or App 624 (1998), the court affirmed a Board order upholding a carrier's denial of the claimant's claim for a cervical condition which occurred while the claimant was performing abdominal "crunches" as a non-prescribed, unsupervised exercise program for his compensable low back condition. The court distinguished Hames, reasoning that the claimant's exercises did not constitute reasonable and necessary medical treatment because the exercises were not curative, but rather were done solely as a preventative measure.

Here, claimant alleges that he injured his knee while performing "squats" designed to improve the fitness level of his low back and legs. Those exercises were not prescribed by Dr. Webb, but were undertaken following claimant's remark to the physical therapist that he had become inactive. As in Rogers, the exercises performed by claimant were not curative, but undertaken to improve cliamant's low back and legs. While Dr. Webb subsequently opined that claimant's exercise program was reasonable and necessary to improve claimant's overall deconditioned state, we do not find this sufficient to establish that the exercises were an integral part of claimant's medical treatment for his compensable cervical injury. See Kip D. Oswald, 49 Van Natta 801 (1997) (claimant's choice to engage in physical activity to relieve stress not "medical treatment" for compensable stress condition, although treating physician subsequently agreed such activities were medically reasonable). For this reason, as well as those set forth in the ALJ's order, we agree that claimant has not established that his left knee injury is compensable.

ORDER

The ALJ's order dated September 4, 1997 is affirmed.

In the Matter of the Compensation of
**RONDA G. PREWITT, Claimant**
WCB Case No. 97-01794
ORDER ON REVIEW
Robert J. Guarrasi, Claimant Attorney
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Black's order that: (1) declined to award interim compensation commencing August 1, 1996; and (2) declined to assess penalties for the self-insured employer's allegedly unreasonable failure to pay medical billings. On review, the issues are interim compensation and penalties. We affirm in part and reverse in part.

## FINDINGS OF FACT

Claimant has an accepted claim for right carpal tunnel syndrome (CTS) arising from a December 1993 injury. Following claim closure, claimant continued to experience right wrist symptoms attributed to a radial and ulnar nerve dysfunction and chronic pain disorder. On March 10, 1996, the employer's claims processing agent received billings for medical services provided for claimant's current condition, along with a cover letter requesting that these billings be paid per ORS 656.245. (Ex. 26A-2 and 26A-4). On March 20, 1996 and, again, on April 2, 1996, claimant filed a Notice of Claim for Aggravation without supporting medical documentation of a worsening supported by objective findings. (Ex. 26A-5, 26A-7). The March 20, 1996 filing was accompanied by a prescription for a TNS unit and ice pack authorized by Dr. Reeves, the attending physician. The April 2, 1996 filing was accompanied by a cover letter from claimant's counsel requesting processing of the claim and payment of time loss.

On May 20, 1996, the claims processing agent received a May 19, 1996 report from Dr. Reeves concluding that claimant's current symptoms were probably attributable to a peripheral neuroma involving the radial nerve. (Ex. 23). On August 1, 1996, the agent received a June 12, 1996 report from Dr. Reeves attributing claimant's current symptoms to radial and ulnar nerve dysfunction, secondary to her accepted 1993 injury, and opining that claimant had experienced a worsening of her compensable injury. (Ex. 26). On November 12, 1996, the employer received a November 1, 1996 report from an unknown doctor attributing claimant's current symptoms to a neuroma in the area of the distal radial nerve, and finding claimant's condition to be medically stationary. (Ex. 27). None of these filings expressly requested acceptance of a radial and ulnar nerve dysfunction and pain disorder.

The claims processing agent did not issue an acceptance or denial of claimant's alleged aggravation claim, commence payment of interim compensation within 14 days of receipt of any of these filings, or pay the medical billings submitted by claimant.

Claimant requested a hearing regarding the failure to pay interim compensation, and the matter was litigated as WCB Case No. 96-06501. A November 20, 1996 Opinion and Order declined to award interim compensation, and claimant requested Board review of that order. (Ex. 28). The Board issued its Order on Review in this matter on June 24, 1997. Ronda G. Prewitt, 49 Van Natta 831 (1996). In that order, the Board concluded that claimant was entitled to interim compensation "payable from August 1, 1996 until such benefits can be terminated under the law."

Meanwhile, on December 18, 1996, claimant filed a written request for acceptance of the diagnosed radial and ulnar nerve condition and pain disorder. (Ex. 35). The claims processing agent issued a formal, written denial on February 21, 1997, and it did not pay interim compensation or the medical billings discussed above. Thereafter, claimant requested a hearing.

## CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant's radial nerve condition and chronic pain disorder are compensably related to the 1993 injury, and the employer does not challenge that ruling on review. The ALJ further concluded that claimant had not perfected an aggravation claim triggering the employer's duty to pay interim compensation prior to its February 21, 1997 denial. The ALJ also declined to assess a penalty for the employer's "non-payment of medical billings" for claimant's compensable radial nerve condition and chronic pain disorder.

Interim Compensation

On review, claimant contends that she is entitled to interim compensation commencing August 1, 1996. In support of that contention, claimant argues that this matter has been decided in her favor pursuant to the Board's June 24, 1997 Order on Review in WCB Case No. 96-06501, which was not appealed and has become final as a matter of law. Prewitt, 49 Van Natta at 831. We agree.

The Board's June 24, 1997 order is an appropriate subject for administrative notice. ORS 40.065(2); Rodney J. Thurman, 44 Van Natta 1572, 1573 (1992). In that order, the Board concluded that claimant was entitled to interim compensation commencing August 1, 1996. The Board's order was not appealed and became final as a matter of law. Consequently, pursuant to that order, the employer had a legal obligation to commence payment of interim compensation on August 1, 1996, and continue payment until the date of its denial on February 21, 1997.

In reaching this decision, we reject the employer's argument that the Board's June 24, 1997 order reserved the employer's right to argue that the August 1, 1996 filing did not trigger the duty to pay interim compensation because it did not "accompany" a Notice of Claim for Aggravation, as required under ORS 656.273. It relies on a footnote in the Board's June 24, 1997 order explaining that the employer did not question the validity of claimant's aggravation claim based on the fact that the "Director's-form" aggravation claim was not "accompanied" by a supporting medical report from the attending physician, as required under ORS 656.273(3). The employer misconstrues the footnote, which was only included to explain why the Board declined to address that particular question. The Board went on to expressly conclude that it was not premature to consider claimant's request for interim compensation, and it ultimately awarded those benefits commencing August 1, 1996. Because the Board's order has become final as a matter of law, the employer is now precluded from challenging our prior award of interim compensation based on the "accompanied" language in ORS 656.273.

Penalties

Claimant also challenges the ALJ's decision that she is not entitled to a penalty for the "non-payment of medical billings" for treatment of claimant's compensable radial nerve condition and chronic pain disorder.[1] Claimant submitted these billings to the employer from March 10, 1996 through April 5, 1996, and on April 14, 1997 and May 1, 1997.

In declining to assess a penalty, the ALJ reasoned that these billings were related to a new medical condition, and that claimant did not perfect a claim for that condition until December 18, 1996. Given the employer's subsequent timely denial of that claim on February 21, 1997, the ALJ concluded that it did not act unreasonably in not paying these medical billings. On review, claimant argues that the failure to pay the billings was unreasonable given claimant's perfected aggravation claim on August 1, 1996.

ORS 656.262(7)(a) provides in pertinent part:

> "After claim acceptance, written notice of acceptance or denial of claims for aggravation or new medical conditions shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the insurer or self-insured employer receives written notice of such claims. New medical condition claims must clearly request formal written acceptance of the condition and are not made by the receipt of a medical claim billing for the provision of, or requesting permission to provide, medical treatment for the new condition. The worker must clearly request formal written acceptance of any new medical condition from the insurer or self-insured employer[.] Notwithstanding any other provision of this chapter, the worker may initiate a new medical condition claim at any time."

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[1] Claimant does not request a penalty for the employer's allegedly unreasonable failure to process these medical billings pursuant to ORS 656.262(6)(a).

This statutory language recognizes a distinction between aggravation and "post-acceptance" new medical condition claims by specifically referencing "claims for aggravation or new medical conditions" and allowing workers to "initiate a new medical condition claim at any time." Here, we are in agreement with the ALJ's finding that the medical billings at issue are for services for a "new medical condition" rather than an "aggravation." Accordingly, given the statutory distinction between aggravation claims and new medical condition claims, the employer did not act unreasonably in not paying the medical billings for claimant's new medical condition based on the perfected aggravation claim.

Furthermore, we agree with the ALJ's conclusion that the employer did not act unreasonably in not paying these medical billings based on claimant's perfection of a new medical condition claim. Such claims "must clearly request formal written acceptance" of the condition and are not made by the receipt of a medical claim billing for the provision of, or requesting permission to provide, medical treatment for the new condition." See Brian D. Shipley, 48 Van Natta 994, on recon 48 Van Natta 2280, 2281 (1996). Here, we agree with the ALJ's conclusion that claimant's December 18, 1996 filing was the first clear request for formal written acceptance of her radial nerve dysfunction and pain disorder. Accordingly, given the employer's subsequent timely denial on February 21, 1996, it did not act unreasonably in not paying the medical billings for claimant's new medical condition. ORS 656.262(6)(a).

ORDER

The ALJ's June 18, 1997 order is reversed in part and affirmed in part. That portion of the order that declined to award interim compensation is reversed. Claimant is awarded interim compensation from August 1, 1996 to February 21, 1997. Claimant's attorney shall receive 25 percent of this increased compensation, not to exceed $3,800, payable directly to claimant's attorney. The ALJ's order is otherwise affirmed.

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March 13, 1998 Cite as 50 Van Natta 392 (1998)

In the Matter of the Compensation of
**KELLI L. JONES, Claimant**
WCB Case No. 97-04481
ORDER ON REVIEW
Reeves, Kahn & Eder, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

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

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

Dr. Utterback, treating physician, acknowledged that genetic and activity factors contribute to claimant's left shoulder problem. He stated, generally, that "there may be a great deal of the genetic and little of the activity involved, or the reverse may be true." (Ex. 9-3). In claimant's case, Dr. Utterback found "work day activities to be responsible for 51% of her symptoms complex and genetic and other factors to represent 49%." (Id., see Ex. 15). Because Dr. Utterback offered no explanation for his quantitative analysis, we agree with the ALJ that his opinion is inadequately explained and unpersuasive. Consequently, in the absence of persuasive medical evidence supporting the claim, we agree that the denial must be upheld.

ORDER

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

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In the Matter of the Compensation of
**MARGARET L. SCOTT, Claimant**
WCB Case No. 97-03965
ORDER ON REVIEW
Burt, Swanson, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

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

## FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for the last paragraph. We do not adopt the ALJ's ultimate findings of fact.

## CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable back injury in 1980 while working for another employer. (Exs. 1-4). In March 1981, she underwent a laminectomy and discectomy at L4-5 on the left. (Ex. 13). Claimant testified that she had a lot of back problems after the 1981 surgery until she had chiropractic treatment from Dr. Womack in 1987. (Tr. 11, 24). After her treatment with Dr. Womack, claimant had no treatment for her back between 1987 and 1996. (Tr. 12).

On July 19, 1996, claimant injured her back while lifting boxes at work. (Ex. 34). SAIF accepted a lumbosacral strain. (Ex. 44). After a Notice of Closure had issued on February 18, 1997 (Ex. 49), Dr. Tihanyi submitted a "palliative care request" on February 27, 1997. (Ex. 49A). On March 13, 1997, SAIF issued a "current condition" denial, asserting that claimant's July 19, 1996 injury was no longer the major contributing cause of her low back condition. (Ex. 50).

The ALJ relied on the opinion of Dr. Tihanyi, claimant's treating physician, to find that claimant's work injury continued to be the major contributing cause of her current low back condition.

SAIF contends that claimant failed to prove that her work injury was the major contributing cause of her current low back condition. SAIF relies on the opinion of Drs. Strum and Wilson, as well as Dr. Tihanyi's concurrence with that opinion.

Claimant agrees that the "major contributing cause" standard of ORS 656.005(7)(a)(B) applies to this case. In light of claimant's previous back surgery and the number of potential causes of claimant's 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). In evaluating the medical evidence concerning causation, we rely on those opinions which are both well-reasoned and based on accurate and complete information. Somers v. SAIF, 77 Or App 259 (1986). In addition, we generally defer to the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983).

Here, we find persuasive reasons not to rely on the opinion of Dr. Tihanyi, claimant's treating physician. On January 4, 1997, Dr. Tihanyi concurred with the October 15, 1996 report from Drs. Strum and Wilson. (Ex. 45). Drs. Strum and Wilson had opined that the major contributing cause of claimant's current symptoms and need for treatment was the preexisting degenerative disc disease. (Ex. 42-7).

In a concurrence letter from SAIF signed on January 24, 1997, Dr. Tihanyi again agreed that claimant's current need for treatment was due to her preexisting degenerative disc disease. (Ex. 47). Dr. Tihanyi also agreed that, on a more probable than not basis, claimant's July 19, 1996 strain would have resolved without permanent impairment, had it not been for her preexisting degenerative disc disease. (Id.)

In a January 24, 1997 chart note, Dr. Tihanyi reported that claimant "appears to be medically stationary in terms of the injury, in that she probably would have returned to baseline by now, except for the fact that she has had a previous back injury." (Ex. 48). On February 27, 1997, Dr. Tihanyi submitted a "palliative care request" for pool therapy. (Ex. 49A).

On May 14, 1997, Dr. Tihanyi reported that she agreed with claimant that "her injury accounted for at least 51% of her problems at this time[.]" (Ex. 53A). Dr. Tihanyi noted that before her injury claimant had been able to perform her job duties, which included setting up equipment and lifting 15 to 20 pounds. Since the injury, claimant was unable to perform those functions. (Id.)

We are unable to reconcile Dr. Tihanyi's various opinions. On January 4, 1997 and on January 24, 1997, Dr. Tihanyi agreed that claimant's current need for treatment was due to her preexisting degenerative disc disease. (Exs. 45, 47). Dr. Tihanyi also agreed that, on a more probable than not basis, claimant's July 19, 1996 strain would have resolved with no permanent impairment had it not been for her preexisting degenerative disc disease. (Ex. 47). She reported that claimant probably would have returned to baseline, except that she had a previous back injury. (Ex. 48). However, on May 14, 1997, Dr. Tihanyi subsequently reported that she agreed with claimant that "her injury accounted for at least 51% of her problems at this time[.]" (Ex. 53A). Because Dr. Tihanyi did not explain her change of opinion regarding causation of claimant's current low back condition, we attach little probative weight to her conclusions. See Kelso v. City of Salem, 87 Or App 630 (1987). Moreover, her conclusion that claimant's injury constituted "at least 51% of her problems at this time" is not persuasive because it lacks adequate explanation.

Claimant also relies on the opinion of the medical arbiter to support compensability. Dr. Mayhall opined that claimant had some limitation due to the accepted condition and the degenerative condition. (Ex. 54-5). He apportioned the overall limitations as 50 percent due to the "new" injury and 50 percent due to the preexisting condition. (Id.) Dr. Mayhall's opinion is not sufficient to establish that claimant's July 1996 injury was the major contributing cause of her current condition. Because there are no other medical opinions that establish that claimant's injury was the major contributing cause of her current low back condition, we conclude that claimant has failed to sustain her burden of proof.

ORDER

The ALJ's order dated October 9, 1997 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

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March 13, 1998 Cite as 50 Van Natta 394 (1998)

In the Matter of the Compensation of
**LEE N. NIDA, Claimant**
WCB Case No. 96-00282
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Ronald W. Atwood & Associates, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Brazeau's order that set aside its denial of claimant's occupational disease claim for a bilateral carpal tunnel syndrome (CTS) condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order.[1]

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[1] We acknowledge the employer's request that we take administrative notice of the "indisputable fact that Dr. Rosenbaum co-authored a treatise on CTS and thus has special expertise on that subject." (Reply Brief, p.1). We would not necessarily find that authorship establishes expertise. In any event, we need not address the employer's request, because the result would be the same even if we noted Dr. Rosenbaum's writing.

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

ORDER

The ALJ's order dated October 9, 1997 is affirmed. Claimant is awarded a $1,000 attorney fee, to be paid by the self-insured employer.

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March 13, 1998 Cite as 50 Van Natta 395 (1998)

In the Matter of the Compensation of
**CLARICE J. STEVENS, Claimant**
Own Motion No. 97-0273M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant, *pro se*, requests review of the insurer's November 11, 1997 Notice of Closure which closed her claim with an award of temporary disability compensation from May 27, 1997 through August 30, 1997. The insurer declared claimant medically stationary as of October 31, 1997. In her request for review, claimant asks "for a review of my claim to decide whether I am entitled to more compensation."

In a January 14, 1998 letter, we requested the parties to submit copies of materials considered in closing the claim. Upon submission of these materials, claimant was allowed 15 days to submit additional materials. The insurer submitted its response on January 20, 1998.[1] On February 13, 1998, the Board received claimant's February 9, 1998 response. Inasmuch as both parties have submitted documentation support their positions, we proceed with our review.

Typically, there are only two issues to be raised when a claimant requests review of an insurer's closure of his or her claim. The most common issue raised is that the claimant asserts that he or she was not medically stationary at claim closure. A second issued raised less often, is that, although the claimant agrees that he or she was medically stationary at claim closure, the claimant asserts that he or she is entitled to additional temporary disability compensation during the time the claim was open.

Here, in her request for review, claimant does not make clear arguments as to why she is contesting the insurer's notice of closure. Rather, in her February 9, 1998 response letter, claimant states that "I [claimant] feel based on my lengthy history, the three shoulder surgeries and the pain I still deal with that I can expect this to be a life long problem. I would like to know that future problems, if they occur, would be covered financially by [the insurer]."[2] We assume that claimant is contending that she was not medically stationary at claim closure. 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).

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[1] As it appeared that the claimant had not been copied with the documents received by the insurer, on January 23, 1998, we sent a copy of the documents to claimant, allowing claimant another 15 days to submit additional materials.

[2] It appears from claimant's statement 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

A claim may not be closed unless the claimant's condition is medically stationary. See OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that she was not medically stationary at claim closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the November 11, 1997 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12, (1980).

On October 15, 1997, claimant underwent an insurer-arranged medical examination performed by Dr. Hunt. Dr. Hunt opined that claimant was medically stationary insofar as her shoulder was concerned. He concluded "It is possible that she may improve over the next 1 to 1-1/2 years following the last surgery, but for insurance purposes I would consider her medically stationary as she has been instructed to come back as needed to her treating doctor."[3] Dr. Zirkle concurred with Dr. Hunt's opinion on October 23, 1997. These opinions are unrebutted.

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

Accordingly, we affirm the insurer's November 11, 1997 Notice of Closure in its entirety.

IT IS SO ORDERED.

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[3] In an August 4, 1997 chart note, Dr. Zirkle, claimant's treating surgeon, noted that claimant had an impingement and treated it with an injection and prescribed an exercise program. He also noted that "she will return depending on symptoms." On August 18, 1997, Dr. Zirkle gave claimant a full work release.

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In the Matter of the Compensation of
**JANET R. CHRISTENSEN, Claimant**
WCB Case No. 97-04701
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that set aside the self-insured employer's partial denial of her current low back condition. On review, the issue is compensability. We reverse.

## FINDINGS OF FACT

Claimant, age 54 at the time of hearing, began working for the employer as a production worker in 1993. (Ex. 1, Tr. 12). On May 16, 1996, she injured her back when she picked up a case of mirrors at work that weighed between 30 and 50 pounds. (Tr. 17). She felt a "pop" in her back and had immediate back pain. (Id.)

On May 22, 1996, she sought medical treatment from Dr. Yarusso. He diagnosed back pain with degenerative joint disease and the possibility of intravertebral disc protrusion. (Ex. 4-3). He recommended a bone scan and a CT scan. A CT scan on May 23, 1996 showed "severe lumbar spondylosis and multilevel degenerative disc disease including marked spinal stenosis at L2-3 secondary to disc herniation in combination with hypertrophic/degenerative changes in the facet joints and narrowing of lateral recesses at multiple levels[.]" (Ex. 5-2). The findings included disc bulges at L5-S1 and L3-4 and disc herniations at L4-5 and L2-3. (Ex. 5-1).

On May 24, 1996, Dr. Yarusso reported that claimant's symptoms were increasing. (Ex. 8-1). He had discussed the CT scan with Dr. Hogan, who said claimant had significant spinal stenosis with a herniated nucleus pulposus at levels 2, 3, and 4 compromising her spinal canal. (Ex. 8-2). Dr. Yarusso said that claimant had an intervertebral disc protrusion "compromising an underlying condition of degenerative disc disease to her spinal cord." (Ex. 8-3). Dr. Yarusso commented that he had notified Ms. Rasmussen, a nurse at the employer, of claimant's condition. (Ex. 8-4, Tr. 34, 47).

An MRI on May 25, 1996 showed mild to moderate disc bulges at L2-3, L3-4 and L4-5 with degenerative changes and spinal stenosis. (Ex. 9-2). The MRI also showed a possible herniation at L5-S1.

On May 28, 1996, Dr. Yarusso diagnosed spinal stenosis and "HNP L3, 4, 5." (Ex. 9A). He referred claimant to Dr. Tanabe for a surgical consultation.

Dr. Tanabe, neurosurgeon, examined claimant on May 29, 1996. (Ex. 10). He diagnosed "[c]hronic lumbar strain, superimposed upon spondylitic changes in the lumbar spine and a mild to moderate lumbar stenosis." (Ex. 10-2). He did not recommend surgery. (Id.)

Dr. Rosenbaum, neurosurgeon, examined claimant on May 31, 1996, and reported that her symptoms suggested a possible disc protrusion, but could also represent primarily musculoskeletal discomfort. (Exs. 12, 13-2). He recommended conservative treatment. (Id.)

On May 31, 1996, Dr. Yarusso diagnosed "degenerative disc, spinal stenosis and HNP x 3." (Ex. 13A). Claimant was referred to Dr. Miller.

On May 31, 1996, the employer accepted "low back pain r/o HNP." (Ex. 11).

Dr. Miller, neurosurgeon, examined claimant on June 5, 1996. (Ex. 14). He reported that the MRI of the lumbar spine demonstrated spinal stenosis at multiple levels. (Ex. 14-2). He did not believe claimant had any true disc herniation in the lumbar discs, although there was a significant disc herniation between T12 and L1. (Ex. 14-2, 14-3). However, he felt the T12 - L1 herniation was asymptomatic. (Ex. 14-3). Dr. Miller did not feel that surgery was indicated and he recommended physiotherapy and exercise. (Id.)

An injection of corticosteroid identified L5 as the source of claimant's radiculopathy. (Ex. 17-1). Dr. Yarusso's diagnosis was an asymptomatic herniated nucleus pulposus at T12, annular bulging at L5 with degenerative joint disease producing radiculopathy and spinal stenosis. (Id.) Claimant had made marginal to no improvement. (Ex. 17-2).

Claimant had a myelogram and CT scan on August 5, 1996. The CT scan showed spinal stenosis and degenerative joint disease at L2-3 and L4-5, and degenerative joint disease at L3-4 and L5-S1, as well as some compression of the right S1 root sleeve. (Ex. 22). The myelogram showed spinal stenosis at L2-3 and L4-5 and mild compression of the right S1 root sleeve. (Ex. 23). Dr. Miller interpreted the test results as a mild disc herniation at L5-S1 and annulus bulging at L3-4, L4-5 and L5-S1. (Ex. 24). He did not recommend surgery. (Id.)

Dr. Wong examined claimant on August 27, 1996 and found that she presented a complex problem of degenerative disc disease and spinal stenosis. (Ex. 26-4). He did not feel she was a surgical candidate and recommended an epidural injection and physical therapy. (Ex. 26-5). Dr. Bedder, pain management specialist, recommended a series of epidural steroid injections. (Ex. 27-3).

Claimant was examined by Dr. Keenen on November 26, 1996. (Exs. 34, 35). After receiving additional information, Dr. Keenen agreed that claimant did not have a specific abnormality that would be amenable to surgical intervention. (Ex. 36).

On January 14, 1997, Dr. Wong became claimant's attending physician. (Ex. 37). He authorized claimant's return to modified work. (Exs. 37, 38). A physical capacities evaluation found claimant capable of performing sedentary-light work. (Ex. 40-1). On February 4, 1997, Dr. Wong indicated claimant was medically stationary. (Ex. 42).

On March 4, 1997, Drs. Stanford and Farris examined claimant on behalf of the employer. (Ex. 44). They diagnosed spinal stenosis, degenerative arthritis, history of low back strain (May 16, 1996), exogenous obesity and deconditioning. (Ex. 44-6). They concluded that claimant had sustained a back strain on May 16, 1996, which was medically stationary and did not cause permanent impairment. (Id.) They did not feel that the May 1996 back strain was a contributing factor in her current symptomatology. (Ex. 44-7).

Dr. Wong concurred with the report from Drs. Stanford and Farris. (Ex. 45-3, 46). Dr. Wong performed a closing evaluation on March 20, 1997 and noted that claimant had a chronic condition that would tend to wax and wane and he released her to sedentary-light work. (Ex. 45).

Dr. Yarusso agreed with Drs. Stanford and Farris that claimant was medically stationary. (Ex. 47-1). However, he did not agree with their conclusion that claimant sustained a mere lumbosacral strain. (Id.) Dr. Yarusso felt that claimant's symptoms were consistent with a disc lesion at L5-S1. (Id.) Nevertheless, he concluded that the May 16, 1996 "industrial injury" was currently causing less than 51 percent of her present symptoms, but she continued to experience symptoms from the injury, be it back strain or intervertebral disc. (Ex. 47-2).

On June 4, 1997, the employer issued a denial that stated, in part:

> "[The employer] has accepted and processed your lumbar sprain/strain resulting from the May 16, 1996 injury. Dr. James Yarusso and Franklin Wong both indicated that your injury combined with preexisting conditions (degenerative disc and joint disease, stenosis and herniation), that your condition is medically stationary, and the injury is no longer the major contributing cause of the combined condition. Pursuant to ORS 656.262(7)(b), [the employer] is hereby denying that your accepted injury is the major contributing cause of your combined condition and submitting your claim for closure." (Ex. 51).

On June 17, 1997, a Notice of Closure was issued, awarding claimant temporary disability benefits. (Ex. 52). The Notice of Closure stated that "[t]his is not a determination of any denial(s) of benefits in effect on the date of this closure." (Id.)

## STIPULATED FACTS

Exhibit 2 was received by the employer on May 31, 1996. (Tr. 28, 46). Exhibit 3 was received by the employer's nurse on May 23, 1996 and by the employer May 29, 1996 and May 31, 1996. (Tr. 28, 44-45).

## CONCLUSIONS OF LAW AND OPINION

At hearing, claimant argued that the employer's June 4, 1997 was a "backup" denial of the compensable injury. The ALJ found that, by accepting "low back pain," the employer accepted all of the conditions that caused "low back pain," which it knew or could have known by the date of acceptance. The ALJ was persuaded that the employer had accepted a combined condition when it accepted the claim for low back pain. The ALJ reasoned that, because the employer did not deny that the claim was compensable or that the strain injury did not occur, the denial was not a backup denial or rescission of the acceptance of the claim. On the merits, the ALJ concluded that claimant had not established that the employer's denial was procedurally or substantively incorrect.

On review, claimant argues that, by accepting "low back pain," the employer accepted the underlying cause or causes of the symptoms and the employer may not subsequently deny the underlying conditions.

If a carrier accepts a claim for symptoms, that acceptance encompasses the causes of the symptoms. Georgia Pacific v. Piwowar, 305 Or 494 (1988). In Piwowar, the carrier accepted a claim for a "sore back." Subsequent medical evidence showed that a preexisting disease (ankylosing spondylitis) caused the sore back, and the carrier denied compensability of that condition. Id. at 497. The Supreme Court explained that an employer is required "to compensate the claimant for the specific condition in the notice of acceptance regardless of the cause of that condition." Id. at 501. The Court concluded that, because the carrier had accepted a claim for a symptom of the underlying disease, and not a separate condition, its denial of the preexisting condition constituted a "back-up" denial. Id. at 501-02.

Here, the employer accepted "low back pain r/o HNP" on May 31, 1996. (Ex. 11). For the reasons that follow, we conclude that claimant's "low back pain" was caused in part by spinal stenosis and degenerative disc disease, including herniated or bulging discs, and its acceptance included those conditions.[1]

Claimant's "801" form indicated that her back "popped" on May 16, 1996 when she picked up a box of mirrors. (Ex. 1). The portion of the form asking about "[n]ature of injury or disease" referred to "HNP BACK." (Id.) On May 22, 1996, claimant sought medical treatment from Dr. Yarusso. He diagnosed back pain with degenerative joint disease and the possibility of intravertebral disc protrusion. (Ex. 4-3). He recommended a bone scan and a CT scan. A CT scan on May 23, 1996 showed "severe lumbar spondylosis and multilevel degenerative disc disease including marked spinal stenosis at L2-3 secondary to disc herniation in combination with hypertrophic/degenerative changes in the facet joints and narrowing of lateral recesses at multiple levels[.]" (Ex. 5-2). The findings included disc bulges at L5-S1 and L3-4 and disc herniations at L4-5 and L2-3. (Ex. 5-1).

On May 24, 1996, Dr. Yarusso reported that claimant's symptoms were increasing. (Ex. 8-1). He had discussed the CT scan with Dr. Hogan, who said claimant had significant spinal stenosis with a herniated nucleus pulposus at levels 2, 3, and 4 compromising her spinal canal. (Ex. 8-2). An MRI on May 25, 1996 showed mild to moderate disc bulges at L2-3, L3-4 and L4-5 with degenerative changes and spinal stenosis. (Ex. 9-2). The MRI also showed a possible herniation at L5-S1.

On May 28, 1996, Dr. Yarusso diagnosed spinal stenosis and "HNP L3, 4, 5." (Ex. 9A). He referred claimant to Dr. Tanabe for a surgical consultation.

Dr. Tanabe, neurosurgeon, examined claimant on May 29, 1996. (Ex. 10). He diagnosed "[c]hronic lumbar strain, superimposed upon spondylitic changes in the lumbar spine and a mild to moderate lumbar stenosis." (Ex. 10-2). He did not recommend surgery. (Id.)

Dr. Rosenbaum, neurosurgeon, examined claimant on May 31, 1996. (Ex. 12). He reported that claimant's symptoms suggested a possible disc protrusion, but could also represent primarily musculoskeletal discomfort. (Exs. 12, 13-2). He recommended conservative treatment. (Id.)

On May 31, 1996, Dr. Yarusso diagnosed "degenerative disc, spinal stenosis and HNP x 3." (Ex. 13A). He referred claimant to Dr. Miller.

On May 31, 1996, the employer accepted "low back pain r/o HNP." (Ex. 11).

Because we find that the medical evidence shows that claimant's low back pain after the May 16, 1996 incident was caused in part by spinal stenosis and degenerative disc disease, including herniated or bulging discs, we conclude that the employer's acceptance of "low back pain r/o HNP" encompassed those underlying conditions. See Georgia Pacific v. Piwowar, 305 Or at 501-02; compare James D. Ortner, 50 Van Natta 29, 30 (1998) (medical evidence after the carrier's acceptance showed that arthritis or degenerative disease did not cause the claimant's right knee pain and, therefore, the carrier's acceptance did not encompass the underlying condition). By not including an adequate degree of specificity in its acceptance, the employer accepted all the causes of claimant's low back pain, including spinal stenosis and degenerative disc disease. See Piwowar, 305 Or at 501-02; Emmert v. City of Klamath Falls, 135 Or App 209, 212 (1995) (employer accepted the condition(s) that caused "severe chest pains").

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[1] The employer argues that the Board must determine the employer's knowledge at the time of acceptance by focusing only on the actual evidence in the possession of its workers' compensation department at 9:48 a.m. on May 31, 1996, when the acceptance was processed. The employer contends that its acceptance could not have included any preexisting conditions and the only relevant evidence consisted of Exhibits 1, 2, 3 and 6.

As we discussed earlier, in Piwowar, the Supreme Court relied on medical evidence submitted after acceptance to hold that, because that evidence showed that a preexisting disease (ankylosing spondylitis) caused the sore back, the carrier could not deny compensability of that condition. 305 Or at 497, 501-02. Therefore, we are not persuaded by the employer's argument that we are restricted to examining only the documents in the possession of its workers' compensation department at the moment of acceptance. In any event, we note that Dr. Yarusso's May 24, 1996 report indicated that he had notified Ms. Rasmussen, a nurse at the employer, of claimant's condition. (Ex. 8-4, Tr. 34, 47). In his May 24, 1996 report, Dr. Yarusso referred to claimant's CT scan, which showed significant spinal stenosis with a herniated nucleus pulposus at levels 2, 3, and 4 compromising her spinal canal (Ex. 8-2), and Dr. Yarusso reported that claimant had an intervertebral disc protrusion "compromising an underlying condition of degenerative disc disease to her spinal cord." (Ex. 8-3).

The question remains concerning the effect of the employer's inclusion of "r/o HNP" in its acceptance. The employer asserts that "r/o HNP" means "rule out herniated nucleus pulposus." The employer contends that, by including "r/o HNP" in its acceptance, it did not accept responsibility for back pain caused by a herniated nucleus pulposus. The employer argues that the phrase "rule out" is obviously a negative one and, to the extent the intent of the phrase is unclear, it should be construed as a denial. We disagree.

Here, the employer's reference to "r/o HNP" in the acceptance is not clear. In Jerry L. Bliss, 49 Van Natta 1471 (1997), the carrier expressly accepted "dermatitis - bilateral forearm and lateral neck rash." We found that the carrier had accepted "dermatitis" without qualification, except the notation of "bilateral forearm and lateral neck rash." However, we did not find that the notation limited the acceptance to a specific type of dermatitis. We reasoned that, if the carrier had intended to limit its acceptance to a type of dermatitis, it should have explicitly done so.

We reach a similar conclusion in this case. Even if we assume that "r/o HNP" means "rule out herniated nucleus pulposus," the effect of that phrase in the employer's acceptance is unclear. We are not persuaded by the employer's argument that the phrase should be construed as a denial, particularly since the employer did not state that the condition was "denied" and did not include a notice of hearing rights. See OAR 436-060-0140(6) (WCD Admin. Order No. 96-053). To the contrary, the employer issued a notice of acceptance. If the employer intended to limit its acceptance and exclude any low back pain caused by a herniated nucleus pulposus, it should have explicitly done so. Instead, we find that the employer accepted claimant's "low back pain" without qualification. See Jerry L. Bliss, 49 Van Natta at 1471.

Alternatively, the employer contends that the June 4, 1997 denial is a proper back-up denial based on later obtained evidence. We disagree.

The employer's June 4, 1997 denial (Ex. 51) was issued pursuant to ORS 656.262(7)(b).[2] ORS 656.262(7)(b) applies only if the accepted condition, whether voluntary or by litigation, was a "combined condition." Robin W. Spivey, 48 Van Natta 2363, 2365 (1996); Elizabeth B. Berntsen, 48 Van Natta 1219, 1221 (1996). Under ORS 656.005(7)(a)(B), a "combined condition" exists when a compensable injury combines with a preexisting condition to cause or prolong disability or a need for treatment. A "combined condition" is compensable "only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause" of the disability or need for treatment of the combined condition.

Here, claimant's degenerative disc disease and spinal stenosis were included as part of the employer's acceptance and are compensable conditions. As such, they do not constitute "preexisting conditions" for purposes of ORS 656.005(7)(a)(B). See Raymond J. Suek, Sr., 49 Van Natta 706, 707 (1997) (carrier's acceptance for "low back pain" included the degenerative condition at L4-5, which was itself a compensable condition and did not constitute a preexisting condition for purposes of ORS 656.005(7)(a)(B)); Lee J. Johnson, 48 Van Natta 2261, 2263 (1996) (since the carrier's acceptance included the osteoarthritis condition, ORS 656.005(7)(a)(B) and 656.262(6)(c) did not apply). There is no evidence that the compensable degenerative and stenosis conditions combined with any other preexisting condition and, therefore, ORS 656.005(7)(a)(B) does not apply. Furthermore, since the employer did not accept a "combined" condition, ORS 656.262(7)(b) is not applicable.

Because we find, for the reasons set forth below, that the employer's "preclosure" partial denial was procedurally invalid, we do not address the merits of the employer's "backup denial" argument.

In Elizabeth B. Berntsen, 48 Van Natta at 1221-23 (1995), we concluded that a "preclosure" denial of a current condition is invalid when that condition is neither a "combined" nor a "consequential" condition, provided the condition is for the same condition previously accepted. Thus, we found that

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[2] ORS 656.262(7)(b) provides:

"Once a worker's claim has been accepted, the insurer or self-insured employer must issue a written denial to the worker when the accepted injury is no longer the major contributing cause of the worker's combined condition before the claim may be closed."

the rationale expressed in Roller v. Weyerhaeuser Co., 67 Or App 743, on reconsideration 68 Or App 743, rev den 297 Or 601 (1984), which precluded preclosure denials of a previously accepted condition, remained viable under these circumstances despite enactment of amended ORS 656.262(6)(c) and (7)(b). In Berntsen, we found that the claimant was seeking treatment for the same condition as her accepted condition. We concluded that, based on Roller, a carrier may not deny further responsibility for any condition arising from the accepted claim while the claim is in open status and before the extent of the accepted condition has been determined pursuant to the statutory procedures for claim closure. Since the claimant's current mid-back condition was the same condition as the accepted mid-back condition and her claim was not yet closed, we concluded that the carrier's partial denial with respect to claimant's mid-back condition was an invalid preclosure denial of an accepted condition and must be set aside. 48 Van Natta at 1223.

Here, the employer accepted a "low back pain r/o HNP." (Ex. 11). On June 4, 1997, before the claim was closed, the employer issued a partial denial, asserting that claimant's "lumbar sprain/strain" injury was no longer the major contributing cause of her "combined condition," which included, according to the employer, the preexisting conditions of degenerative disc and joint disease, stenosis and herniation. (Ex. 51). Although the employer did not accept a combined condition, it attempted to deny claimant's current condition on the grounds that the "lumbar strain/sprain" condition was no longer contributing to that condition.

A preclosure denial may be appropriate when the worker's current condition is completely separate from, or unrelated to, the accepted condition. See 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).

Here, in contrast, we find that claimant's current conditions are the same as the conditions accepted by the employer, which included degenerative conditions and spinal stenosis. On March 4, 1997, Drs. Stanford and Farris examined claimant on behalf of the employer. They reported that the imaging studies showed significant stenosis and degenerative change. (Ex. 44-5). They diagnosed claimant with a history of low back strain, May 16, 1996, and underlying spinal stenosis and degenerative arthritis. (Ex. 44-6). They concluded that, absent the underlying conditions, claimant's back strain would have resolved within three months. (Id.) They opined that the back strain was not a contributing factor in her symptomatology. (Ex. 44-7). In other words, Drs. Stanford and Farris concluded that claimant's current symptoms were caused by the underlying spinal stenosis and degenerative arthritis.

Dr. Wong, claimant's attending physician (Ex. 37), performed a closing examination on March 20, 1997. (Ex. 45). He reported that claimant had chronic, constant low back pain with occasional radiation to her right lower extremity. (Ex. 45-1). He diagnosed a lumbar strain and multiple level degenerative disc disease with spinal stenosis. (Ex. 45-3). Dr. Wong concurred with the report from Drs. Stanford and Farris. (Exs. 45-3, 46). Dr. Wong felt that claimant would have been released to full and regular work without the preexisting underlying degenerative disc disease. (Ex. 49).

Dr. Yarusso, claimant's previous attending physician, did not agree with Drs. Stanford and Farris that claimant had sustained a mere lumbosacral strain. (Ex. 47). He felt that claimant's symptoms were consistent with a disc lesion at L5-S1. (Id.) Dr. Yarusso subsequently agreed that the diagnostic tests were inconclusive as to whether claimant's L5 symptoms were caused by osteoarthritis, degenerative disc disease, stenosis or a disc encroachment. (Ex. 48).

We conclude that claimant's current conditions, which include degenerative conditions and spinal stenosis, are the same as the conditions accepted by the employer on May 31, 1996. At the time the employer's June 4, 1997 denial was issued, the claim was not yet closed. Under these circumstances, we conclude that the employer's partial denial with respect to claimant's current conditions was an invalid preclosure denial of accepted conditions, and must be set aside. See Elizabeth B. Berntsen, 48 Van Natta at 1223.

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

ORDER

The ALJ's order dated October 6, 1997 is reversed. The self-insured employer's June 4, 1997 denial is set aside and the claim is remanded to the employer for processing according to law. For services at hearing and on review concerning the June 4, 1997 denial, claimant's attorney is awarded an assessed fee of $4,000, payable by the self-insured employer.

**Board Member Haynes specially concurring.**

Although I agree with the analysis in the lead opinion, I write separately to express my concern about the employer's acceptance in this case. Claimant was injured on May 16, 1996 and the employer accepted the claim on May 31, 1996. As the ALJ pointed out, the legislature has granted carriers a 90 day period to investigate claims and determine what conditions it should accept or deny. See ORS 656.262(6). It is a mystery to me why the employer chose to accept this claim in such a short time frame when the cause of claimant's low back pain was unclear. The limited information available to the employer on May 31, 1996 should have prompted further investigation into the nature of claimant's condition before it decided what condition(s) to accept. Although the employer could not disregard its statutory duty to timely accept or deny a claim, its potential liability might have reduced had it delayed acceptance until a definitive diagnosis was offered.

The employer's attorney did a masterful job of litigating this case. Nevertheless, because the employer chose to accept "low back pain r/o HNP[,]" I feel compelled to apply Georgia Pacific v. Piwowar, 305 Or 494 (1988), and conclude that the employer accepted the conditions that caused claimant's low back pain following her injury on May 16, 1996.

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In the Matter of the Compensation of
**VERNAL M. GATCHET, Claimant**
WCB Case No. 97-03922
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that upheld the SAIF Corporation's denial of her claim for a right ankle injury. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

At all pertinent times, claimant worked as a Habilitative Technician at Fairview Training Center, which provides services to disabled children. One of claimant's duties was to distribute medications to the children at specific times, as medications could not be given to children who were rotated onto their stomachs. On December 17, 1996, claimant was hurrying to her cart from which she was to deliver medications, including those prescribed for children who had been on an outing. She was walking rapidly from the upper end of the building to the lower, when she slowed down and turned to her right to open the door to Ward 3. She put her right foot down to pivot, lifted her left foot for the turn, and her right ankle "popped." Claimant was subsequently diagnosed with a partially torn Achilles tendon.

Claimant was wearing boots with non-skid soles and the floor was linoleum tile over concrete.

CONCLUSIONS OF LAW AND OPINION

Citing to Johnson v. Beaver Coaches, Inc., 147 Or App 234 (1997), James R. Montoya, 48 Van Natta 1841 (1996), and Jimmy D. Ellis, 42 Van Natta 590 (1990), the ALJ determined that claimant could not show that her ankle injury arose out of her work because she identified no risk of employment to cause the injury. The ALJ reasoned that, although claimant was injured during the course of her regular work activity, the injury did not occur as a direct result of any specific anticipated risk of her work, nor did it occur as a result of her hurrying.

On review, claimant cites Helen L. Good, 49 Van Natta 1295 (1997), contending that claimant's uncontradicted testimony that she injured herself while hurrying to complete a work task proved that her injury resulted from a risk associated with her employment. We agree.

An injury arises out of employment where there exists "a causal link between the occurrence of the injury and a risk associated with [the] employment." Norpac Foods Inc. v. Gilmore, 318 Or 363, 366 (1994). If there is no causal connection between the claimant's injury and his or her work activities other than the fact the injury occurred at work, the injury is not compensable. Johnson v. Beaver Coaches, Inc., 147 Or App at 235. However, where the claimant's injury results from either an employment-related risk or a neutral risk where the employment put the claimant in a position to be injured, the injury is compensable under ORS 656.005(7)(a). See, e.g., Henderson v. S.D. Deacon Corp., 127 Or App 333 (1994) (worker's injury when she stepped out of an elevator while attempting to leave the building for a lunch break was in the course and scope of employment); Pamela M. Ahlstrom, 48 Van Natta 1665 (1996) (the claimant's knee injury, which occurred as she bent over to pick up merchandise off the floor, was within the course and scope of employment). Moreover, where a specific work activity is part of a claimant's job, the risk of injury from that activity is a risk of that job. Folkenberg v. SAIF, 69 Or App 159, 165 (1984).

In Good, the claimant, an accounting technician, injured her ankle while in a hurry to complete a task during the busiest time of the year. The claimant had gone to speak to a co-worker about a "somewhat urgent" matter and was in a rush as she walked out of the co-worker's cubicle because she was completing a work-related assignment that needed to be taken care of as soon as possible. Under those circumstances, we concluded that the claimant's haste in walking from another worker's work station in order to complete a task during the busiest time of the year was a condition of the claimant's employment that put her in a position to be injured.

Our view in Good is similar to that taken by the Supreme Court in Wilson v. State Farm Insurance, 326 Or 413 (1998). There, the Court reversed the Court of Appeals' opinion, 142 Or App 205 (1996), that had affirmed our order in Donna M. Wilson, 47 Van Natta 2160 (1995), that had found that the claimant's leg injury, which occurred when she "skip-stepped" around a corner at her workplace after she had been told by her employer she could leave work early, did not arise out of her employment. In reaching our conclusion, we had found that the claimant's injury did not result from an act that was an ordinary risk of, or incidental to, her employment. The claimant contended that her injury arose out of her employment because moving about in the workplace involves certain inherent work-related risks and "skip-stepping" around a corner was not so unusual as to take her injury outside the realm of work-related injuries.

The Supreme Court agreed. Noting that an objective of the Workers' Compensation Law is to provide, regardless of fault, sure, prompt and complete medical treatment for injured workers, the Court stated that the claimant's possible negligence in maneuvering around the corner of her employer's workplace was irrelevant. See ORS 656.012(2)(a).

Citing Andrews v. Tektronix, Inc., 323 Or 154, 163 (1996), the Court also reiterated that it had rejected a previous argument that, by disobeying an employer's instruction to avoid lifting heavy objects, the worker lost his entitlement to compensation. If an injury resulting from a prohibited method of accomplishing a task is compensable, the Court reasoned that an injury resulting only from an unusual method of doing so generally is compensable.

Consequently, the Supreme Court determined that the fact that the claimant's employer did not contemplate or expect her precise method of rounding the corner as she returned to her office did not render her resulting "skip-stepping" injury noncompensable. Accordingly, the Court held that the claimant had satisfied the "arising out of" prong of the work-connection test by showing a causal link between her injury and her work.

In this case, as in Good, claimant was rushing to complete her rounds disbursing medications on a specific schedule and during the particular times the children were able to take them. (Tr. 5, 6, 7, 11). It was while she was hurrying to perform her work assignment in a timely manner that she attempted to pivot to open a door, which resulted in her ankle injury.[1] Under these circumstances, we conclude

[1] There is some evidence that claimant's non-skid soles stuck to the floor when she was trying to pivot. (Tr. 6).

that claimant's act of walking hastily to and from different ends of the building while she was concentrating on her task of delivering medications to the children as scheduled on a timely basis was a condition of claimant's employment that put her in a position to be injured. Consequently, we find a sufficient causal connection between claimant's injury and her employment to conclude that her injury is compensable.

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

ORDER

The ALJ's order dated August 18, 1997 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant is awarded an attorney fee of $3,500, to be paid by SAIF.

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In the Matter of the Compensation of
**JEFFREY J. HYSON, Claimant**
WCB Case No. 96-06960
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that affirmed an Order on Reconsideration which awarded 30 percent (96 degrees) unscheduled permanent disability for a cerebral concussion condition. Claimant cross-requests review of that portion of the ALJ's order that declined to set aside the employer's partial denial of claimant's "organic brain syndrome." On review, the issues are extent of permanent disability and compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We briefly summarize the relevant facts.

Claimant was compensably injured on October 26, 1993 when a brake assembly fell and struck him on the forehead. The employer initially accepted the claim for a lacerated forehead, but later expanded its acceptance to include scalp laceration, cervical strain and cerebral concussion.

After the injury, claimant reported symptoms such as headaches, blurred vision, fuzzy thinking and dizziness.

The claim was closed by a February 29, 1996 Determination Order which awarded temporary disability benefits only. Claimant requested reconsideration and a medical arbiter panel examination was conducted by Drs. Dinneen, Thomas and Belville. Dr. Belville, a psychiatrist, rated claimant's impairment due to the accepted concussion as a class 2 brain impairment under OAR 436-035-0390(10). In his report, Dr. Belville listed a diagnosis of "traumatic brain injury resulting in a mild organic brain syndrome with residual symptoms." A July 15, 1996 Order on Reconsideration awarded 30 percent unscheduled permanent disability for claimant's concussion based on Dr. Belville's arbiter report.

On October 15, 1996, the employer issued a partial denial of "traumatic brain injury resulting in a mild organic brain syndrome with residual symptoms."

The ALJ found that, in rating claimant's permanent disability, Dr. Belville, the medical arbiter, used the term "organic brain syndrome" as a synonym for the accepted post-concussion syndrome. The ALJ found that the conditions were the same for purposes of awarding permanent disability benefits. Thus, the ALJ affirmed the Order on Reconsideration award for claimant's post-concussion syndrome. The ALJ further found that claimant did not have a separate condition of "organic brain syndrome." However, the ALJ declined to set aside the employer's denial of that condition on the ground that the denial was "pointless except as it is used by the employer to avoid paying the compensation awarded by the Order on Reconsideration, if that has occurred."

On review, the employer argues that claimant is not entitled to a permanent disability award. We disagree.

When 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). We rely on the most thorough, complete and well-reasoned evaluation of the claimant's injury related impairment. See Kenneth W. Matlack, 46 Van Natta 1631 (1994).

Here, assuming for the sake of argument that the medical evidence cited by the employer from Drs. Strauss, Watson, Logan and McNeill can be considered in rating claimant's impairment, we find Dr. Belville's medical arbiter report to be the most persuasive evidence of claimant's impairment. First, Dr. Belville's examination was performed closest in time to the reconsideration order. Second, his conclusion is based on complete information and he provides a well-reasoned evaluation. Accordingly, we rely on Dr. Belville's evaluation of claimant's permanent impairment.

Dr. Bellville specifically opined that claimant was within Class 2 with regard to his residual problems from the accepted cerebral concussion. We note that although he listed "mild organic brain syndrome" as a diagnosis in his report, Dr. Belville expressly related claimant's impairment to the accepted cerebral concussion, not to organic brain syndrome or any other condition. On the basis of this reasoning, we agree with the ALJ that the Order on Reconsideration award should be affirmed.

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

With regard to the compensability of the "organic brain syndrome," after reviewing the medical evidence, we are not persuaded that claimant has such a condition.

In this regard, clinical psychologist, Dr. Losk, testified that he did not make a diagnosis of "organic brain syndrome," which he described as an "over-arching term to describe some type of physiological or neurochemical problem in the brain that persistently stays with the person." (Tr. 53).

Dr. Peterson, a neurologist, differentiated between an "organic brain syndrome" and a post-concussive syndrome by explaining that "organic brain syndrome is a more serious subset of post-concussive syndrome in which there's demonstrable brain damage on formal testing." In contrast, she explained that a post-concussive syndrome was a collection of signs and symptoms following a head injury. According to Dr. Peterson, organic brain syndrome is a less specific and less technical definition and need not have the underpinnings of an abnormal neuropsychiatric evaluation.

Based on our reading of Dr. Peterson's deposition testimony, she does not believe that claimant has "organic brain syndrome," although she believes that claimant sustained some brain damage as a result of the injury and has symptoms of post-concussion syndrome which resulted from the accepted cerebral concussion. Although Dr. Peterson refers to organic brain syndrome as being a more serious "subset" of post-concussion syndrome, based on her explanation of the significant differences between the two conditions, we conclude that the two conditions are separate and different.

In summary, based on the medical evidence, we find no persuasive evidence that claimant has a compensable "organic brain syndrome." Under such circumstances, we uphold the denial.

Claimant argues that the present case is similar to Boise Cascade v. Borgerding, 143 Or App 371 (1996), and that the employer's denial is an improper "back-up" denial of the previously accepted condition.

We find the present case distinguishable from Borgerding. There, the employer had accepted the claimant's symptoms which were diagnosed as an allergy to red spruce and fir. More than two years later, the employer issued a "partial" denial of the claimant's condition after receiving new medical evidence indicating that the claimant's condition had been misdiagnosed and that the condition was actually "chronic urticaria/angioedema" unrelated to the claimant's work exposure. The ALJ and the Board concluded that the employer's denial was for the same condition it had previously accepted and found that the denial should be set aside. The court affirmed the Board, finding that substantial evidence supported the Board's conclusion that the employer was attempting to deny the same condition it had previously accepted.

As explained above, in the present case, the medical evidence does not establish that the "organic brain syndrome" denied by the employer is the same as the cerebral concussion the employer previously accepted. In addition, in the present case, the employer accepted a specific condition, cerebral concussion, and did not merely accept symptoms. Accordingly, we are not persuaded that the denial is a "back-up" denial.

## ORDER

The ALJ's order dated May 8, 1997 is affirmed. The self-insured employer's October 15, 1996 partial denial is upheld. For services on review with regard to the permanent disability issue, claimant's attorney is awarded an assessed fee of $1,200, payable by the employer.

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In the Matter of the Compensation of
**RONALD L. JONES, Claimant**
WCB Case No. 97-01376
ORDER ON REVIEW
Emerson G. Fisher, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that set aside its denial of a herniated disc at L4-5. On review, the issue is compensability. We reverse.

## FINDINGS OF FACT

Claimant, age 50 at the time of hearing, works as a truck driver. On March 31, 1995, he experienced the onset of low back pain while throwing straps to secure a load on his truck. He sought treatment the next day, complaining of lumbar pain with radiation into the left buttocks and leg. Dr. Curtis noted a history of back pain in the past with treatment by Dr. Melson and diagnosed "lumbago." The insurer accepted that condition.

Claimant's symptoms continued, and Dr. Curtis ordered a lumbar CT scan. On April 20, 1995, Dr. Gilmore interpreted the CT scan as showing moderate spinal stenosis at L4-5, with no disc herniation or other acute abnormality. Dr. Sinnott also reviewed the CT scan and noted that the left L4-5 nerve root ganglion appeared doubled in appearance, which appeared to represent an abnormality. Dr. Sinnott reported that the abnormality could represent a small disc fragment, a neuritis-type of swollen-type root pattern or a small neuroma. He recommended further evaluation with an MRI.

Claimant was referred back to Dr. Melson. On May 2, 1995, Dr. Melson diagnosed degenerative disc disease with L4-5 radiculopathy as a consequence of the injury of March 31, 1995. He reviewed the lumbar CT scan, finding that it showed a broad based disc protrusion midline and left at L4-5 with spinal stenosis at that level.

On August 8, 1995, claimant had an upper GI series. The radiologist, Dr. Cook, noted that the scout film showed mild degenerative change in the lumbar spine. The examination was normal.

On October 11, 1995, claimant was examined by Drs. Neumann and Maukonen at the insurer's request. Among other things, Drs. Neumann and Maukonen diagnosed preexisting degenerative arthritis, low back strain and herniated nucleus pulposus secondary to the incident of March 31, 1995. They did not review claimant's imaging studies.

On March 1996, Dr. Blumberg reviewed claimant's medical records. On July 31, 1996, Dr. Gilmore re-reviewed claimant's April 20, 1995 lumbar spine CT. He confirmed that he saw no evidence of a disc herniation or bulging disc, but some minor spurring from the vertebral bodies at L1-2 and L2-3 levels, which was not mentioned in his original report.

On February 10, 1997, the insurer issued a denial providing, in pertinent part, as follows:

> "Currently we are in receipt of a claim for a medical diagnosis, herniated disc at L4-5. After review of the information received to date, we find that there is insufficient evidence that establishes that the industrial injury of March 31, 1995 is the cause of a herniated disc at L4-5.
>
> "Therefore, * * * we hereby issue this formal partial denial for a herniated disc at L4-5."

In April 1997, Dr. Melson confirmed his diagnosis of a "lumbar disc" based on claimant's clinical examination of May 1995. He noted what he believed to be a broad-based disc occluding the left L4-5 neural foramen on the CT scan.

Dr. Arkless reviewed claimant's chartwork and imaging studies in May 1997 at the insurer's request. He concluded that it was not possible to state with any degree of certainty that claimant had a herniated disc at L4-5.

## CONCLUSIONS OF LAW AND OPINION

The ALJ found that the employer's denial did not deny that a herniated disc existed, but only whether that condition was caused by claimant's work injury. The ALJ further found that claimant's disc condition arose out of the accepted injury and directed the employer to accept it.

On review, the employer argues that its denial encompassed a challenge to the existence of the disc herniation at L4-5 as well as a challenge to causation. The employer further asserts that a preponderance of the evidence fails to prove the existence of such a condition. For the reasons set forth below, we agree with both contentions.

As noted above, the employer's denial asserted that there was insufficient evidence that "the industrial injury of March 31, 1995 is the cause of a herniated disc at L4-5" and therefore denied "a herniated disc at L4-5." Although a carrier is bound by the express language of its denial, see Tattoo v. Barrett Business Services, 118 Or App 348 (1993), we do not find that the employer's denial of "a herniated disc" expressly acknowledges the existence of such a condition. Rather, we conclude that the wording of the employer's denial encompasses a denial of the diagnosis as well as a denial based on causation.[1]

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[1] Even if the denial could not be read to deny the existence of a herniated disc, we have previously held that the parties may, by agreement, try an issue that is outside the express terms of the denial. See, e.g., Linda G. Landreth-Wiese, 49 Van Natta 1123 (1997); Terry Hickman, 48 Van Natta 1073 (1996). Based upon the parties' framing of the issue at hearing, we find an agreement to try the employer's challenge to the diagnosis of a herniated disc.

Our determination in this regard is further supported by the medical evidence developed in the record (which focused primarily on the diagnosis, rather than the cause) and the parties' framing of the issue at hearing. Claimant's counsel advised the ALJ that claimant had asked the employer "to accept a herniated disc" and that the employer responded by issuing "a denial of a disc." Claimant's counsel then asserted that "we're trying to get the disc condition accepted and then attorney's fees if we prevail." (Tr. 1).

Having determined that the parties' dispute in this case centers on whether claimant has established the existence of the denied condition, a herniated disc at L4-5, we proceed to the merits. Claimant's treating doctor, Dr. Melson, opined that claimant suffered a ruptured L4-5 disc during his injury of March 31, 1995. (Ex. 37-1). He later explained that this diagnosis was based on his clinical examination of claimant on May 2, 1995, in which claimant had weakness in the extensor hallucis, tibualis anterior and perhaps in the everters of the foot, subjective hyperthesia on the lateral left thigh and suppressed left knee jerk. Dr. Melson noted that although the diagnosis of a lumbar disc cannot be made with any confidence on a CT scan, he could point to what he believed to be a broad-based disc occluding the left L4-5 neural foramen. (Ex. 65-2). In his deposition, Dr. Melson testified that stenosis can mimic the same symptoms that a herniated disc might create, although he continued to believe that claimant's stenosis was not significant and that his radicular symptoms stemmed from a disc injury. (Ex. 67-14).

Dr. Gilmore, a radiologist, interpreted claimant's April 20, 1995 CT scan as showing moderate spinal stenosis, but no disc herniation or other acute abnormality. He noted some bony overgrowth of the facet joints at each level causing moderate impingement upon the lateral aspects of the thecal sac at the L4-5 level. (Ex. 21). Dr. Gilmore later re-reviewed claimant's lumbar spine CT and again found no evidence of a disc herniation or bulging disc. (Ex. 56).

Dr. Sinnott also reviewed claimant's April 20, 1995 CT scan and noted that the left L4-5 nerve root ganglion appeared to be slightly doubled in appearance and somewhat abnormal compared to the right nerve root ganglion. He opined that this abnormality "could represent a small disc fragment, could represent a neuritis-type of swollen-type root pattern, and may represent a small neuroma." Dr. Sinnott concluded that this lumbar area required further evaluation and recommended a MRI. (Ex. 21A).

Finally, Dr. Arkless of Advanced Diagnostic Imaging reviewed claimant's imaging studies at the employer's request. Dr. Arkless reported that, on the imaging studies, all lumbar levels showed some small hypertrophic changes. He also found a slight bulge of the annulus just lateral to the left neural foramen at L4-5 associated with slight posterior placement of the L4 nerve root, but no herniated disc. He further noted that associated small but definite hypertrophic bone change under this bulge indicated that at least some of the problem was long-standing and concluded that it was not possible to state with any degree of certainty that claimant had a herniated disc at L4-5. Dr. Arkless concluded that claimant's symptoms might be related to the hypertrophic changes.

Where, as here, there is a dispute between medical experts, we rely on those medical opinions which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). Claimant argues that we should give greater weight to the opinion of Dr. Melson because he is the treating physician, and his opinion is based on his clinical findings. See Weiland v. SAIF, 64 Or App 810 (1983). We find, however, that the dispute in this case (i.e., whether claimant suffered a herniated disc at L4-5 as a result of his March 1995 compensable injury) involves expert analysis rather than expert external observations, and therefore, the status of treating physician confers no special deference. See Allie v. SAIF, 79 Or App 284 (1986); Hammons v. Perini Corp., 43 Or App 299 (1979).

After considering the expert medical evidence, we conclude that claimant has failed to prove that he sustained a herniated disc at L4-5 as a result of his compensable injury. In reviewing claimant's lumbar CT scan, Drs. Gilmore, Sinnott and Arkless all found signs of stenosis or hypertrophic changes at the L4-5 level, but none of these physicians specifically diagnosed a herniated or ruptured disc as the source of claimant's need for treatment. Dr. Melson believed claimant had a herniated disc because his clinical examination was consistent with such a diagnosis, but admitted that the diagnosis could not be confirmed by the CT scan. Although the record reveals the possibility that claimant's symptoms stem from a herniated disc at L4-5, claimant has not proven the existence of this diagnosis as a medical

probability. We therefore uphold the employer's denial of this specific condition.[2] See Gormley v. SAIF, 52 Or App 1055 (1981).

ORDER

The ALJ's order dated October 2, 1997 is reversed. The employer's denial of a herniated disc at L4-5 is reinstated and upheld. The ALJ's attorney fee award is also reversed.

[2] The employer's denial does not deny the compensability of claimant's current condition, only the diagnosis and causation of a herniated disc at L4-5. (See Ex. 63).

March 17, 1998 Cite as 50 Van Natta 409 (1998)

In the Matter of the Compensation of
**SCOTT ALLTUCKER, Claimant**
WCB Case No. 97-03007
ORDER ON REVIEW
Bennett, et al, Claimant Attorneys
Garrett, 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) Michael Johnson's order that set aside its denial of claimant's injury claim for a fracture of the left radius and ulna. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant has been employed as a firefighter/paramedic with the employer since 1984. (Tr. 9). His schedule consists of alternating shifts as a paramedic on an ambulance or as a hoseman on a fire truck. (Tr. 9, 11). He may be assigned to any of the employer's stations.

The employer issues a monthly report posted in all stations, which shows shift schedules for the entire month. (Tr. 10). The employer issues a daily report that may change information in the monthly report, based on vacations and illnesses. (Tr. 13, 17). Claimant testified that the employer cannot be sure which employees will be coming to work until 7:00 a.m. (Tr. 13). Employees are expected to call in the morning to check for any schedule changes. (Tr. 17).

Claimant's shift begins at 8:00 a.m. (Tr. 18). He testified that the employer expects employees to be in uniform and ready to work at 8:00 a.m. (Tr. 13, 14). It was generally expected that, once an employee has arrived at the station and the bell rings announcing an emergency, that employee will take the place of an individual who would be ending his/her shift at 8:00 a.m. (Tr. 14).

Claimant's practice was to arrive at work at 7:00 a.m. in order to perform his required physical exercises. (Tr. 12). He testified that, if he called into work at 7:00 a.m. to check for schedule changes, he would get to work after 7:00 a.m. and, for that reason, he generally called the night before to check on schedule changes. (Tr. 17, 18, 19).

On March 23, 1996, claimant worked as firefighter at Station 5. (Tr. 11). The monthly report indicated that claimant's next shift was on March 26, 1996 and he was scheduled to be a medic at Station 2. (Id.) Claimant testified that his paramedic shifts rarely changed and he had only been pulled off the ambulance shift approximately five times in 13 years. (Tr. 9, 11-12, 15). He did not call into work on the evening of March 25, 1996 or on the morning of March 26, 1996 to check for schedule changes. (Tr. 18, 19).

On March 26, 1996, claimant arrived at Station 2 close to 7:00 a.m., planning to perform his exercises and work as a medic. (Tr. 12, 18). He was informed that he was scheduled to work at Station 5 as a hoseman instead. (Tr. 13, 18). Claimant left Station 2 about 7:10 a.m. and rode his bicycle to Station 5. (Tr. 13, 18). On his way to Station 5, claimant was injured on the railroad tracks at approximately 7:20 a.m. (Tr. 13, 18-19). An injury report indicated that claimant's bike trailer with his "turn out gear" became caught in the railroad tracks, throwing claimant over the handle bars. (Ex. 3). Claimant sustained a fracture of the left radius and ulna. (Exs. 1, 4).

On April 4, 1997, the employer denied the claim on the ground there was insufficient evidence that claimant's condition arose out of or in the course and scope of his employment. (Ex. 8). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant was in the course of his employment at the time of the accident. The ALJ reasoned that claimant's injury occurred during a span of time when he typically did his exercises and during which he would have gone out on a fire call or ambulance run, even though it was not yet 8:00 a.m. The ALJ also found that claimant's incident arose out of his employment. The ALJ reasoned that it was a "simple mistake" that claimant had gone to the wrong station on March 26, 1996 and he was transporting his firefighting outfit in the bicycle trailer at the time of the accident.

The employer contends that claimant's left wrist injury was not compensable because it did not arise out of and was not in the course of his employment.

ORS 656.005(7)(a) provides that a "'compensable injury' is an accidental injury * * * arising out of and in the course of employment[.]" There are two elements in determining whether the relationship between the injury and the employment is sufficient to establish compensability of the injury: (1) "in the course of employment" concerns the time, place, and circumstances of the injury; and (2) "arising out of employment" tests the causal connection between the injury and the employment. Norpac Foods, Inc. v. Gilmore, 318 Or 363, 366 (1994). Both elements must be evaluated; neither is dispositive. Id.

We first examine the time, place and circumstances of the injury. An injury occurs "in the course of" employment if it takes place within the period of employment, at a place where a worker reasonably may be expected to be, and while the worker reasonably is fulfilling the duties of the employment or is doing something reasonably incidental to it. Fred Meyer, Inc. v. Hayes, 325 Or 592, 598 (1997).

Claimant contends that his injury occurred during the course of employment because it occurred during a time when the employer had, either expressly or impliedly, acquiesced to claimant's presence on the premises to perform preparatory or incidental acts.

We find that whether or not the employer had acquiesced to claimant's presence on the premises to perform preparatory acts before his shift began is not particularly relevant in this case because claimant was not injured on the employer's premises.[1] Rather, claimant's injury occurred when he was riding a bicycle to Station 5 to begin his daily work. Claimant was not on paid time at the time of his injury. Moreover, claimant's injury, which occurred while riding a bicycle on the railroad tracks, did not occur in a place where he was normally employed.

Ordinarily, an injury sustained while a worker is going to or coming from work is not considered to have occurred "in the course of" employment and, therefore, is not compensable. Hayes, 325 Or at 597; Krushwitz v. McDonald's Restaurants, 323 Or 520, 526 (1996). That general rule is called the "going and coming" rule. The reason for the "going and coming" rule is that the relationship of employer and worker ordinarily is suspended from the time the worker leaves work to go home until he or she resumes work because, while going to or coming from work, the worker is rendering no service for the employer. Hayes, 325 Or at 597.

Here, there is no evidence that claimant was compensated for any travel time in commuting to Station 5. Claimant's "travel" in this case amounted to commuting to Station 5 because he had

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[1] In Hayes, the Supreme Court described the principle of preparatory or incidental acts as follows:

"The course of employment, for employees having a fixed time and place of work, embraces a reasonable interval before and after official working hours while the employee is on the premises engaged in preparatory or incidental acts. The rule is not confined to activities that are necessary; it is sufficient if they can be said to be reasonably incidental to the work. What constitutes a reasonable interval depends not only on the length of time involved but also on the circumstances occasioning the interval and the nature of the employee's activity." Hayes, 325 Or at 599 (quoting 2 Larson's Worker's Compensation Law § 21.60(a) at 5-45 to 5-46; footnotes omitted; emphasis supplied).

originally gone to Station 2, where he was not assigned to work.[2] Claimant's riding a bicycle to Station 5 was not reasonably incidental to his employment. There is no evidence that either party contemplated the activity of riding a bicycle between stations as part of claimant's employment.

Under these circumstances, we conclude that claimant's injury did not occur "in the course of" employment because it did not take place within the period of employment or at a place where claimant was reasonably expected to be. See Hayes, 325 Or at 598. Moreover, we are not persuaded that, by commuting to work, claimant was reasonably fulfilling the duties of his employment or that he was doing something reasonably incidental to work. Rather, claimant was merely on his way to work to begin his shift, bringing his commute squarely within the "going and coming" rule. See Krushwitz, 323 Or at 532.

We also examine whether claimant's injury "arose" out of his employment. That inquiry tests the causal connection between the claimant's injury and a risk connected with employment. Wilson v. State Farm Insurance, 326 Or at 416. In Redman Industries, Inc. v. Lang, 326 Or 32, 35-36 (1997), the Court explained:

> "A causal connection requires more than a mere showing that the injury occurred at the workplace and during working hours. A causal connection must be linked to a risk connected with the nature of the work or a risk to which the work environment exposed claimant." (Citations omitted).

Here, claimant's injury did not occur at work or during working hours. Nevertheless, claimant contends that his injury arose out of his employment because the injury occurred when he was "acting solely for the benefit" of the employer. He argues that he was exposed to the risk of injury because he was moving from one station to another station to perform his duties for the employer. We disagree.

The nature of claimant's employment as a firefighter/paramedic did not involve the activity of riding a bicycle to Station 5 and his work did not expose him to a risk of injury from riding a bicycle. The employer did not have any right to control the time, manner of travel, or route to be taken on claimant's trip. Moreover, there is no evidence that claimant's injury occurred as a result of any employer-created hazard. If we accept claimant's argument that he was exposed to the risk of injury because he was moving from one station to another station to perform his duties, any employee who is injured while commuting to work would sustain an injury in the "course and scope" of employment. The reason for the "going and coming" rule is that, while going to or coming from work, the worker is rendering no service for the employer. Hayes, 325 Or at 597. We find no reason to deviate from the "going and coming" rule in this case.

In sum, we conclude that claimant did not meet his burden of proving that his injury occurred within the course and scope of his employment.

## ORDER

The ALJ's order dated August 20, 1997, as reconsidered on October 21, 1997, is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

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[2] The employer contends that claimant's injury resulted from his failure to comply with the employer's verification procedure regarding daily schedules. Claimant's possible contributory negligence is irrelevant. Workers' 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. Wilson v. State Farm Insurance, 326 Or 413, 417 (1998).

In the Matter of the Compensation of
**RIGOBERTO B. CASIMIRO, Claimant**
WCB Case No. 96-11092
ORDER ON REVIEW
Bryant, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Baker's order that set aside its denial of claimant's occupational disease claim for a back condition. On review, the issues are res judicata and compensability. We reverse.

## FINDINGS OF FACT

Claimant began working for the employer in or around 1988, and he experienced the onset of left upper back pain in January 1995. At that time, claimant was working as a wood/lumber marker, which involved repetitive pulling of pieces of wood. Claimant sought medical treatment and was diagnosed with musculoskeletal pain of the thoracic rib cage. Claimant filed a claim for "left back pain," and SAIF issued a July 31, 1995 denial on the stated grounds that there was no diagnosable condition supported by objective findings. Claimant did not appeal the denial and it became final by operation of law. (Exs. 1 thru 4).

On September 9, 1996, claimant sought chiropractic treatment for left-sided thoracic/lumbar pain from Dr. Mullins, D.C. Examination findings included point tenderness and some loss of thoracolumbar motion. (Exs. 7, 10). Claimant filed a claim for "back pain" which SAIF denied on October 14, 1996.

Dr. Altrocchi, M.D., evaluated and treated claimant on January 7 and 14, 1997. Dr. Altrocchi reported that claimant's major complaint was pain in the right upper buttock, radiating into the posterior thigh. An MRI on January 11, 1997 showed no evidence of focal disc herniation, spinal canal stenosis or nerve root impingement. An EMG on January 14, 1997 demonstrated old neuropathic abnormalities in a right S1 distribution with no evidence of acute denervation.

Dr. Fuller evaluated claimant for SAIF on February 26, 1997.

On March 11, 1997, Dr. Kendrick, neurosurgeon, evaluated claimant on referral from Dr. Altrocchi.

## CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that the unappealed July 1995 denial did not create a bar to the current occupational disease claim, and that the medical record satisfied claimant's burden of establishing compensability of that claim. On review, SAIF contends that the unappealed denial either created a claim preclusion bar to the current claim, or established a preexisting condition within the meaning of ORS 656.802(2)(b) so that claimant must establish a pathological worsening of his alleged occupational disease. SAIF further contends that the medical record does not establish that claimant's work activity was the major contributing cause of his current condition under either ORS 656.802(2)(a) or (b).

We agree that the medical record does not establish compensability of claimant's current condition under either ORS 656.802(2)(a) or (b). Accordingly, we do not address SAIF's alternative preclusion arguments.

Claimant must prove the existence of an occupational disease by medical evidence supported by objective findings. ORS 656.802(2)(d). In addition, claimant must establish that her work activity for the employer is the major contributing cause of the onset or worsening of that occupational disease. ORS 656.802(2)(a) and (b). Resolution of these issues 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 medical record includes relevant opinions from Drs. Mullins, Fuller, Altrocchi and Kendrick.

Dr. Mullins provided chiropractic care in September and October 1996. He initially attributed claimant's complaints to "T/L strain/sprain, chronic recurrent and work related." (Ex. 7-1). In a subsequent October 1996 chart note, Dr. Mullins commented on claimant's increasingly diffuse symptoms, noted that he was at a loss to identify any significant pathology, and raised the possibility of functional overlay. (Ex. 12-1). Then, in early November 1996, Dr. Mullins opined that claimant's work activity prior to the July 1995 denial was the major contributing cause of claimant's "current need for medical care." (Ex. 7). In support of that opinion, Dr. Mullins noted that "[t]here is no history of intervening trauma to suggest other reasons for his current need." (Ex. 14).

Dr. Fuller performed a medical examination for SAIF in February 1997. He opined that there was no particular evidence of lumbar muscle strain causative of pain and, instead, diagnosed a congenital defect at L5-S1 producing isthmic spondylolysis and facet sclerosis, facet arthropathy and innervation. Dr. Fuller opined that claimant's preexisting congenital problems had combined with the twisting activities at work to create a resultant low back pain and need for medical treatment. Dr. Fuller further opined that claimant's work activity was not the major contributing cause of his disability or need for treatment. Dr. Fuller also noted that his opinion was consistent with the fact that claimant's symptoms did not resolve during a three week vacation from work.

Dr. Altrocchi evaluated and treated claimant on two occasions in January 1997. Dr. Altrocchi initially diagnosed a probable herniated disc at L5-S1 on the right, a cervical and thoracic sprain, an exhalation restriction of the first three ribs on the right, and diverse vertebral rotational abnormalities. (Ex. 14AA). After reviewing the normal January 1997 MRI and Dr. Fuller's report, Dr. Altrocchi opined that all of claimant's back and right leg complaints were due to the "mechanical abnormalities" described in his January 7, 1997 examination report, and that none of claimant's symptoms were due to the congenital abnormalities identified by Dr. Fuller. Dr. Altrocchi reasoned that claimant would have become symptomatic prior to 1995 if claimant's preexisting congenital abnormalities were the major cause of his condition. (Exs. 14B, 19).

Dr. Altrocchi then asked Dr. Kendrick, neurosurgeon, to comment on Dr. Fuller's report. After reviewing that report, Dr. Kendrick attributed claimant's complaints to a mild sprain/strain injury secondary to pain impulses being radiated from innervation at the L5-S1 facet joint. (Ex. 21). The record does not contain any further comment from Dr. Altrocchi in response to Dr. Kendrick's opinion.

The ALJ concluded that the opinions of Drs. Altrocchi and Kendrick establish compensability of claimant's occupational disease claim. We, instead, conclude that the medical record does not establish compensability of claimant's back condition under the major contributing cause standard required by ORS 656.802.

Dr. Altrocchi's opinion is based on two examinations in January 1997, rather than a long-term treating relationship. Furthermore, his opinion is conclusory and does not explain why claimant's work activity is the primary cause of claimant's condition, as distinct from the precipitating cause. See Robinson v. SAIF, 147 Or App 157 (1997); Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev dismissed 321 Or 416 (1995). In particular, Dr. Altrocchi does not explain how the mechanical abnormalities he identified contributed to claimant's pain or were caused by his work activities. Nor does Dr. Altrocchi adequately consider the possible contribution of the preexisting facet degeneration identified by Drs. Kendrick and Fuller. At best, Dr. Altrocchi's reasoning is consistent with a finding that the work activities were the precipitating cause of claimant's current condition, but not the major cause.

Moreover, the record does not otherwise establish compensability of claimant's current condition under ORS 656.802. Dr. Mullins' opinion is not persuasive because he does not discuss the possible contribution of the functional overlay he himself noted in October 1993. Furthermore, Dr. Mullins has never reviewed or responded to the alternative diagnoses and causation opinions of Drs. Kendrick and Fuller. See Dietz, 130 Or App at 401. Finally, Dr. Kendrick does not opine that claimant's work activity or work-related strain is the major contributing cause of his current condition.

In summary, we find persuasive reasons not to defer to the opinions of Drs. Altrocchi and Kendrick, and we conclude that the medical record does not otherwise establish that claimant's work activity is the major contributing cause of his current complaints. Consequently, claimant has not satisfied his burden of establishing a compensable occupational disease claim under either ORS 656.802(2)(a) or (b).

ORDER

The ALJ's order dated October 16, 1997 is reversed. The SAIF Corporation's October 14, 1996 denial, as amended January 16, 1997, is reinstated and upheld. The ALJ's attorney fee award is reversed.

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In the Matter of the Compensation of
**FLORELLA E. CONNOR, Claimant**
WCB Case No. 96-10320
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that upheld the insurer's denial of claimant's current upper back/neck condition. On review, the issue is compensability.

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

Claimant continues to assert on review that her condition has not changed. Thus, she contends, the insurer should be barred from denying the accepted claim, pursuant to ORS 656.262(6)(c) and Harry L. Lyda, 48 Van Natta 1300 (1996), aff'd State Farm Insurance Company v. Lyda, 150 Or App 554 (1997). We disagree.

In this case, the preponderance of the medical evidence indicates that there has been a change in claimant's accepted condition or a change of circumstances such that the otherwise compensable injury has ceased to be the major contributing cause of the combined condition. See ORS 656.262(6)(c).[1]

Dr. Marble, an orthopedic surgeon who examined claimant for the insurer, opined that claimant's degenerative disc disease (DDD) "of some significance" in the lower cervical spine predated her May 1996 injury and that, given the usual two to four months duration expected of her cervicothoracic strain injury, the preexisting DDD is presently the major contributing factor causing her symptoms. (Ex. 15-7).

Dr. Atkins, claimant's attending physician, agreed with Dr. Marble's assessment, noting that claimant's pain had shifted higher into the neck, such that the arthritic component of her pain had increased while the sprain had not improved as expected. (Ex. 16). Subsequent to neurosurgical evaluation by Dr. Camp, Dr. Atkins opined that the "severe" degenerative arthritis in claimant's neck was at that point the most persistent reason that claimant was having pain. (Ex. 20). Finally, in his deposition, Dr. Atkins opined that claimant's preexisting DDD was the major factor (at least 51 percent) in her ongoing pain complaints. He explained that the DDD was preventing her recovery, and the longer her pain continued, the more likely it was that the arthritis was causing it. (Ex. 24-16, -18, -19, -20).

This medical evidence shows that, even though claimant's "combined condition" continued to exist, there is insufficient proof that the compensable injury was the major contributing cause after December 23, 1996. See ORS 656.005(7)(a)(B); Kathy A. Zuercher, 48 Van Natta 2612 (1996).

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[1] ORS 656.262(6)(c) provides:

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

Moreover, Lyda is inapposite. In Lyda, the insurer issued a denial based on information received during an arbiter examination, alleging that the claimant's current chronic pain syndrome was not compensable. In evaluating the medical record, we found that, although the arbiters opined that the claimant's present condition was not related to the compensable injury in a "major way," they did not identify any change in the claimant's condition or a change of circumstances such that the claimant's compensable injury was no longer, or "ceased" to be, the major contributing cause of his combined condition. We also found that an examining physician's opinion did not identify the requisite change of condition or circumstances. Finally, even though the claimant's attending physician opined that the degenerative conditions had generally deteriorated, he also observed that there had been no "major changes." Based on the medical record, we concluded that there had not been a change in the claimant's condition or circumstances sufficient to warrant the issuance of a denial under ORS 656.262(6)(c). Alternatively, we held that, even if the requisite change of circumstances was present to support the procedural validity of the denial, the persuasive medical evidence did not establish that the claimant's compensable injury had "ceased" to be the major contributing cause of his chronic pain disorder.

Here, in contrast to Lyda, the medical record establishes that there has been a change in claimant's accepted condition or change in circumstances sufficient not only to support the procedural validity of the insurer's denial, but to establish that claimant's compensable injury had "ceased" to be the major contributing cause of her current combined condition. Thus, claimant has failed in her burden to prove compensability of her current condition under ORS 656.266.[2]

ORDER

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

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[2] ORS 656.266 provides that the burden to prove compensability is upon the worker. See also State Farm Insurance Company v. Lyda, 150 Or App at 559.

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In the Matter of the Compensation of
**ROGER C. ATCHLEY, JR., Claimant**
WCB Case No. 95-13677
ORDER ON REMAND
Swanson, Thomas & Coon, Claimant Attorneys
Lundeen, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Atchley v. GTE Metal Erectors, 149 Or App 581 (1997). The court has reversed our prior order, Roger C. Atchley, 48 Van Natta 1065 (1996), that declined to award temporary disability benefits to claimant between September 19, 1995 and January 5, 1996. Concluding that claimant was substantively entitled to these temporary disability benefits during that period, the court has held that we erred in denying claimant's request for temporary disability benefits. Consequently, the court has remanded for reconsideration.

Consistent with the court's holding, we reverse that portion of the Administrative Law Judge's January 29, 1996 order that declined to award temporary disability benefits. Claimant is awarded temporary disability from September 19, 1995 through January 5, 1996. Claimant's counsel is awarded an "out-of-compensation" attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's counsel.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**LINDA L. HARPER, Claimant**
WCB Case Nos. 96-11266, 96-09823, 96-00664 & 96-09042
ORDER ON REVIEW
Aller & Morrison, Claimant Attorneys
Hoffman Hart & Wagner, Defense Attorneys
William J. Blitz, Defense Attorney
Judy C. Lucas (Saif), Defense Attorney
Moscato & Hallock, Defense Attorneys

Reviewed by the Board en banc.

The noncomplying employer, A Bite of Wyoming, requests review of that portion of Administrative Law Judge (ALJ) Mongrain's order that: (1) found it was precluded from challenging the compensability of claimant's right wrist injury and left shoulder calcific bursitis conditions which were previously accepted by the SAIF Corporation; and (2) set aside SAIF's denial of claimant's current left shoulder condition. On review, the issues are jurisdiction and compensability. We reverse.

## FINDINGS OF FACT

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

Claimant worked for the noncomplying employer for many years (on and off) during the 1960's, 1970's and 1980's, until she quit in approximately January 1990. During the 1980's, she began to experience right shoulder symptoms and by 1988, she wore a sling at home because of her right shoulder pain. In June 1989, she sought treatment for right wrist pain and was diagnosed with tendinitis. In December 1989, she saw Dr. Perry for right wrist and shoulder pain, and was diagnosed with calcific tendinitis of the right shoulder and avascular necrosis of the right scaphoid with probable post-traumatic changes from a previously fractured scaphoid, age indeterminate.

Claimant made a claim for right wrist pain. She was later diagnosed with avascular necrosis of the right carpal naviclar. In October 1990, A Bite of Wyoming was determined to be a noncomplying employer and SAIF Corporation was ordered to process the claim. Around the same time, claimant filed a new 801 form, alleging a specific injury to her right hand/wrist in June 1989. Pursuant to a Stipulation and Order entered April 19, 1991, SAIF agreed to accept claimant's October 1990 claim for a June 1989 wrist injury (claim No. 7745771B). (Ex. 24).

In May 1991, SAIF accepted a claim for displaced fracture of the right wrist, and mailed a copy of the acceptance to the noncomplying employer and its owners. SAIF did not, however, notify the noncomplying employer of its right to contest compensability. Claimant underwent two surgeries on her right wrist in 1991, the second in late December. In April 1992, claimant returned to Dr. Perry complaining of right wrist and left shoulder pain, increasing since December 1991. Dr. Perry diagnosed calcific rotator cuff tendinitis. Claimant continued to experience left shoulder symptoms when she was seen by Dr. Nye in June 1992, although Dr. Perry noted improvement following a July 1992 injection.

On November 25, 1992, SAIF advised claimant that it was accepting calcific bursitis of the left shoulder, now resolved, as part of her right wrist injury claim. This letter was copied to the Compliance Section, but apparently not to the noncomplying employer. The claim was closed pursuant to a December 22, 1992 Notice of Closure (amended January 7, 1993), which awarded temporary disability and scheduled permanent disability for loss of use or function of the right wrist. Claimant's permanent partial disability award was then increased to 55 percent of the right forearm (wrist) pursuant to a July 30, 1993 Order on Reconsideration.

Meanwhile, in April 1993, Dr. Woolpert reviewed claimant's medical records at the request of the noncomplying employer's counsel. He concluded that claimant's right wrist condition was unrelated to her work activity for the noncomplying employer. The noncomplying employer also obtained an opinion from Dr. Perry indicating that claimant's right wrist navicular fracture likely occurred prior to the stated injury date of June 7, 1989.

In August 1993, claimant returned to Dr. Perry complaining of bilateral shoulder pain, left more symptomatic than right. He diagnosed rotator cuff tendinitis with calcific tendinitis. In April 1994, Dr. Perry found recurrent calcific tendinitis, right greater than left shoulder. In July 1994, Dr. Perry reported

that claimant's left shoulder calcific tendinitis has resolved, although she needed further treatment for her right shoulder. In August 1995, Dr. Perry suggested the claim be reopened to address claimant's chronic rotator cuff tendinitis with calcific tendinitis, right greater than left shoulder.

Claimant was examined by Dr. Dinneen at SAIF's request on October 20, 1995. He concluded, among other things, that the major cause of claimant's bilateral shoulder condition was spontaneous degenerative changes.

On November 30, 1995, SAIF denied the request to reopen the claim, asserting that claimant's accepted conditions had not worsened since the last award or arrangement of compensation. The denial was copied to the noncomplying employer and its current counsel. Claimant requested a hearing, challenging SAIF's denial.

In March 1996, claimant made an occupational disease claim, asserting that her right and left shoulder conditions were caused by her work activity for the noncomplying employer. At SAIF's request, Dr. McKillop performed a records review. On March 27, 1996, Dr. McKillop reported that the major cause of claimant's shoulder condition was unknown and probably developed spontaneously without any particular trauma or cause. Thereafter, in June 1996, SAIF issued a compensability and responsibility denial of claimant's occupational disease claim, which was also copied to the noncomplying employer.

On September 11, 1996, SAIF mailed to the noncomplying employer a copy of its acceptance regarding claimant's June 1989 injury. The noncomplying employer then requested a hearing, challenging the compensability of claimant's right wrist injury and left shoulder condition.

Between January 1990 and October 1990, claimant worked 40 hours a week for D & D Market. Her duties included cashiering and stocking shelves. In June 1993, she began working at His and Hers Pizza. By the summer of 1994, claimant reduced her hours at His and Hers to part time.

## CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, the ALJ determined that the noncomplying employer was barred from contesting SAIF's acceptance of claimant's right wrist injury and her left shoulder calcific bursitis pursuant to ORS 656.319(6).[1] In this regard, the ALJ found that, although SAIF did not advise the noncomplying employer in 1991 of its right to request a hearing (as it was required to do), the noncomplying employer nevertheless knew, or should have known, that it had a right to request a hearing challenging the compensability of these conditions by the time it solicited the medical opinions of Drs. Woolpert and Perry in 1993. The ALJ reasoned that because the noncomplying employer "sat on its known rights" for over three years, its right to request a hearing was extinguished by the provisions of ORS 656.319(6).

On the compensability issue, the ALJ concluded that claimant's current left shoulder condition is the same condition accepted by SAIF in 1992 as a consequence of her right wrist injury, and that, in the absence of evidence that her subsequent work activity caused a pathological worsening of that condition, SAIF remained responsible for the left shoulder condition under ORS 656.308(1) and 656.802(2). Noting that there had been no accepted claim involving claimant's right shoulder, the ALJ further determined that claimant failed to prove the compensability of that condition under ORS 656.802(2)(a).[2]

On review, the noncomplying employer argues that, pursuant to ORS 656.283(1), it is entitled to request a hearing challenging SAIF's acceptances "at any time" and that the ALJ erred in applying ORS 656.319(6) to extinguish its right to a hearing. We agree, for the reasons set forth below.

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[1] This section, which was enacted in 1995, provides as follows:

"A hearing for failure to process or an allegation that the claim was processed incorrectly shall not be granted unless the request for hearing is filed within two years after the alleged action or inaction occurred."

[2] SAIF does not contest its responsibility for claimant's left shoulder condition on review, nor does claimant challenge the determination that her current right shoulder condition is not compensable.

As the noncomplying employer notes, ORS 656.283(1) provides, in pertinent part, that "Subject to ORS 656.319, any party * * * may *at any time* request a hearing on any matter concerning a claim, except matters for which a procedure for resolving the dispute is provided in another statute, * * * ." (Emphasis added). Although ORS 656.319(6) creates a two year limitations period for challenging a carrier's processing of a claim, that provision, which was enacted in 1995 as part of SB 369, may not be applied retroactively to shorten a procedural time limitation with regard to an action on a claim taken before the Act's effective date. See Or Laws 1995, ch 332, Sec. 66(6) (SB 369, Sec. 66(6)); Motel 6 v. McMasters, 135 Or App 583, 587 (1995); see also Ronald E. Rogers, 49 Van Natta 267 (1997) (declining to apply ORS 656.319(6) retroactively to the claimant's request for hearing challenging the carrier's failure to process his 1979 claim).

In this case, because SAIF's allegedly incorrect claim processing (i.e., the acceptance of claimant's purportedly noncompensable right wrist and left shoulder conditions) occurred prior to the effective date of SB 369, ORS 656.319(6) does not apply to shorten the time limitation on the noncomplying employer's right to request a hearing on compensability.[3] See Ronald E. Rogers, 49 Van Natta at 268.

In Blain v. Owen, 106 Or App 285 (1991), the court held that the unambiguous language of ORS 656.283(1) allowed an employer to request a hearing on compensability "at any time."[4] Finding that a noncomplying employer's right to challenge the compensability of a claim originates from ORS 656.283(1) rather than ORS 656.262, the court remarked: "We cannot insert a time limitation; only the legislature can do that." In accordance with Blain, the Board has held that, unless a noncomplying employer waives the right to contest compensability by failing to raise it during an earlier proceeding, the employer is entitled to a hearing on the issue of compensability at any time. See, e.g. Connie M. Krone, 43 Van Natta 1875 (1991); Alice M. Sketo, 43 Van Natta 866 (1991).[5]

In this case, although it appears that the noncomplying employer was aware of SAIF's acceptance of the claim (at least by the time it solicited the medical opinions in 1993), there has been no prior proceeding at which the noncomplying employer knowingly relinquished its objections to SAIF's acceptances. Therefore, we conclude that the noncomplying employer did not waive its entitlement to a hearing under ORS 656.283(1) concerning the compensability issue.

Claimant argues that, even if the noncomplying employer is procedurally entitled to request a hearing under ORS 656.283(1), the "back up" denial provisions of ORS 656.262(6)(a) prevent that right from substantively affecting SAIF's prior acceptances of claimant's right wrist and left shoulder conditions. Based on the court's analysis in Blain, we disagree. There, the court expressly found that, in the noncomplying employer context, SAIF is not the employer's agent. The court also indicated that the policies regarding certainty and stability in worker's compensation system enunciated in Bauman v. SAIF, 295 Or 788 (1983) did not apply to the controversy existing between the noncomplying employer and SAIF. 106 Or App at 290. Considering the court's reluctance to apply the Bauman standard to noncomplying employer's challenge to compensability, we conclude that the provisions of ORS 656.262, which limit an insurer's or self-insured employer's ability to revoke an acceptance, do not preclude the noncomplying employer's right to contest compensability in this case.[6]

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[3] Because we find that ORS 656.319(6) may not be applied retroactively, we do not address the noncomplying employer's other assertion that this provision does not apply to a noncomplying employer's challenge to the compensability of a claim in any event.

[4] Although ORS 656.283(1) has been amended since 1991 to include certain exceptions (not applicable here), the "at any time" language remains unchanged.

[5] Prior to the court's decision in Blain, the Board held that once the statutorily designated claims processing agent for the noncomplying employer had accepted a claim and more than 60 days had passed, the noncomplying employer could not defeat the compensability of the claim without proving fraud, misrepresentation or other illegal activities capable of affecting the acceptance. See, e.g., Kristi L. Chase, 42 Van Natta 1247 (1990). In so holding, we reasoned that a noncomplying employer should not be able to defeat the compensability of a claim under circumstances in which a complying employer or its insurer could not. Id. We subsequently found, however, that the Blain decision effectively overruled the rationale we had expressed in Kristi L. Chase. See Connie M. Krone, 43 Van Natta at 1875; Cindy L. Brooks-Lusk, 43 Van Natta 1235 (1991).

[6] Although ORS 656.262(6) has been amended since the Blain decision to authorize "back up" denials under specific circumstances and to prohibit such denials under other circumstances, we continue to find that this particular provision does not apply to a noncomplying employer's challenge to the compensability of the claim.

Finally, we note that in 1991, subsequent to the Blain decision, the legislature amended ORS 656.054(1) to require that the Director notify a noncomplying employer of the referral to SAIF and of its right to object to the claim and also to require that the noncomplying employer request a hearing objecting to the claim within the time provided in ORS 656.262.[7] Relying on the amended law, the Board has held that, assuming proper notice is given, a noncomplying employer has 90 days after the claim is referred to SAIF to request a hearing objecting to the claim. See Thomas R. Lee, 46 Van Natta 69 (1994). We nevertheless conclude, for the reasons addressed below, that this provision does not apply to the noncomplying employer's challenge to SAIF's acceptances in this case.

The amendments to ORS 656.054(1) became effective in July 1991, and did not provide for retroactive application. Because claimant's injury occurred (and the claim was filed and accepted) before July 1991, the statutory changes do not apply. See Astleford v. SAIF, 122 Or App 432, 438 (1993), aff'd 319 Or 225 (1994) (holding that the 1991 amendments to ORS 656.054(1) did not apply to claim for injuries suffered in 1988 and 1990). Moreover, even if the 1991 amendments to ORS 656.054(1) did apply to claimant's claim, the noncomplying employer did not receive proper notice of SAIF's acceptances and its right to object to the claim.[8] Consequently, ORS 656.054(1) does not preclude the noncomplying employer's request for hearing.

Having determined that, under the circumstances of this case, the noncomplying employer remains entitled to contest the compensability of claimant's claim, we turn to the merits of the compensability issue. Claimant alleged a specific injury to her right wrist occurring in June 1989, when she struck her hand on the handle of a milk dispensing machine.[9] At a minimum, therefore, claimant must prove that this incident was a material contributing cause of her right wrist condition. See ORS 656.005(7)(a); Albany General Hospital v. Gasperino, 113 Or App 411 (1992) (the material contributing cause test applies to a condition or need for treatment that is directly caused by an industrial accident (primary consequence), whereas the major contributing cause test applies to a condition or need for treatment that is caused by a compensable injury (secondary consequence)).

The persuasive medical evidence fails to relate claimant's right wrist fracture and avascular necrosis to any work-related incident occurring at that time. In fact, claimant's treating doctor, Dr. Perry, essentially agreed with Dr. Woolpert's assessment that claimant's wrist fracture likely predated June 1989 by six months to a year or more. (Exs. 47A, 83). Dr. Dinneen also opined that claimant's right wrist condition preexisted June 1989 and was not related to any event at that time. (Ex. 63-2). Although Dr. Dickerman, who evaluated claimant at SAIF's request in February 1991, reported that claimant's wrist condition could have developed as a result of striking her hand on the milk machine, his opinion was based on the erroneous assumption that claimant's 1989 wrist x-ray did not show evidence of abnormalities. (Exs. 21-6, 47A). On this record, we find insufficient evidence linking claimant's right wrist condition to a June 1989 injury arising out of and in the course of claimant's employment with the noncomplying employer.

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[7] As amended in 1991, ORS 656.054(1) provided in relevant part:

"A compensable injury to a subject worker while in the employ of a noncomplying employer is compensable to the same extent as if the employer had complied with this chapter. The director shall refer the claim for such an injury to the State Accident Insurance Fund Corporation within 60 days of the date the director has notice of the claim. At the time of the referral of the claim the director shall notify the employer in writing regarding the referral of the claim and the employer's right to object to the claim. * * * At any time within which the claim may be accepted or denied as provided in ORS 656.262, the employer may request a hearing to object to the claim."

[8] Although the noncomplying employer probably received a copy of SAIF's acceptance of claimant's right wrist claim in 1991, there is no evidence that SAIF notified the noncomplying employer of its right to request a hearing concerning compensability, as was required under former OAR 436-80-060(2)(a). Also, there is no evidence that the noncomplying employer was properly notified of SAIF's November 1992 acceptance of the left shoulder as a consequential condition.

[9] Although claimant had also filed a claim in June 1989 for a progressive injury to her right wrist (claim no. 7735158), that claim was denied by SAIF and the denial was affirmed by the parties' April 1991 Stipulation. (Exs. 3, 24).

With regard to the left shoulder, claimant must prove that her calcific bursitis was caused in major part by her work activity for the noncomplying employer.[10] See ORS 656.802(2). Both Dr. Dinneen and Dr. McKillop relate claimant's bilateral shoulder symptoms to spontaneous degenerative change rather than any particular work injury or work activity for the noncomplying employer. Although Dr. Perry initially reported that claimant's left shoulder symptoms were due to having to favor her left arm during her recovery from her right wrist surgeries (See, e.g. Exs. 33, 70), he later agreed with Dr. Dinneen's assessment that claimant's bilateral shoulder problems were caused by spontaneous degenerative change. (Exs. 63, 68). Then, in March 1997, Dr. Perry confirmed that claimant's left shoulder condition was "caused in major part by the work activity which was the basis for SAIF's acceptance of this claim in 1992." (Ex. 84). We are unpersuaded by Dr. Perry's opinions because they are inherently inconsistent and unexplained. See Kelso v. City of Salem, 87 Or App 630 (1987) (an unexplained change of opinion renders a physician's opinion unpersuasive). Consequently, the evidence also fails to establish that claimant's left shoulder condition arose out of her employment with the noncomplying employer.

ORDER

The ALJ's order dated July 25, 1997 is reversed in part and affirmed in part. That portion of the order barring the noncomplying employer from contesting the compensability of claimant's 1989 right wrist injury and consequential left shoulder condition is reversed. Claimant's 1989 right wrist injury and left shoulder calcific bursitis are declared not compensable. That portion of the order setting aside SAIF's denial of claimant's current left shoulder condition is also reversed, as is the attorney fee award. The remainder of the order is affirmed.

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[10] Even if the medical evidence persuasively established that claimant's left shoulder condition was a secondary consequence of her right wrist injury, the left shoulder would not be a compensable consequential condition because, as we have found above, the right wrist condition is not compensable.

**Board Member Haynes specially concurring.**

Although I believe the majority opinion correctly applies the applicable law, I write separately to address my concerns regarding what I consider to be an inequitable result in this case. Because ORS 656.283(1) has been construed to allow the noncomplying employer to request a hearing on compensability "at any time," the noncomplying employer continues to enjoy an advantage under the workers' compensation law that a complying employer or carrier does not.[1]

Even assuming ORS 656.319(6) could be applied retroactively in this case, that provision does not expressly limit the time for a noncomplying employer's challenge to the compensability of the claim. The statute places a two year limitation on a request for hearing "for failure to process or an allegation that the claim was processed incorrectly." Arguably, a noncomplying employer's request for hearing asserting that a claim (which has been accepted by the assigned claims agent) is not compensable is the equivalent of "an allegation that the claim was processed incorrectly." The Board has yet to construe this language and consider the legislative history of ORS 656.319(6), however.

Because it is not readily apparent whether ORS 656.319(6) is intended to encompass a noncomplying employer's challenge to compensability, I believe that a statutory amendment is needed. I would suggest that either ORS 656.262(6) be amended to provide that, notwithstanding ORS 656.283(1), a noncomplying employer cannot seek revocation of the assigned claims agent's claim acceptance more than two years after the date of the initial acceptance in a case not involving fraud, misrepresentation or other illegal activity, or that ORS 656.319(6) be amended to specifically include noncomplying employer challenges to compensability. In that way, the accepted injuries of subject workers of noncomplying employers would truly be compensable to the same extent as the accepted injuries of subject workers of complying employers. See ORS 656.054(1).

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[1] As the majority notes, ORS 656.262 limits the ability of insurers or self-insured employers to challenge the compensability of a previously accepted claim. In cases, such as this one, not involving allegations of fraud, misrepresentation or other illegal activity, an insurer or employer may not issue a "back up" denial more than two years from the date of initial acceptance. ORS 656.262(6)(a). Therefore, in this case, SAIF would be precluded from revoking its 1991 and 1992 acceptances of claimant's right wrist and left shoulder conditions.

In the Matter of the Compensation of
**CHARLES F. BRIESCHKE, Claimant**
WCB Case No. 96-0455M
OWN MOTION ORDER
Black, Chapman, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation initially submitted claimant's request for temporary disability compensation for his compensable injury. Claimant's aggravation rights on that claim expired on April 19, 1994.

On September 4, 1996, SAIF denied the responsibility of claimant's current cervical radiculopathy, cervical spinal stenosis and degenerative disc disease, herniated disc C4-5 and tendonitis of the right shoulder. SAIF contended that claimant's employment at the self-insured employer and most recent work activities were responsible for his current condition. The self-insured employer also denied responsibility, as well as compensability, of claimant's current condition. Claimant requested a hearing on all denials. (WCB Case Nos. 96-08508 and 96-07634). The Board postponed action on the own motion matter pending resolution of that litigation.

By Opinion and Order dated July 3, 1997, Administrative Law Judge (ALJ) Brown set aside SAIF's September 4, 1996 denial and upheld the self-insured employer's denials dated June 17 and July 25, 1996. Claimant requested Board review of ALJ Brown's order, and, by an order issued on today's date, the Board affirmed ALJ Brown's order.[1]

Under ORS 656.278(1)(a), we may exercise our own motion authority to reopen a claim for additional temporary disability compensation when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization.

On May 16, 1996, Dr. Purtzer examined claimant on a referral from Dr. Grant, claimant's attending physician. Dr. Purtzer opined that "[A]t a minimum he [claimant] would require at least a decompression at C5-6 and C6-7. He may in addition require a decompression at C4-5 to include corpectomy at C5 and C6 with anterior strut graft and plating." Thus, we are persuaded that claimant's compensable injury worsened requiring surgery.

Accordingly, we authorize the reopening of claimant's 1986 injury claim to provide temporary disability compensation beginning July 17, 1996, the date claimant was hospitalized for the proposed surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

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

IT IS SO ORDERED.

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[1] Following ALJ Brown's Opinion and Order, by letter dated July 18, 1997, SAIF recommended that claimant's claim be reopened "for time loss under the Board's Own Motion jurisdiction."

In the Matter of the Compensation of
**JANICE K. CONNELL, Claimant**
Own Motion No. 98-0052M
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 her compensable cervical strain with fusion C4-C7, lumbar strain with surgery L2-S1. Claimant's aggravation rights expired on June 22, 1986. SAIF opposes authorization of temporary disability compensation, contending that claimant has withdrawn from the work force. Further, SAIF opposes reopening of the claim, contending that "there is no objective medical evidence of a worsening. Per case law, surgery by itself, such as hardware removal, does not constitute a 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.

On November 19, 1997, claimant underwent a posterior L4-5 bilateral pedicle screw internal fixation removal and inspection of fusion. SAIF contends that the removal of the hardware does not constitute a worsening of claimant's compensable condition. We have previously found that hardware removal surgery evidences a worsening of a compensable condition. See Michael D. Hays, 1994 WL 663071, on recon. (Case No. 94-0547M); Caroline S. Nordyke, 1994 WL 441085 (Case No. 92-0217M); Gladys Biggs, 1994 WL 79276 (Case No. 93-0788M). Thus, in this instant case, we conclude that, as of November 19, 1997, claimant's current condition worsened requiring surgery, which is the time of disability.

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 she was in the work force on November 19, 1997, when her condition worsened requiring surgery. A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, but is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

SAIF contends that claimant is not in the work force. Claimant contends that she qualifies for temporary disability compensation because she was willing to work and making reasonable efforts to obtain work until her compensable injury worsened requiring surgery. Claimant has the burden of proof on this issue and must provide evidence, such as a medical opinion supporting her contention that she is unable to work because of the compensable injury, and an affidavit supporting her position that she was willing to work and would be employed or seeking employment but for the compensable injury.

Claimant's physician, Dr. Nash, has opined that claimant remains "totally unemployable," and has been unable to be productively employed since the date of injury on October 7, 1979. In her affidavit, submitted in response to our February 3, 1998 letter, claimant continues to rely on Dr. Nash's opinion regarding her employability. Claimant further asserts "[b] ut for my industrial injury disabilities I would either be working or looking for work if I was not employed." Thus, claimant has satisfied the third criterion set forth above.

On this record, we conclude that claimant has established that she is willing to work, but is unable to work because of the compensable injury. In addition, SAIF has not responded to the evidence claimant submitted which supports her contention. Therefore, claimant's contention is unrebutted.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning the date she is hospitalized for surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-12-055.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,050, payable by the insurer directly to claimant's attorney. See OAR 438-15-010(4); 438-15-080.

IT IS SO ORDERED.

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March 18, 1998 Cite as 50 Van Natta 423 (1998)

In the Matter of the Compensation of
**CHARLES F. BRIESCHKE, Claimant**
WCB Case Nos. 96-08508 & 96-07634
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Brown's order that: (1) set aside the SAIF Corporation's denial of claimant's aggravation claim for a C4-5 disk herniation; and (2) upheld the self-insured employer's denial of an occupational disease claim for the same condition. On review, the issues are compensability and responsibility.

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

We agree with the ALJ that SAIF can shift responsibility to the self-insured employer if claimant's subsequent work activity was the major cause of the combined condition and pathological worsening of the disease. ORS 656.308(1) and 656.802(2)(b); Jack L. Barbee, 48 Van Natta 1855 (1996); Tivis E. Hay, 48 Van Natta 558 (1996). The only medical opinion supporting compensability under that standard is from Dr. Kirkpatrick, who opined that "the major cause of [claimant's] cervical condition is his work activity as a forklift operator [for the self-insured employer]." We discount Dr. Kirkpatrick's opinion because he did not weigh the relative contribution of claimant's preexisting degenerative condition, as required under Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev den 321 Or 416 (1995). For this reason, the record does not establish a new occupational disease with the self-insured employer, and SAIF remains responsible for claimant's current C4-5 disk herniation under ORS 656.308(1).

ORDER

The ALJ's July 3, 1997 order is affirmed.

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In the Matter of the Compensation of
**TAMARA A. MATTHEISEN, Claimant**
WCB Case No. 96-10520
ORDER ON REVIEW
Black Chapman Webber & Stevens, Claimant Attorneys
Hornecker, Cowling, 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) Stephen Brown's order that set aside its "de facto" denial of claimant's injury claim for sacroiliac ligament strain. On review, the issue is compensability. We reverse.

## FINDINGS OF FACT

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

## CONCLUSIONS OF LAW AND OPINION

On November 2, 1995, claimant felt a "pop" in her mid-back while lifting and moving a box of bananas at work. Claimant first treated with Dr. Naugle, who referred claimant to Dr. Peterson, orthopedic surgeon. In January 1996, Dr. Peterson referred claimant to Dr. Costa, physical medicine and rehabilitation specialist. The employer accepted a claim for right paravertebral muscle strain.

In April 1996, claimant began treating with Dr. Thomas, osteopath, who diagnosed sacroiliac ligament strain. After requesting that the employer accept such condition, claimant requested a hearing. The ALJ, relying on Dr. Thomas' opinion, found that claimant proved the compensability of the sacroiliac ligament strain condition.

The employer challenges this conclusion, asserting that Dr. Thomas' opinion is not sufficiently reliable to carry claimant's burden of proof. We agree with the employer.

The record contains numerous opinions concerning claimant's condition. In March 1996, examining neurologist, Dr. Melson, and examining orthopedic surgeon, Dr. Donahoo, found that claimant's "subjective complaints are far out of proportion to any objective findings[.]" (Ex. 25-4). Examining psychiatrist, Dr. Middlekauff, diagnosed a "pain disorder" that was "associated with psychological factors," including secondary gain. (Ex. 26-5).

In response, Dr. Thomas reported that the examining physicians found no "objective findings" because "they have no training in making a diagnosis of sacroiliac ligament sprain[.]" (Ex. 38-1).

Examining neurologist, Dr. Zivin, found that the record and his examination showed "significant anger/sociological/possible secondary gain climate" and that Dr. Thomas "engendered in [claimant] a 'scare-quotient'[.]" (Ex. 40-8).

Dr. Thomas responded that he did not concur with Dr. Zivin's report and "congratulated" the claims processor "on finding yet another 'Board Certified' specialty physician to claim that there is absolutely no physical basis for [claimant's] subjective complaints of pain in the low back and sacroiliac area." (Ex. 44-1).

Numerous physicians concurred with reports drafted by the employer's attorney. First, Dr. Naugle indicated he had difficulty in "countenancing" the diagnosis of sacroiliac ligament strain because that joint "is a highly stable and essentially fixed joint" and "one would have to presume some kind of movement in the joint which would stretch the ligaments" in order to strain them. (Ex. 48-2). The report further stated that Dr. Naugle also had difficulty in relating the diagnosis to the accepted injury because, when Dr. Naugle examined claimant, "she showed evidence of and gave a history consistent with a strain/sprain of the paravertebral muscles" without showing "evidence of an injury to the sacroiliac joint ligaments." (Id.) Finally, the report stated that "the described injury" was not likely to result in a strain to the sacroiliac ligaments "given the relatively low level of force involved and the fixity of the joint in question." (Id.)

Dr. Peterson concurred that sacroiliac ligament strain was "not a generally accepted orthopedic diagnosis" and, during his treatment of claimant, Dr. Peterson "did not appreciate any such condition or any complaints which might legitimately give rise to such a diagnosis." (Ex. 49-2).

Dr. Zivin also agreed that the condition was "not an accepted diagnosis" because there was no "good 'test'" to confirm or dispute its existence. (Ex. 50-2). The report further stated that the sacroiliac joint was "'an immensely tight' union heavily supported and maintained by thick, fibrous banding" which became mobile only during pregnancy; even during pregnancy, however, "it would require an extreme force to wrench or move this joint at all, let alone to move it to a degree sufficient to actually strain these ligaments" and such movement would have to be greater "than a twist and turn while handling boxes[.]" (Id.)

Finally, Dr. Melson also agreed that the diagnosis was "not generally recognized" and that his examination did not reveal "any problem affecting the sacroiliac joint[.]" (Ex. 52-1).

Dr. Fuller, orthopedic surgeon, performed a record review for the employer. Dr. Fuller first commented that a "pop" in the mid-back "is not connected in any way to sacroiliac pathology and does not cause the subsequently claimed injury to the sacroiliac ligaments[.]" (Ex. 51-1). According to Dr. Fuller, an injury to the sacroiliac joint would have caused immediate pain in the buttock area. (Id.) Instead, Dr. Fuller thought that the "mechanism of injury" was to the "low back." (Id. at 7). Dr. Fuller also explained that the sacroiliac joint "is one of the most strongly constructed joints in the body" and that "it makes no sense to claim sacroiliac disruption through sitting down a box of bananas." (Id. at 8). Finally, Dr. Fuller commented that surveillance videotapes "illustrates no dysfunction whatsoever," which suggested "malingering." (Id. at 8-9).

Dr. Thomas responded to the reports in an affidavit. According to Dr. Thomas, there was a "difference of opinion among most orthopedic surgeons" in that some thought the sacroiliac joint had no mobility and others thought "that the joint definitely is a moveable functioning joint and can be injured with sometimes even minor motion depending on the situation." (Ex. 51-2). Dr. Thomas also disagreed that strain to the sacroiliac ligaments would cause immediate pain to the buttock area, explaining that such an injury "takes several hours to swell and become inflamed and then lead to increasing severity of pain over a matter of hours to within days[.]" (Id. at 3).

Dr. Thomas further stated that Dr. Naugle's reports that claimant felt "a lot of right lower back pain in the form of burning or stinging" was typical of a "ligament type of sprain or strain injury[.]" (Id. at 4). Although Dr. Thomas agreed that the sacroiliac joint "is very strongly constructed," he thought that ligament could be overstretched and injured in "someone who is not in good shape" if "the position of the body is just right and the forces are just right[.]" (Id. at 5).

Dr. Thomas also stated that "all the physicians involved in giving opinions" lacked the expertise to assess sacroiliac joint injuries because they were not trained in osteopathic medicine. (Id.) According to Dr. Thomas, the condition "is an accepted diagnosis in all medical fields[.]" (Id. at 6).

In responding to Dr. Thomas' affidavit, Dr. Fuller again stated that the record did not support a sacroiliac ligament strain in the absence of pain, swelling and discomfort with palpation in that area. (Ex. 55-2). Dr. Fuller also found it illogical that claimant could injure "one of the strongest joints in her body" while "less strong built joints remain normal." (Id.) In response to Dr. Thomas' assertion that osteopaths were better trained in sacroiliac joint injuries, Dr. Fuller stated that, "[t]o suggest an orthopedic surgeon is unable to palpate is patently ridiculous since an orthopedic surgeon sets fractures for a living and is most accustomed to palpating and aligning joints." (Id.)

Dr. Thomas then provided a report reiterating that, based on Dr. Naugle's reports, "the mechanism of injury, the subjective complaints, and objective findings on physical exam are all consistent with a lumbosacral musculoligamentous strain injury as well as a right [sacroiliac] ligament sprain injury." (Ex. 57-1). Dr. Thomas stated that claimant, as the videotape reflected, could perform some activities without pain, "but 8-24 hours later they are in an acute flare up of their symptoms again." (Id. at 4-5). Dr. Thomas also thought Dr. Fuller was "entirely incorrect" that the record did not reflect disruption in the sacroiliac ligament or joint. (Id.)

In evaluating medical opinions, 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. Thomas' opinion. First, he did not examine claimant or become her treating physician until April 1996, approximately six months after the compensable injury. Consequently, he did not have the benefit of examining claimant shortly after her injury and determine whether she exhibited symptoms in her sacroiliac area.

In the same vein, we are not convinced of the accuracy of Dr. Thomas' history that claimant's condition at the time she saw Dr. Naugle was consistent with a strain or sprain in her sacroiliac ligaments. Because Dr. Naugle was the initial treating physician and actually examined claimant shortly after the November 1995 injury, we find more persuasive his opinion that claimant did not exhibit symptoms, or report a history, consistent with injury to the sacroiliac joint ligaments when he examined her following the injury. That is, we are more persuaded by Dr. Naugle's personal observations than Dr. Thomas' interpretation of Dr. Naugle's chartnotes.

Furthermore, Dr. Thomas' opinion is not well-reasoned in that it does not specifically explain how the November 1995 incident injured claimant's sacroiliac joint ligaments. The absence of such an explanation is particularly significant in light of the countervailing opinions from treating physicians Dr. Naugle and Dr. Peterson and examining physicians Dr. Melson, Dr. Zivin and Dr. Fuller that the sacroiliac joint must sustain a high degree of force in order for the ligaments to be injured. In response, Dr. Thomas stated only that the ligament could be overstretched and injured in "someone who is not in good shape" if "the position of the body is just right and the forces are just right[.]" Dr. Thomas did not specifically explain how the twist and turn movement claimant performed in November 1995 resulted in the diagnosed condition. In other words, we find Dr. Thomas' general description of injury an inadequate basis for explaining how claimant's particular movement resulted in straining her sacroiliac ligaments.

For these reasons, we find that Dr. Thomas' opinion is no more persuasive than the other medical opinions. At best, the record is in equipoise. Consequently, claimant failed to carry her burden of proving the compensability of her sacroiliac ligament strain condition.

ORDER

The ALJ's order dated September 4, 1997, as amended September 8, 1997, is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

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March 18, 1998 Cite as 50 Van Natta 426 (1998)

In the Matter of the Compensation of
**RANDALL C. OTTE, Claimant**
WCB Case No. 97-04832
ORDER ON REVIEW
Glen J. Lasken, Claimant Attorney
Meyers, Radler, 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) Otto's order that set aside its denial of claimant's L4-5 disc herniation. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

On December 2, 1992, claimant began working as a warehouseman for the employer in its candy distribution business on the 10:30 p.m. to 7 a.m. shift. (Ex. A, Tr. 6). His job duties included unloading pallets of boxed candy from trucks and reorganizing them in the warehouse for shipment to customers. With the help of another coworker, claimant typically unloads four to six trucks per shift. (Tr. 10). A forklift is used to take the pallets off the trucks. (Tr. 10). There are approximately 20 to 25 pallets per truck with 20 to 50 cases per pallet. (Tr. 11). Each case weighs from five to 60 pounds. (Tr. 22, 45). Claimant's work is physically demanding and involved repetitive bending, lifting and twisting.

Claimant testified that he never had any low back symptoms or treatment before working for the employer. (Tr. 6-7). On June 3, 1994, claimant picked up a metal plate in a truck bed and experienced an immediate onset of low back pain. (Tr. 7, Ex. A). On June 6, 1994, he was examined by Dr. Carlisle, who diagnosed a low back strain. (Ex. C). A lumbar spine x-ray on the same date showed mild disc narrowing at L3-4 and L4-5 with a slight lipping and spurring at that level, as well as spina bifida occulta at L5. (Ex. OA). On July 7, 1994, Dr. Carlisle reported that claimant's back was markedly improved and claimant felt "100 percent." (Ex. 8-3). Dr. Carlisle found no evidence of radicular symptomatology and felt that claimant was ready for full duty. (Id.)

On July 18, 1994, the employer accepted claimant's acute low back strain. (Ex. B). On March 16, 1995, the claim was closed by a Notice of Closure without a permanent partial disability award. (Ex. D).

Claimant testified that he thought he had recovered from the 1994 injury. (Tr. 19). However, he said that after the claim closed in March 1995 until February 1997, his back pain did not completely go away. (Tr. 8, 9). He said that his back "still gets sore after a night's work." (Tr. 9). Claimant went to a chiropractor "a couple times" between mid-1995 and early 1997. (Id.) He did not remember the name of the chiropractor. (Tr. 20).

On February 14, 1997, claimant was working with Mr. Wolf. Mr. Wolf's back was sore that night and he was wearing his back brace. (Tr. 14, 35-36). Claimant's back was also sore that night. (Tr. 24, 36). Claimant and Mr. Wolf both testified that claimant was working a little bit harder to pick up the slack. (Tr. 14, 36). At the end of the shift, claimant's back was feeling sore and he mentioned it to Mr. Wolf. (Tr. 15). Claimant went home and took two prescription muscle relaxers from his girlfriend and slept until 4:00 p.m. (Tr. 16, 25). That evening claimant stayed home and watched videos. (Tr. 17).

On February 15, 1997, claimant woke up at 5:00 a.m. and was getting ready to get up when he leaned over and coughed. (Tr. 17, 29). He immediately experienced severe leg pain all the way down to his ankle. (Tr. 17, 34). Claimant said that was the first time he had experienced pain like that in his leg. (Tr. 17, 34).

On February 18, 1997, claimant sought treatment for severe right leg pain from Dr. Wolfe. (Ex. 1A). Dr. Wolfe reported that claimant had a cold over the last few days and was in bed and coughing when he had a sudden pain in his right calf. (Id.) Claimant saw his attending physician, Dr. Carlisle, on February 20-21, 1997. (Ex. 8-1). Dr. Carlisle reported that claimant had leg pain for a week and was turning and lifting in bed with a cough, when he had a pop in his back and severe pain going down his leg. (Ex. 1A). Claimant was referred to Dr. Schmidt, who diagnosed an extruded disc, left L4-5 with L5 radiculopathy. (Ex. 3). On February 21, 1997, Dr. Schmidt performed a left L4-5 microdiskectomy. (Ex. 3). On February 24, 1997, Dr. Schmidt noted that claimant had inquired whether his condition was related to the injury two years ago and Dr. Schmidt noted "probably not unless there was l/e pain." (Ex. 4).

On May 27, 1997, the employer denied compensability of claimant's L4-5 disc herniation. (Ex. 6). Claimant requested a hearing.

## CONCLUSIONS OF LAW AND OPINION

The ALJ found that the claim was properly analyzed as an occupational disease, rather than an industrial injury. The ALJ relied on Dr. Schmidt's opinion to conclude that the 1994 low back strain and continuing work activities were the major contributing cause of claimant's L4-5 disc herniation.

On review, claimant contends that the claim is compensable as either an accidental injury under a "material contributing cause" standard, or as an occupational disease. In light of claimant's previous back injury, the off-work coughing incident and the number of potential causes of claimant's condition and 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).

In determining the appropriate standard for analyzing compensability, we focus on whether claimant's current low back condition occurred as an "event," as distinct from an ongoing condition or state of the body, and whether the onset was sudden or gradual. Mathel v. Josephine County, 319 Or 235, 240 (1994); James v. SAIF, 290 Or 343, 348 (1981); Valtinson v. SAIF, 56 Or App 184, 187 (1982).

Claimant acknowledges that he did not have a specific incident at work. Nevertheless, he contends that his work activities on February 14, 1997 were sufficiently "discrete" to constitute an injury claim. We disagree.

After reviewing the record, we agree with the employer that claimant has not established that he sustained an accidental injury at work that involved his low back or legs. In any event, the medical opinions do not establish an accidental injury. According to Dr. Carlisle, claimant had not related his

current low back condition to his work activities and he felt that the condition was caused by an acute off-the-job event. (Ex. 8-2). The only medical opinion that supports compensability is from Dr. Schmidt. He did not have a history that claimant's pain was unusual on the day before the coughing incident and he did not focus on a specific injury as causing claimant's condition. (Ex. 7-2). Rather, he felt that the 1994 injury and claimant's continuing work activities were the major contributing cause of his condition. (Ex. 7-3).

We proceed to analyze the claim as an occupational disease. Claimant must show that employment conditions were the major contributing cause of the disease. ORS 656.802(2)(a).

Claimant relies on the opinion of Dr. Schmidt, who performed his surgery. In a concurrence letter from claimant's attorney, Dr. Schmidt indicated he was aware that claimant had a previous accepted back injury when he injured his back while lifting up on a metal plate and was off work for several weeks. (Ex. 7-2). He did not have a history that claimant's pain was unusual on the day before the coughing incident. (Id.) Dr. Schmidt agreed with the following:

> "Fifth, regarding causation, you indicated that the coughing incident undoubtedly helped extrude the disc fragement. However, you felt [claimant] probably would not have suffered this extruded fragment from a cough if he had a healthy back at that time. You felt that the prior on-the-job injury contributed significantly to the development of the extrusion of the disc fragment, and essentially laid the groundwork for this resulting injury. You also felt that his continuing work activities and lifting at work caused further wear and tear on material that surrounds the discs and helps hold them in place. As such, you felt that the most probable explanation for the injury was the combination of the initial on-the-job injury and his continuing work activities caused a weak spot or tear in the annulus, allowing a seemingly harmless mechanism like coughing to help extrude a disc fragment." (Ex. 7-2).

Dr. Schmidt agreed that the coughing incident materially contributed to claimant's condition, but he also felt that "the combination of the initial on-the-job injury and the continuing work activities were much more significant and therefore would constitute the major contributing cause of his condition." (Ex. 7-3).

On the other hand, Dr. Carlisle, claimant's family physician, felt that claimant's L4-5 herniation was caused by an acute off-the-job incident. Dr. Carlisle had treated claimant for the June 1994 mechanical low back strain. (Ex. 8-1). When he had last seen claimant on July 7, 1994, he was back to normal and ready for full duty. (Id.) He found no evidence of a neurological impingement syndrome or any radicular component. (Id.) In a concurrence letter from the employer's attorney, Dr. Carlisle agreed that claimant had fully recovered from the 1994 injury without impairment. (Id.) He agreed that, based on the history he and Dr. Wolfe had obtained in February 1997, claimant had not related his current low back condition to his employment. (Ex. 8-2). Moreover, claimant had not indicated that he had ongoing symptoms or problems related to the 1994 low back strain. (Id.) Dr. Carlisle felt that claimant's L4-5 disc herniation and resulting surgery was caused by the acute off-the-job event and was not work-related. (Id.) He commented that claimant's "work level may have predisposed him to injury, but he did not relate any history of work injury." (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). Although claimant relies on Dr. Schmidt's opinion to establish compensability, we are not persuaded by his opinion for the following reasons.

In a chart note dated February 24, 1997, Dr. Schmidt said claimant had inquired whether his condition was related to his injury two years ago and Dr. Schmidt commented "probably not unless there was l/e pain." (Ex. 4). We find no evidence that claimant had lower extremity pain as a result of the 1994 injury. Claimant testified that his first leg pain occurred on Saturday, February 15, 1997. (Tr. 17, 33- 34). Dr. Carlisle, claimant's treating physician for the 1994 injury, indicated that claimant had no evidence of a neurological impingement syndrome or any radicular component as a result of that injury. (Ex. 8-1). Thus, based on the lack of evidence of lower extremity pain after the June 1994 injury, Dr. Schmidt's February 24, 1997 chart note indicates that claimant's current back condition was not related to his previous injury.

Nevertheless, in a later concurrence letter from claimant's attorney, Dr. Schmidt agreed that claimant's 1994 injury "contributed significantly to the development of the extrusion of the disc fragment, and essentially laid the groundwork for this resulting injury." (Ex. 7-2). It is unclear whether Dr. Schmidt was aware that claimant did not have any lower extremity pain as a result of the 1994 injury. Because Dr. Schmidt did not explain his apparent change of opinion regarding causation we attach little probative weight to his conclusions. See Kelso v. City of Salem, 87 Or App 630 (1987).

Furthermore, it is unclear from the record whether Dr. Schmidt was aware that Dr. Carlisle had reported that claimant had fully recovered from the 1994 injury without any impairment. (Ex. 8-1). At hearing, claimant testified that he thought he had recovered from the 1994 injury. (Tr. 19). Dr. Schmidt does not explain how, since claimant had fully recovered from the 1994 injury, that injury could contribute "significantly" to the L4-5 herniated disc in 1997. Because Dr. Schmidt's opinion lacks adequate explanation, it is not persuasive.

Claimant contends that Dr. Schmidt had an accurate history of his symptoms and he asserts that he had a particularly heavy load of boxes to move at work on February 14, 1997. Claimant's attorney asked Dr. Schmidt if he agreed that "while [claimant] did not have any specific lifting injuries at work in February of 1997, on the Friday in question, he had a particularly heavy load of boxes to move" and had some back pain as a result. (Ex. 7-2). Dr. Schmidt did not agree with those statements and commented "I don't have history that pain was unusual on day before[.]" (Id.) Under these circumstances, we disagree with claimant that Dr. Schmidt had an accurate history of his symptoms.

There are no other medical opinions that support compensability of claimant's condition. Dr. Carlisle opined that claimant's L4-5 disc herniation was caused by an acute off-the-job event and was not work-related. (Ex. 8-2). We conclude that claimant has not established compensability of the L4-5 disc herniation.

ORDER

The ALJ's order dated October 10, 1997 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

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March 18, 1998 Cite as 50 Van Natta 429 (1998)

In the Matter of the Compensation of
**ROBERT P. THEOBALD, Claimant**
WCB Case No. 97-02628
ORDER ON REVIEW
Darris K. Rowell, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order that upheld the SAIF Corporation's denial of claimant's injury claim for a herniated L4-5 disk. On review, the issue is compensability.

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

Claimant contends that the record establishes the compensability of a separate lumbosacral strain injury as a result of the alleged December 8, 1996 injury. In support of that contention, claimant relies on the opinion of Dr. Williams that claimant's alleged work injury resulted in a lumbosacral strain that was a separate condition from his L4-5 disk herniation and preexisting disk degeneration, and that claimant's slip and fall at work was the major cause of this acute strain and claimant's initial need for treatment.

We read Dr. Williams' remarks in the context of his opinion as a whole. In particular, Dr. Williams clarified that, by saying that the initial treatment was due to the injury, he meant that the

injury was the precipitating cause of the treatment. Dr. Williams further explained that, even though a strain, a disk herniation and disk degeneration are medically distinguishable, they could not be separated out when they were biologically present at the same time. Finally, Dr. Williams reiterated that the total combined condition was the strain, preexisting degeneration and disc herniation, and that the preexisting degeneration was the major cause of this combined condition. When read as a whole, Dr. Williams' opinion does not establish that claimant sustained a separate, compensable low back strain as a result of the alleged work incident.

ORDER

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

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March 18, 1998 Cite as 50 Van Natta 430 (1998)

In the Matter of the Compensation of
**DAVID W. ENTRIKEN, Claimant**
WCB Case No. 97-00487
ORDER DENYING RECONSIDERATION
Welch, Bruun, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

The insurer requests reconsideration of our February 27, 1998 Order on Review which adopted and affirmed an Administrative Law Judge's (ALJ's) order that set aside the insurer's partial denial of claimant's injury claim for a current right knee condition. Specifically, the insurer contends that we erred in relying on the attending physician's opinion concerning causation and improperly found claimant credible in light of his previously reported "back [sic] problems."

Having fully considered the insurer's contentions, we have nothing further to add to our prior decision.[1] Accordingly, the insurer's motion for reconsideration is denied. The parties' rights of appeal shall continue to run from the date of our February 27, 1998 order.

IT IS SO ORDERED.

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[1] The insurer also asserts that the absence of an opinion on review compromises its confidence that the matter received the attention it requires. Based on the following reasoning, any such concerns would be ill-founded.

In considering each case presented for review, the Board conducts a thorough and methodical review of the record, which necessarily includes the ALJ's order and the parties' respective written arguments on review. Pursuant to ORS 656.295(6), the Board may affirm, reverse, modify or supplement the ALJ's order and make such disposition of the case as it determines to be appropriate. While particular orders of the Board may provide instructional value for the parties, the primary purpose of Board review and the resulting order is to adjudicate the parties' dispute. See e.g., Jorge Pedraza, 49 Van Natta 1019 (1997) (by adopting an ALJ's order, the Board agrees with the facts and conclusions contained in the ALJ's order and considers the ALJ's order to be sufficient for appellate review).

In the Matter of the Compensation of
**DUSTIN L. CROMPTON, Claimant**
Own Motion No. 97-0523M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Glen J. Lasken, Claimant Attorney

Claimant requested reconsideration of our December 11, 1997 order, as reconsidered January 21, 1998, in which we declined to reopen his claim for the payment of temporary disability compensation because he failed to establish that he was in the work force at the time of disability. With his request for reconsideration, claimant submits an affidavit regarding the work force issue.

In order to allow sufficient time to consider the motion for reconsideration, we abated our prior orders. The self-insured employer was allowed time to respond to claimant's motion. The time for response has passed without receiving any response from the employer. Therefore, we proceed with our reconsideration. After further consideration, we issue the following order in place of our December 11, 1997 order, as reconsidered January 21, 1998.

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

In our December 11, 1997 order, as reconsidered January 21, 1998, we concluded that claimant met his burden of proving a worsening under ORS 656.278(1) in that he proved his compensable low back injury worsened requiring surgery on March 12, 1997 and April 22, 1997. We continue to adhere to the reasoning and conclusions in our prior orders concerning the issue of claimant's worsening.

However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). Here, claimant must prove that he was in the work force on March 12, 1997, when his low back condition worsened requiring surgery. A claimant is deemed to be in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, but is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989). Claimant has the burden of proving he was in the work force at the time of disability. ORS 656.266.

In our prior orders, relying on the unrebutted opinion of Dr. Treible, treating surgeon, we concluded that claimant was unable to work due to the compensable injury as of March 11, 1997. Claimant underwent his first surgery the next day. We continue to adhere to the reasoning and conclusions in our prior orders concerning the timing of claimant's inability to work.

The only remaining issue is whether claimant has met his burden of proving that he remained in the work force at the time of disability. Based on the following reasoning, we conclude that claimant met this burden.

Previously, claimant's attorney asserted that claimant remained in the work force and claimant submitted an affidavit stating, in part: "I briefly worked for A&F Transportation, and then worked for approximately one year for Precision Images. I left that job in the middle of 1996, and was attempting to find other work when my condition worsened in 1997." The self-insured employer challenged that affidavit, noting that it contained no indication of the efforts made by claimant to obtain employment at the time of the aggravation. In our January 21, 1998 Own Motion Order on Reconsideration, we found that claimant's attorney's unsupported assertions regarding claimant's work force status and claimant's challenged general statements in his affidavit, without more, did not meet claimant's burden of proving he was in the work force at the time of disability.

With his current request for reconsideration, claimant submitted a more detailed affidavit. Claimant listed his work activities and his job search activities for the period from July 1996, when he left his job at Precision Images because he felt that job required too much bending and lifting and was causing increased pain, to March 1997, when his compensable condition worsened to the point he was

unable to work. Claimant listed the part-time jobs he held during that period and listed the firms to which he applied for employment. Also, claimant stated that during that period he provided daycare for a relative's three children, including a pre-school child. Claimant stated that he received room and board in addition to the small income for the daycare duties. Finally, claimant listed several firms to which he applied for full-time employment during this period, in addition to seeking employment at the unemployment office.

We note that claimant did not submit any supporting evidence for his detailed affidavit. The current affidavit, however, is not challenged by the employer. The Board would still require supporting evidence if the employer had challenged the affidavit.

Therefore, on this record, we find that claimant has established that he remained in the work force at the time of his disability. In addition to working several part-time jobs during the period between his last full-time job and the worsening of his compensable injury, he also applied for several jobs. Furthermore, claimant worked as a daycare provider during this period. Although claimant received "relatively little pay" for his daycare work, he received room and board for those activities. See ORS 656.005(29) (defines "wages" to include the "reasonable value of board, rent, housing, lodging or similar advantage received from the employer"); James L. Emerich, 45 Van Natta 1701 (1993) (finding the claimant was in the work force as result of his work as a watchperson performed for the employer in exchange for the use of a trailer and payment of all utilities; additionally, the claimant received separate payment for any work performed outside of his watchperson duties). Thus, we find that claimant remained in the work force at the time of his March 12, 1997 surgery.

Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning March 12, 1997, the date he was hospitalized for surgery. When claimant is medically stationary, the employer shall close the claim pursuant to OAR 438-012-0055.

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 self-insured employer directly to claimant's attorney. See OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**LINDA J. (SMITH) COLLINS, Claimant**
WCB Case No. 97-04207
ORDER ON RECONSIDERATION
Cole, Cary, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

In a February 27, 1998 Order on Review, we affirmed the Administrative Law Judge's (ALJ's) order that upheld the SAIF Corporation's denial of claimant's low back aggravation claim. Noting that the Supreme Court has granted review in SAIF v. Walker, 145 Or App 294 (1996), rev allowed 325 Or 367 (1997), claimant requests abatement of our order pending the Court's decision in Walker. We decline to do so. See Weston C. Foucher, 47 Van Natta 1518 (1995) (in the absence of agreement from the opposing party, declining to hold case in abeyance pending resolution of court appeal in another case).

Accordingly, we withdraw our February 27, 1998 order. On reconsideration, as supplemented herein, we adhere to and republish our February 27, 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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In the Matter of the Compensation of
**BRYAN M. FITZSIMMONS, Claimant**
WCB Case No. 96-08824
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Herman's order that found that the Hearings Division lacked jurisdiction to consider claimant's contention that his temporary disability rate had been incorrectly calculated, because he had not raised the issue during the 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. We summarize the relevant facts as follows.

Claimant injured his left elbow on September 2, 1995. Per a stipulated settlement agreement approved on July 1, 1996, SAIF agreed to accept "left lateral epicondylitis." In addition, the December 13, 1995 denial of an elbow strain and left wrist strain/sprain condition was upheld.

Upon acceptance of the claim, claimant was paid temporary total disability from December 3, 1995 through December 13, 1995 at an average weekly wage of $247.67.

The claim was closed by Notice of Closure dated September 24, 1996 as corrected on October 8, 1996. Claimant was awarded temporary disability from December 7, 1995 through January 4, 1996 and from March 11, 1996 through March 12, 1996. Claimant requested reconsideration of the closure on October 14, 1996. Extent of permanent disability and temporary disability dates were raised as issues. The temporary disability rate was not mentioned.

Pursuant to the request, a medical arbiter was appointed and conducted an examination on November 20, 1996. The medical arbiter concluded that claimant's left lateral epicondylitis was completely resolved and no longer symptomatic.

A December 23, 1996 Order on Reconsideration affirmed the September 24, 1996 Notice of Closure, as corrected on October 8, 1996.

Claimant requested a hearing regarding the Notice of Closure. At the hearing, claimant sought an award of scheduled permanent disability. Claimant also sought temporary total disability benefits from January 20, 1996 to March 11, 1996 and contended that SAIF had incorrectly calculated his rate of temporary total disability. Claimant requested Board review, only contesting that portion of the ALJ's order finding that the Hearings Division lacked jurisdiction to address the issue of the rate of temporary disability benefits.

## 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).[1] In Hosey, the temporary disability rate was not manifest in the Notice of Closure. Instead, the insurer had merely awarded certain dates of temporary disability and indicated that deduction of overpaid disability benefits was allowed. The rate issue had arisen in the course of an audit the insurer conducted separate from the closure. Under those circumstances, we found that 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).

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[1] Although bound by stare decisis to follow the Board's decision in Hosey, Board Member Haynes directs the parties to her dissent in that case.

Here, as in Hosey, the Notice of Closure did not specify the amount of claimant's temporary disability rate. Under such circumstances, as in Hosey, we find that the rate issue was not manifest in the closure document. Consequently, we find that it was not necessary for claimant to raise the temporary disability rate issue at reconsideration in order to preserve the issue at hearing. See Blaine P. Hosey, 50 Van Natta at 361.[2]

Rate of Temporary Disability

Claimant argues that his temporary disability rate was incorrectly calculated by SAIF and that the correct rate should be $378.79.[3] Claimant relies on Hadley v. Cody Hindman Logging, 144 Or App 157 (1996), to argue that his "extended gaps" in employment are excluded when computing the temporary disability rate.

The rate of temporary disability benefits is based on a worker's wage at the time of injury. ORS 656.210(1), (2)(b)(A). For workers whose remuneration is not based solely on daily or weekly wages, the Director of the Department of Consumer and Business Services (Director) may prescribe rules for establishing the worker's weekly wage. ORS 656.210(2)(c).

At the time of claimant's injury on September 2, 1995, former OAR 436-60-025 (WCD Admin. Order 94-055) provided, in material part:

> "(5) The rate of compensation for workers regularly employed, but paid on other than a daily or weekly basis, or employed with unscheduled, irregular or no earnings shall be computed on the wages determined by this rule. * * *.
>
> "(a) For workers employed seasonally, on call, paid hourly, paid by piece work or with varying hours, shifts or wages, insurers shall use the worker's average weekly earnings with the employer at injury for the 52 weeks prior to the date of injury. For workers employed less than 52 weeks or where extended gaps exist and where there has been no change in the amount or method of the wage earning agreement, insurers shall use the actual weeks of employment with the employer at injury up to the previous 52 weeks. * * *."

In Hadley, the court rejected an interpretation of the phrase "extended gaps" in former OAR 436-60-025(5)(a)[4] that required a change in employment for the "extended gaps" exception to apply. The court did not otherwise define the phrase "extended gaps," but explained simply that it would be improper to require more than a hiatus in employment to establish an "extended gap." 144 Or App at 161-62.

On remand, we held that 16-1/2 weeks of unemployment in a 26-week period constituted "extended gaps." Earin J. Hadley, 49 Van Natta 1101, 1103 (1997). Finding no guidance for a definition of "extended gaps" in the Director's rules or rule adoption documents, we turned to the dictionary, which defines "extended" as "drawn out in length *** esp. in length of time[.]" Webster's Third New Int'l Dictionary 804 (unabridged ed. 1993). 49 Van Natta at 1102. We reasoned that whether a gap in employment is "drawn out in length" depends on the particular circumstances of each case. We noted, however, that, pursuant to the court's instructions, we would not consider whether a change in the work relationship had occurred in determining whether there was an "extended gap" in employment. Under the circumstances of the Hadley case, we concluded that an unemployment period that 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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[2] In Hosey, we disavowed the William T. Masters decision to the extent that it was inconsistent with our holding.

[3] Claimant's calculation of the wage rate is apparently based on an "extended gap" in employment of 18 weeks. However, based on the record, we find that the gap in claimant's employment was 15 weeks. (Exs. 44; 61A).

[4] 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 15 weeks of unemployment during the 52-week period preceding his injury.[5] (Exs. 44; 61A). The period of unemployment consisted of a three and one half month period from December 6, 1994 to April 1, 1995. Considering that claimant was unemployed for approximately three and one half months of the year preceding his injury, or 28.8 percent of 52 weeks, we conclude that claimant's period of unemployment constituted an "extended gap" within the meaning of former OAR 436-060-0025(5)(a). See 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)).

In Dyer, we found that the plain meaning of "actual weeks of employment" in former OAR 436-060-0025(5)(a) referred only to those weeks when the claimant was actually employed; that is, earning remuneration for services performed for the employer. We found this interpretation to be consistent with the administrative rule and the statutory scheme, which is based on providing fair, adequate and reasonable income benefits to an injured worker. See ORS 656.012(2)(a)[6]; Thomas R. Hellingson, 49 Van Natta 1562, 1564 (1997) (only weeks when the claimant earned wages included in "actual weeks" under wage earning agreement); Randell R. Brood, 48 Van Natta 1783 (1996) ("extended gap" excluded from "actual weeks" under wage earning agreement).

Here, claimant was actually employed 37 weeks during the 52-week period preceding his injury. During this period, he earned gross wages of $12,879. Therefore, claimant's temporary disability rate should be calculated on the basis of an average weekly wage of $348.08 ($12,879 divided by 37 weeks). SAIF is directed to calculate claimant's temporary disability rate accordingly.

Because our order may result in increased compensation and claimant requested Board review, claimant's attorney is entitled to an "out-of-compensation" attorney fee. ORS 656.386(2); OAR 438-015-0055(1). Consequently, claimant's counsel is awarded a fee equal to 25 percent of any increased compensation created by this order, payable directly to claimant's attorney. However, the total "out-of-compensation" attorney fee granted by the ALJ's order and our order shall not exceed $3,800.

ORDER

The ALJ's order dated July 3, 1997 is reversed in part and affirmed in part. SAIF is ordered to pay temporary disability benefits to claimant based on an average weekly wage of $348.08. Claimant's attorney is awarded 25 percent of any increased compensation created by this order, payable directly to claimant's counsel. However, the total "out-of-compensation" attorney fee awarded by the ALJ's order and this order shall not exceed $3,800. The remainder of the ALJ's order is affirmed.

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[5] In his brief, claimant argues that he worked 34 weeks of the 52 week period which would mean that claimant was off work for 18 weeks. However, based on Exhibits 44 and 61A, it appears that claimant actually worked 37 weeks of the 52 week period and was off work for 15 weeks.

[6] According to ORS 656.012(2)(a), some of the objectives of the Workers' Compensation Law are:

"To provide, regardless of fault, sure, prompt and complete medical treatment for injured workers and fair, adequate reasonable income benefits to injured workers and their dependents[.]"

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March 19, 1998 Cite as 50 Van Natta 435 (1998)

In the Matter of the Compensation of
**DAVID L. DYLAN, (fka DAVID H. HUBBARD), Claimant**
WCB Case No. 96-04448
ORDER OF ABATEMENT
Cole, Cary, et al, Claimant Attorneys
Ronald W. Atwood & Associates, Defense Attorneys

Claimant requests abatement and reconsideration of 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 his aggravation claim for lack of jurisdiction. Specifically, claimant contends that regardless of whether

his aggravation claim was timely filed, we retain jurisdiction to address the compensability of his current disc condition and the medical services related thereto, which were in issue at hearing.[1]

In order to further consider the underlying compensability issues, we withdraw our February 24, 1998 Order and proceed with our reconsideration. After completing our reconsideration, we will issue our decision.

IT IS SO ORDERED.

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[1] In responding to claimant's motion for reconsideration, the employer agrees that the compensability of medical services remains an issue on review.

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In the Matter of the Compensation of
**MARCIA C. LEMIRE, Claimant**
WCB Case No. 96-08700
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Bock.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Galton's order that set aside its denial of claimant's occupational disease claim for a mental disorder. On review, the issue is compensability. We affirm.

## FINDINGS OF FACT

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

Claimant, age 35 at the time of hearing, worked for the employer as a hairstylist. On February 20, 1996, she was cleaning up the salon when a young man entered, pulled a gun and demanded money. The robber stood across the counter from claimant, pointed the gun at her head, and yelled at her to open the cash register and hand him the money. Once she gave him the money, he turned and ran out the door.

Claimant had been seeking treatment for anxiety problems prior to the robbery, but her anxiety symptoms worsened after the February 20, 1996 incident. Her attending psychologist, Dr. Warren, diagnosed her as having two different (but related) mental disorders, post-traumatic stress disorder (PTSD) and panic disorder with agoraphobia.

The insurer denied claimant's stress condition, asserting that any psychological conditions that claimant may have were caused in major part by preexisting personality problems and non-work related stressors. Claimant requested a hearing.

## CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant established by clear and convincing evidence that the February 20, 1996 robbery at work was the major contributing cause of two related mental disorders, PTSD and panic disorder with agoraphobia. In so finding, the ALJ also determined that the employment conditions producing these mental disorders (the robbery) existed in a real and objective sense, that the employment conditions that produced her mental disorders were conditions other than those generally inherent in every working situation, and that the diagnosed mental disorder were generally recognized in the medical or psychological community. See ORS 656.802(3).

On review, the insurer does not specifically contest the ALJ's determination that claimant's PTSD is compensable. Rather, the insurer argues that claimant's panic disorder with agoraphobia preexisted the robbery and that the robbery was not the major contributing cause of claimant's need for treatment for this condition. We disagree.

As noted above, Dr. Warren diagnosed claimant as having two different (but related) mental disorders, PTSD and panic disorder with agoraphobia. He testified at hearing, and opined that the primary cause of both of these conditions was the robbery at gun point. (Tr. 31, Ex. 69). Dr. Warren acknowledged that claimant had significant stress in her life and problems with anxiety attacks prior to the work incident, but concluded that her problems did not rise to the level of diagnosable disorders until after (and as a result of) the robbery. (Tr. 33-41). Dr. Wilson, who treated claimant both prior to and after the February 1996 robbery incident, similarly opined that claimant had PTSD and panic disorder with agoraphobia, and also that the robbery incident was the major contributing cause of her need for treatment of these conditions. (Ex. 67).

Claimant was examined by Dr. Goranson and Dr. Davies at the insurer's request. Dr. Goranson, who saw claimant in December 1996, found no psychiatric diagnosis. He attributed any issues she may have to preexisting personality traits and anger at her employer, but not to the robbery. (Ex. 66A-12). Dr. Davies, who also testified at hearing, concluded that claimant suffered from an anxiety disorder, but that this condition preexisted the robbery and was not worsened by the work incident. (Ex. 68, pp. 9-10, Tr. II, p. 17).

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 the complete and well-reasoned testimony and report of Dr. Warren, whose opinion is supported by claimant's prior treating psychologist, Dr. Wilson.

Even though he did not begin treating claimant until several months after the February 20, 1996 robbery, Dr. Warren was aware of claimant's medical history, including complaints of anxiety symptoms in the months prior to the February 20, 1996 robbery. Unlike Drs. Davies and Goranson, Dr. Warren had the opportunity to evaluate claimant on a number of occasions. He explained that although claimant had preexisting anxiety issues, the trauma of the robbery elevated her prior problem to the level of a diagnosable panic condition. He noted that claimant experienced a dramatic increase in her anxiety symptoms, as well as intrusive thoughts, images and nightmares as a result of the robbery. He concluded that the robbery significantly worsened her panic attack condition and was the major cause of her need for treatment thereafter. Dr. Wilson, who, as noted above, had the opportunity to evaluate claimant over a number of years, similarly reported that her anxiety attacks increased in frequency and intensity following the February 1996 robbery. Dr. Wilson also concluded that the robbery was the major contributing cause of her condition and need for treatment.

Accordingly, on this record, we conclude that claimant has established that her employment conditions, namely the robbery at gun point on February 20, 1996, was the major contributing cause of her panic disorder with agoraphobia.

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 insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and claimant's counsel's statement of services), the complexity of the issue, and the value of the interest involved.

## ORDER

The ALJ's order dated July 30, 1997 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $2,000, payable by the insurer.

In the Matter of the Compensation of
**STEPHEN D. PERRY, Claimant**
WCB Case No. 97-01105
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Biehl, Bock, and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Poland's order that upheld the self-insured employer's denial of his injury claim for a right inguinal hernia. 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, who had previously undergone surgical repair in 1989 for a non-industrial right inguinal hernia, felt a popping and sudden onset of right groin pain on October 25, 1996, after bending down and pulling on the bottom rail of a cart at work. Dr. Yeo, who had performed the 1989 surgery, diagnosed a recurrent indirect right inguinal hernia, for which he performed another surgical repair on October 28, 1996.

The ALJ upheld the employer's January 22, 1997 denial of the hernia claim, applying ORS 656.005(7)(a)(B).[1] In upholding the denial, the ALJ discounted the opinion of Dr. Yeo, who concluded that the October 1996 incident was the major contributing cause of claimant's need for treatment. The ALJ reasoned that Dr. Yeo's opinion was conclusory and did not satisfy the requirements of Dietz v. Ramuda, 130 Or App 397 (1994), rev dismissed 321 Or 416 (1995) (the proper application of ORS 656.005(7)(a)(B) requires an evaluation of the relative contribution of each cause, including the precipitating cause, to establish which is the primary cause).

On review, claimant contends that Dr. Yeo's opinion is persuasive and establishes that the October 1996 incident was the major contributing cause of the right inguinal hernia. We concur.

The parties agree, and we find, that the claim is governed by ORS 656.005(7)(a)(B), because the medical evidence establishes that claimant's preexisting hernia condition "combined" with the alleged October 1996 incident to cause claimant's need for treatment. (Ex. 18-2). Therefore, to establish medical causation, claimant must prove that the October 1996 incident was the major contributing cause of his disability and need for treatment of the "combined" condition. Ramona Andrews, 48 Van Natta 1652 (1996).

Considering the presence of claimant's preexisting hernia condition, the determination of the major cause of claimant's current right inguinal hernia condition is complex and requires expert medical opinion. Uris v. Compensation Dept., 247 Or 420 (1967). We generally defer to the medical opinion of an attending physician, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983). Here, we do not find persuasive reasons to do otherwise.

On March 17, 1997, Dr. Yeo responded to claimant's counsel's letter requesting an opinion on the causation of claimant's hernia. (Exs. 19, 20). Claimant's counsel briefly recounted the history of the claim and enclosed copies of the medical records. Dr. Yeo noted that claimant had a preexisting right inguinal hernia that was repaired in 1989 and that claimant had no further problems until the October 1996 incident. (Ex. 20). According to Dr. Yeo, the October 10, 1996 incident was the major contributing cause of the recurrent right inguinal hernia. Id.

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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."

Although the ALJ determined that Dr. Yeo's opinion was conclusory and did not sufficiently address the relative contribution of the preexisting hernia condition, we do not agree. Instead, we are persuaded that Dr. Yeo's opinion is adequately explained and that he properly weighed the contribution of the various causal factors in arriving at his opinion. We also note that Dr. Yeo's history is accurate and that Dr.Yeo is very familiar with claimant's condition, having performed both the 1989 and 1996 surgical repairs.

Dr. Blumberg provided the only other opinion regarding causation. (Ex. 18). Dr. Blumberg concluded that, while claimant's work activity on October 25, 1996 may have made his right inguinal hernia symptomatic, claimant's congenital predisposition to hernias and his prior surgery (which was also a predisposing factor for recurrence of the hernia) were the major contributing cause of claimant's need for treatment. (Ex. 18-2). See ORS 656.005(24) (congenital abnormality or similar condition that "predisposes" a worker to disability or a need for treatment is a "preexisting condition").

We do not find Dr. Blumberg's opinion as persuasive as Dr. Yeo's because Dr. Blumberg did not examine claimant, but instead based his opinion on a review of the medical records. More importantly, Dr. Yeo had a distinct advantage over Dr. Blumberg in that he performed both of claimant's surgeries and thus had greater familiarity with the nature of claimant's hernia condition. See Argonaut Insurance Company v. Mageske, 93 Or App 698, 702 (1988) (deference to treating physician who was able to observe the affected body part during surgery). Accordingly, we conclude that claimant sustained his burden of proof under ORS 656.005(7)(a)(B). Because the ALJ concluded otherwise, we reverse.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate brief), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

## ORDER

The ALJ's order dated July 31, 1997 is reversed. The employer's denial dated January 22, 1997 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 counsel is awarded an assessed fee of $3,500, to be paid by the employer.

**Board Member Moller dissenting.**

Deferring to the attending physician's (Dr. Yeo's) opinion, the majority finds that claimant sustained his burden of proving that his right inguinal hernia is compensable under ORS 656.005(7)(a)(B). Because I find Dr. Yeo's opinion unpersuasive, I must part company with the majority and dissent.

In evaluating medical evidence concerning causation, we rely on those opinions that are both well-reasoned and based on accurate and complete information. Somers v. SAIF, 77 Or App 259 (1986). In this case, I do not find Dr. Yeo's opinion to be well-reasoned. I reach this conclusion for the following reasons.

Dr. Yeo's opinion is contained in Exhibit 20, a March 17, 1997 response to a letter from claimant's counsel. Dr. Yeo's report contains mostly conclusory statements, including an assertion that the October 25, 1996 incident was the major contributing cause of claimant's right inguinal hernia. Dr. Yeo's "reasoning" consists merely of a brief recitation of claimant's history that he felt a "pop" while pulling a veneer cart (allegedly about 600 pounds) and an acknowledgment that claimant has a preexisting right inguinal hernia, but that it did not cause any further problems after a 1989 surgical repair.

It seems clear that, to the extent Dr. Yeo's opinion is "reasoned," it depends on a temporal relationship between the October 1996 incident and the onset of symptoms. Moreover, Dr. Yeo's opinion only establishes that the October 1996 incident was the "precipitating" cause of claimant's need for treatment. Particularly in the context of a preexisting condition, both the precipitating-cause and temporal-relationship rationales are insufficient to establish medical causation. 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"); Allie v. SAIF, 79 Or App 284, 288 (1986) (finding medical opinion based on chronology of events unpersuasive). In addition, Dr. Yeo's opinion does not satisfy the weighing requirements of Deitz. 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).

I acknowledge that Dr. Yeo did perform both of claimant's hernia surgeries, and that his opinion would ordinarily be entitled to some deference on that basis. See Argonaut Insurance Company v. Mageske, 93 Or App 698, 702 (1988). However, there is nothing in Dr. Yeo's opinion that indicates his surgical experience with claimant provided him with any special insight into the etiology of claimant's hernia condition.

In conclusion, Dr. Yeo's opinion is not worthy of deference due to its deficient reasoning. Because the only other opinion to address causation (Dr. Blumberg's) is well-reasoned and does not support compensability, the majority should have affirmed the ALJ's decision. Inasmuch as it does not do so, I must dissent.

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In the Matter of the Compensation of
**RICHARD T. SHERMAN, Claimant**
Own Motion No. 66-0448M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Welch, Bruun, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requested reconsideration of our September 19, 1997 Own Motion Order, as reconsidered on December 24, 1997, in which we ultimately declined to authorize reopening his 1962 low back injury claim for medical services and temporary disability benefits. Claimant requested that we abate our prior orders and allow him 30 days to gather additional medical information to support his position.

On January 8, 1998, we granted claimant's request, abated our prior orders, and set up a schedule allowing the parties to submit additional evidence and argument. The parties' submissions having been received, we proceed with our reconsideration.

In our September 19, 1997 order, we authorized reopening of claimant's 1962 claim for the requested medical services and payment of temporary disability compensation. Subsequently, the SAIF Corporation requested reconsideration of that order. With its request for reconsideration, SAIF submitted additional medical evidence consisting of a copy of the operative report for claimant's December 6, 1962 L4-5 disc surgery and a copy of a December 16, 1996 report from Dr. Malos, the surgeon who performed claimant's January 3, 1997 low back surgery. On October 17, 1997, we abated our order and granted claimant an opportunity to respond to SAIF's motion.

On December 24, 1997, after receiving claimant's response and reconsidering the record, including the new evidence submitted by SAIF, we issued our Own Motion Order on Reconsideration in place of our initial order and found that claimant failed to meet his burden of proving his current low back condition which required surgery was causally related to his compensable 1962 low back injury claim. Consequently, we declined to reopen his claim for medical services and temporary disability.

In his current request for reconsideration, claimant contends that we changed our decision based on identical medical evidence. We disagree. As noted above, with its request for reconsideration, SAIF submitted additional medical evidence regarding claimant's medical condition at the time of his 1962 surgery and his condition at the end of 1996, just prior to the January 3, 1997 surgery.

Because more than 30 years passed between claimant's compensable 1962 low back surgery and his January 3, 1997 low back surgery, 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).

However, claimant need not demonstrate medical causation to a scientific certainty. Hutcheson v. Weyerhaeuser, 288 Or 51 (1979); Ford v. SAIF, 71 Or App 825, rev den 299 Or 118 (1985). The appropriate measure of certainty in a workers' compensation claim is reasonable medical probability. Coday v. Willamette Tug & Barge, 250 Or 39, 47 (1968).

On reconsideration, claimant submits a January 30, 1998 letter from Dr. Malos. In this letter, Dr. Malos recited claimant's history regarding his low back problems. This history included the surgery for a disc herniation on the left at L4-5 more than 30 years earlier and a history of episodic low back pain over the years since that surgery, which Dr. Malos noted was not uncommon following a lumbar strain and subsequent surgery. Dr. Malos stated that claimant reported a history on December 26, 1996, of having symptoms in his left leg of about two months duration after a hunting trip. On January 3, 1997, Dr. Malos performed surgery for a recurrent disc herniation on the left at L4-5. Dr. Malos also reported that claimant recently returned to him on January 9, 1998. At that time, claimant had incapacitating pain that was not responding to conservative measures and an MRI showed "yet another recurrent disc herniation on the left at L4-5." As a consequence, on January 22, 1998, claimant underwent surgery to remove that disc herniation.[1]

As to causation, although noting that claimant's three disc herniations had always been at the same location, Dr. Malos stated he was "uncertain" whether or not claimant's initial injury has a material relationship to his recurrent disc herniations that required surgery in 1997 and 1998.

Dr. Malos' opinion does not meet claimant's burden of proof because it does not establish with reasonable medical probability that claimant's compensable 1962 injury was a material contributing cause of his current need for medical treatment. Dr. Malos was only able to say he was "uncertain" as to the relationship between the 1962 injury and claimant's recurrent disc herniations. Furthermore, the record contains no other medical evidence that would support claimant's claim. Therefore, we continue to conclude that claimant failed to carry his burden of proof.

Accordingly, our December 24, 1997 order, which was issued in lieu of our September 19, 1997 order, is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our December 24, 1997 order effective this date. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

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[1] This is the first mention in the record of the January 22, 1998 surgery for a L4-5 recurrent disc herniation. However, the issue before us is limited to the question of whether claimant has established sufficient causal connection between the January 3, 1997 surgery for a recurrent disc herniation and his 1962 back injury claim to entitle him to having the 1962 claim reopened. We stress that the January 22, 1998 surgery is not before us at this time and our decision in the present case does not affect any future request for reopening claimant may make regarding the January 22, 1998 surgery. Nonetheless, if claimant should request reopening based on the January 22, 1998 surgery, he must prove the necessary causal connection between that surgery and the 1962 low back injury claim in order to prevail.

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In the Matter of the Compensation of
**GLENDA JENSEN, Claimant**
WCB Case No. 95-07344
ORDER OF ABATEMENT
Ransom & Gilbertson, Claimant Attorneys
Lundeen, et al, Defense Attorneys

On March 9, 1998, we issued an Order on Remand that found that claimant was not entitled to additional temporary disability (TTD) or penalties. We based our conclusion on the court's holding, Liberty Northwest Insurance Corporation v. Jensen, 150 Or App 548 (1997), that the insurer had complied with OAR 436-60-030(12)(c) (1996) prior to its termination of claimant's TTD benefits. Asserting that she raised other grounds for her contention that the insurer had improperly terminated her TTD benefits, claimant seeks reconsideration.

In order to further consider this matter, we withdraw our March 9, 1998 order and implement the following supplemental briefing schedule. Claimant's opening supplemental brief must be filed within 21 days from the date of this order. The insurer's supplemental response must be filed within 21 days from the date of mailing of claimant's brief. Claimant's supplemental reply must be filed within 14 days from the date of mailing of the insurer's response. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**WILLIAM R. FERDIG, Claimant**
WCB Case No. 97-01086
ORDER ON REVIEW
W. Todd Westmoreland, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Moller and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Davis' order that set aside its denial of claimant's right shoulder injury claim. On review, the issue is compensability. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following exception. We do not adopt the last sentence of the findings of ultimate facts.

## CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's work injury combined with his preexisting degenerative right shoulder condition. Therefore, the ALJ found that, pursuant to ORS 656.005(7)(a)(B), claimant must prove that the otherwise compensable injury is the major contributing cause of the disability or need for treatment of the combined condition. We adopt the ALJ's reasoning and conclusions on this issue and find that ORS 656.005(7)(a)(B) applies to claimant's injury claim. Claimant agrees that ORS 656.005(7)(a)(B) applies to his claim and asserts that he has met his burden of proof under that statute.

Although finding the medical evidence close, the ALJ found that a preponderance of the evidence supported compensability of claimant's injury claim for a right shoulder rotator cuff tear. SAIF argues that the only medical evidence that supports claimant's claim is not persuasive. For the following reasons, we agree with SAIF.

Claimant's claim is for an industrial injury. Claimant explicitly denied he was making an occupational disease claim. (Tr. 23). While claimant has done some sheet rock work in his job as maintenance man for a group of condominiums, he asserts that he injured his right shoulder while lifting and moving six panels of sheet rock from his truck to a shed on March 7, 1996. (Tr. 11, 19, 24).

Claimant has the burden of proving a compensable injury. ORS 656.266. As stated above, in order to establish compensability, claimant must prove that his work activities on March 7, 1996 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 (1994), rev dismissed 320 Or 416 (1995); Gregory C. Noble, 49 Van Natta at 765-66. Furthermore, given the combination of the preexisting degenerative shoulder condition and the March 7, 1996 work incident, 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); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986).

Only the opinions of Dr. Waldram, consulting orthopedist, and Dr. Betlinski, treating physician, might support claimant's claim. Dr. Waldram diagnosed early degenerative arthritis of bilateral shoulders, right rotator cuff rupture, and bilateral impingement syndrome. (Ex. 16-1). Dr. Waldram opined that claimant's "work of sheet rocking certainly is heavy and a lot of overhead activity involved, this certainly in all probability could have led to a rupture of [claimant's] tendon." (Ex. 16-2).

Dr. Waldram's causation opinion presents several problems. First, claimant contends that he injured his right shoulder on March 7, 1996 while lifting and moving six panels of sheet rock from his truck to a storage shed. Thus, it appears that Dr. Waldram has an inaccurate history of the work incident. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977) (medical opinions based on incomplete or inaccurate information are not afforded persuasive force). Moreover, even disregarding any problem with the accuracy of Dr. Waldram's history, his causation opinion is stated in terms of possibility rather than medical probability. The indication of a possible work connection is not sufficient to meet claimant's burden of proof. Gormley v. SAIF, 52 Or App 1055 (1981). Finally, although acknowledging that claimant had "some underlying degenerative arthritis and a degenerative rotator cuff," Dr. Waldram did not evaluate the relative contribution of these degenerative conditions to claimant's need for treatment, as is required to determine the major contributing cause. (Ex. 16-2). Dietz v. Ramuda, 130 Or App at 401.

Claimant argues that, as his treating physician, Dr. Betlinski is in the best position to evaluate his condition. We agree that, absent persuasive reasons to the contrary, we generally defer to the opinion of the treating physician. Weiland v. SAIF, 64 Or App 810, 814 (1983). However, we find persuasive reasons not to defer to Dr. Betlinski's opinion.

On April 30, 1997, claimant's attorney wrote to Dr. Betlinski, summarized claimant's medical history and asked Dr. Betlinski to check "yes" or "no" to a series of questions. (Ex. 19). In that letter, claimant's work activities were described as including "lifting and hanging full sheets of sheet rock." (Ex. 19-2). Dr. Betlinski checked "yes" to all of the questions, including the ones indicating that, although claimant had preexisting "early" or "mild" arthritis, it was "more probable than not that the diagnosed rotator cuff tear could have been caused lifting and hanging sheet rock" and that "[claimant's] work activities described above" were the major cause of the diagnosed torn right rotator cuff. (Id.)

Dr. Betlinski's causation opinion presents some of the same problems that Dr. Waldram's opinion presented. Specifically, there is some question as to whether Dr. Betlinski had an accurate history of the mechanism of the work injury, given the fact that claimant's testimony regarding his injury did not include "hanging" sheet rock. Miller v. Granite Construction Co., 28 Or App at 476. However, even disregarding any possible problem regarding Dr. Betlinski's history, his opinion offers no reasoning or explanation. Because Dr. Betlinski's opinion is lacking in reasoning and explanation, we give it little weight. See, e.g., Marta I. Gomez, 46 Van Natta 1654 (1994) (Board gives the least weight to conclusory, poorly analyzed opinions, such as unexplained, conclusory "check-the- box" reports). Finally, like Dr. Waldram, although Dr. Betlinski acknowledged claimant's preexisting arthritis, he did not evaluate the relative contribution of this degenerative condition to claimant's need for treatment, as is required to determine the major contributing cause. Dietz v. Ramuda, 130 Or App at 401.

For the above reasons, we find the opinions of Drs. Waldram and Betlinski unpersuasive. Because the record contains no other medical opinion that might support claimant's claim, and in light of the medical evidence that does not support compensability, we find that claimant has failed to meet his burden of proof. Accordingly, we uphold SAIF's denial of claimant's torn right shoulder rotator cuff injury claim.

## ORDER

The ALJ's order dated November 7, 1997 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

In the Matter of the Compensation of
**ERIC J. FIRKUS, Claimant**
WCB Case No. 96-07527
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Bock and Haynes.

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

## FINDINGS OF FACT

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

## CONCLUSIONS OF LAW AND OPINION

The ALJ relied on Dr. Podemski's opinion and found that claimant established objective findings of a bilateral wrist strain. The ALJ concluded that claimant had established that his work activities were a material and the major contributing cause of the bilateral wrist strain.

The insurer contends that claimant did not establish objective findings of an injury or disease. The insurer also argues that Dr. Podemski's opinion is not persuasive and claimant failed to prove that his wrist condition was work-related.

Because we are not persuaded by the medical evidence that claimant's wrist condition is work-related, it is not necessary for us to address whether he has established "objective findings" of injury or disease.

The ALJ relied on the opinions of Drs. Utterback and Podemski to conclude that claimant's condition was causally connected with his work activities. Drs. Utterback and Podemski answered "yes" to the following question from claimant's attorney:

> "Given that arthritic, inflammatory and neurologic testing has eliminated other causes of [claimant's] bilateral wrist pain, and given that the pain was abrupt in onset with specific work activities, and resolved rapidly with treatment, is it reasonably medically probable that the bilateral wrist strain injury was caused by activities of employment on June 19, 1996?" (Exs. 13A-3, 14-3).

We are not persuaded by the opinions of Drs. Utterback and Podemski because they are based on an inaccurate history. Although they were asked to assume that claimant's pain "resolved rapidly with treatment," claimant testified that he last worked for the employer on June 19, 1996 and was off work for six months. He said that his symptoms did not get any better while not working and he still had the same symptoms at the time of hearing that he did in June 1996. (Tr. 10, 12). The causation opinions of Drs. Utterback and Podemski are not persuasive because they are based on an incomplete and inaccurate history. See Miller v. Granite Construction Co., 28 Or App 473, 478 (1977).

In addition, we are not persuaded by Dr. Podemski's opinion because it is inconsistent with his July 10, 1996 report, in which he diagnosed "[u]pper extremity pain and tingling, etiology unclear." (Ex. 6). Dr. Podemski did not explain why, in a later report, he agreed that claimant had a bilateral wrist strain injury caused by work activities. (Ex. 14-3).

In responding "yes" to claimant's attorney's question on causation, Dr. Utterback explained that he treated claimant's injury as work-related "primarily on the basis of chronological circumstance." (Ex. 13A-3). Dr. Utterback's opinion is not persuasive because he apparently relies only on a temporal relationship between claimant's symptoms and the June 1996 work activities and he did not explain why claimant's symptoms did not decrease when he quit working.

The only other medical opinion on causation is from Dr. Baertlein, which does not support compensability. We conclude that claimant has not sustained his burden of proving compensability of his bilateral wrist strain.

## ORDER

The ALJ's order dated October 10, 1997 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

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March 20, 1998 Cite as 50 Van Natta 445 (1998)

In the Matter of the Compensation of
**KENNETH J. FREDA, Claimant**
WCB Case No. 97-00235
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes, Bock, and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Herman's order that upheld the insurer's partial denial of claimant's repeat rupture of the left extensor pollices longus of the left thumb. On review, the issue is compensability. We reverse.

## FINDINGS OF FACT

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

Claimant compensably injured his left thumb on November 20, 1996 while handling a skill saw. He sought emergency treatment and was advised to keep the wound clean and dry. Two days later, Dr. Nolan surgically repaired a laceration of the extensor pollices longus of claimant's left thumb and placed a spica plaster splint on the thumb to keep it in extension and to protect the tendon repair. The insurer accepted the left thumb fracture/laceration.

The next day, Saturday, November 23, 1996, claimant and his family moved from their apartment to a house in Kalama, Washington. The day was very rainy. Claimant helped pack and carry his family's goods in the move and his cast got wet and soft. He pulled off the cast and rewrapped the injury.

On November 26, 1996, when he returned for his follow-up appointment, Dr. Nolan found that claimant's IP joint once again had the extensor lag that he had repaired in the first surgery. Dr. Nolan then performed a second surgery to re-repair the extensor pollices longus.

The insurer denied the compensability of claimant's need for the second surgery asserting that the treatment was a consequential condition that was caused in major part by getting his cast wet and engaging in moving activities rather than his compensable injury.

## CONCLUSIONS OF LAW AND OPINION

The ALJ found that the major cause of claimant's re-ruptured tendon and his need for the second surgery was his off-work activities and that his condition was not a direct result of his compensable injury. On review, claimant asserts that the his second surgery is compensable because it bears a material relationship to his compensable laceration and because the reinjury to his left thumb was unintentional. Claimant also contends that the ALJ erred in utilizing a "consequential condition" analysis to find the treatment not compensable. We agree with claimant.

Under ORS 656.156(1), a worker is not entitled to compensation where his injury results from his deliberate intention to produce such injury. In this case, there is no evidence that claimant deliberately intended to reinjure his thumb. Therefore, ORS 656.156(1) is inapplicable.[1]

In the absence of a deliberate intention to reinjure his left thumb, claimant's need for treatment to re-repair the torn tendon must be analyzed under ORS 656.245(1). This section provides that the carrier is liable for medical services for conditions caused in material part by the compensable injury for such period as the nature of the injury or the process of the recovery requires. Although this section also provides that, for consequential and combined conditions, the insurer is liable for only those medical services directed to medical conditions caused in major part by the injury, this case does not involve a consequential or combined condition.

In Roseburg Forest Products v. Ferguson, 117 Or App 601, rev den 316 Or 528 (1993), the court held that ORS 656.005(7)(a)(A) is not applicable when a claimant needs continued medical treatment under ORS 656.245 for a previously compensated condition. In that case, the claimant had received surgery for his compensable carpal tunnel syndrome. One week after the surgery, he fell at home and his sutures came out. He needed emergency room treatment to repair the broken sutures. The employer refused to pay the emergency room bill, contending that the fall at home, rather than the compensable carpal tunnel syndrome, was the major cause of his need for treatment.

The court rejected the employer's argument that the emergency room treatment was a consequence of a compensable injury that would not be compensable unless the carpal tunnel syndrome was the major contributing cause of the need for the emergency room suture repair. The court reasoned that when claimant fell at home and damaged his sutures, he suffered no new "injury" or condition different from the carpal tunnel syndrome. The court concluded that the treatment necessary to resuture the wound was compensable under ORS 656.245 as continued medical treatment bearing a material relationship to the compensable carpal tunnel syndrome. Id. at 604.

In this case, we find that claimant's off-work activities subsequent to the first surgery did not give rise to a new "injury" or "consequential condition" different from the accepted fracture/laceration injury.[2] Rather, like the claimant's fall at home in Ferguson, claimant's moving activities and failure to keep the plaster cast dry were simply events that intervened to require further treatment to his already compensable laceration. Because claimant's need for a second surgical repair bears a material relationship to the compensable injury, we conclude that this treatment is compensable.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $4,000, payable by 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 October 23, 1997 is reversed. The insurer's denial of claimant's repeat rupture of the extensor pollices longus of the left thumb is set aside, and the claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant's counsel is awarded an assessed fee of $4,000, payable by the insurer.

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[1] This is also not, at this time, a case involving ORS 656.325(2). Although, under ORS 656.325(2), a claimant may not receive compensation "for any period of time during which the worker commits unsanitary or injurious practices which tend to either imperil or retard recovery," the insurer's remedy for such conduct by the worker is to obtain the Director's consent to suspend compensation for the period in dispute. See, e.g., Rick D. Brady, 42 Van Natta 1611 (1990) (if insurer can establish claimant had engaged in injurious practices, the remedy is to request the Director to suspend benefits, not to unilaterally terminate medical services). Here, there is no evidence that the insurer has sought the Director's consent to suspend compensation related to claimant's second surgery.

[2] See, e.g., Fred Meyer, Inc. v. Crompton, 150 Or App 531 (1997) (explaining that a consequential condition under ORS 656.005(7)(a)(A) is "a separate condition that arises from the compensable injury" and "not different occurrences of the same condition").

In the Matter of the Compensation of
**IGNACIO RAMIREZ, Claimant**
WCB Case Nos. 96-02277, 96-02276 & 95-03917
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that (1) upheld the insurer's denials of claimant's injury claims for an L4-5 disc condition and a transient eye irritation; and (2) upheld the insurer's partial denial of claimant's "current back condition." On review, the issues are compensability and scope of the "current condition" denial. We reverse in part and affirm in part.

## FINDINGS OF FACT

Claimant, a Spanish-speaking laborer, has been an orchard worker for the insured for about 23 years. (Tr. 6; Ex. 41-3).

On August 27, 1992, claimant fell from a ladder at work, injuring his mid and upper back. (Exs. 2, 3). The insurer accepted claimant's injury claim as a "nondisabling cervical/dorsal strain" (Ex. 4). Claimant continued to suffer mid-back pain over the years following the 1992 injury. (Exs. 8-2, 10-2, 23-1, 24-4-7, 27-3-4, 30-1-2).

On December 20, 1994, claimant was exposed to toxic chemicals when a sprayer hose broke at work. He sought treatment.

On February 15, 1995, the insurer denied claimant's injury claim for toxic exposure.

On December 26, 1995, the insurer denied claimant's current back condition as unrelated to the accepted 1992 injury. (Ex. 32).

On July 28, 1995, claimant fell from a ladder at work, injuring his low back.

On May 20, 1996, the insurer denied claimant's low back injury claim. That same day, Dr. Purtzer operated on claimant's low back.

Claimant requested a hearing from the insurer's denials.

## CONCLUSIONS OF LAW AND OPINION

### L4-5 Disc Condition

As a preliminary matter, we consider the ALJ's finding that claimant was not a credible witness, because he did not seek treatment for his low back for about 4 months following his July 28, 1995 fall at work. The ALJ reasoned that claimant should have been motivated to seek medical help sooner. According to the ALJ, this would be especially true since claimant was paid "piece work" (i.e., by the tree, for his orchard work); he earned less after the injury because he worked slower (due to his back pain); and he needed the income to support his large family. We disagree with the ALJ's reasoning and conclusion.

Claimant testified (through an interpreter) that he kept working after his July 1995 injury despite low back pain, because he needed the work. He stated, "I have eight children, and I was on a contract what I could do. There were times that I would make $20 and $25 a day, but I needed them, and I continued working." (Tr. 9).

Finally, in mid-November 1995, after working until noon on a Saturday, claimant went home, sat down, and could not get up because of low back pain. He then sought treatment at La Clinica de Valle on November 17, 1995. (Ex. 28).

We accept claimant's explanation for continuing to work without seeking medical treatment despite his low back pain, after his injury: He needed the money.

The ALJ also implicitly determined that claimant was not a reliable historian, because there is some evidence that claimant denied pre-injury low back problems, despite chart notes indicating that he sought treatment for his low back before the July 1995 fall at work. (See Exs. 8-1-2). However, claimant acknowledged at hearing that he did have low back problems before July 1995. He also stated that he had entirely new symptoms after the 1995 injury. (Tr. 6, 8, 16). Thus, although claimant sought treatment for low back pain once in 1993 and once in 1994, his prior symptoms were right-sided (after the 1995 injury they were left sided) and they resolved with conservative treatment so that claimant was able to continue working, apparently without time loss or additional treatment.

We accept claimant's reporting that he did not have significant (or similar) low back symptoms before the July 1995 work injury, but he has had such symptoms since the injury. Accordingly, based on claimant's credible testimony and the consistent medical histories, we find that claimant injured his low back when he fell at work on July 28, 1995 and he has had experienced low back pain since that time.

The insurer does not dispute that the July 28, 1995 injury happened. (Tr. 2). The issue is whether medical causation is proven.

Numerous physicians have examined and treated claimant for several medical problems. Some of his doctors speak Spanish and some do not; claimant does not speak English.

With this in mind, we consider the medical evidence.

The record indicates that claimant had low back degeneration which preexisted his July 1995 injury.

Dr. Young stated that preexisting degeneration may become symptomatic without injury and therefore claimant's condition is not injury-related. (Exs. 51, 53). We do not find Dr. Young's opinion persuasive in this case because it fails to address claimant's particular circumstances, especially his clinical course.

The remaining medical evidence addressing the etiology of claimant's current low back condition is provided by Drs. Marble, Rich, Grant, Weinman, and Purtzer. Drs. Marble and Rich recorded claimant's history of falling from halfway up a 14 foot ladder and landing heavily on his left side, noting that the injury was followed by left back and leg pain. (Ex. 41-5). Drs. Marble and Rich opined that claimant's July 1995 injury was the major contributing cause of his "need for treatment and/or time loss," observing that claimant was not symptomatic or in need of treatment before the injury. (Ex. 41-6). They also opined, without explanation, that claimant's then-current low back impairment (and range of motion findings) and his future limitations resulted from his degeneration, rather than from the 1995 injury. (Exs. 41-7-8).

Dr. Weinman examined claimant on December 6, 1995 and reported a history of numerous falls at work, including a July 1995 incident involving a twisted ankle without increase in back pain. Dr. Weinman also reported that claimant's lower left back pain "began" in the latter part of November 1995 and that claimant did not have that pain "prior to any of the falls." (Ex. 31-2). There is no indication that Dr. Weinman speaks Spanish or that an interpreter was present during his examination. (See Tr. 14-15).

Dr. Weinman subsequently concurred with the report by Drs. Marble and Rich, which described claimant's history of the July 1995 fall (through an interpreter). (Exs. 41, 42). That history did not mention a 1995 ankle injury (neither does claimant's testimony or any other medical report).

We do not find the conclusions of Drs. Marble, Rich, and Weinman particularly helpful, standing alone, because of the above-described internal inconsistencies. However, we note that Drs. Marble and Rich had an accurate history, which is materially consistent with claimant's testimony and the remainder of the record regarding claimant's July 28, 1995 low back injury. (See Exs. 34, 41-1-2; Tr. 7-9).

Dr. Weinman referred claimant to Dr. Grant, who examined claimant with an interpreter present to help with the history and physical examination. (Ex. 34). Dr. Grant reported claimant's history accurately, noting that claimant did not have left leg pain before the July 1995 fall. (Id). On May 21, 1996, Dr. Grant reviewed the report by Drs. Marble and Rich and indicated areas of agreement and disagreement. Specifically, Dr. Grant identified the inconsistency between the examiners' opinion that the work injury caused claimant's need for treatment and/or time loss and their conclusion that degenerative disease caused his impairment. (Ex. 45). Dr. Grant reasoned:

> "I feel that this patient's current difficulties, prior need for treatment, previous time loss, and need for physical capacity limitations at this time and in the future are in major part due to his injury and to a lesser degree due to the underlying degenerative disk disease in his back. With respect to this comment, it is important to re-emphasize the fact that this patient had no significant back problem prior to his injury (despite the fact that he had the same advanced degenerative disk disease in the lumbosacral spine [] that he does now)." (Ex. 45-1).

Dr. Grant considered and evaluated claimant's history (including his preexisting degeneration) and explained his conclusion. In our view, Dr. Grant's opinion is persuasive because it is well-reasoned and based on an accurate history.

Dr. Campbell examined claimant for low back pain on numerous occasions beginning on November 17, 1995, when claimant first sought treatment after the July 28, 1995 fall. (See Ex. 28). He concurred with Dr. Grant's conclusion that claimant's current need for treatment for his low back was "far more likely" a consequence of the fall at work, rather than the preexisting condition, for the same reasons as Dr. Grant. (Ex. 49).

Dr. Purtzer, treating surgeon, also initially agreed with Dr. Grant's reasoning and conclusions. (Ex. 50). Subsequently, Dr. Purtzer changed his opinion and stated that he did not believe that the "alleged work event of July 28, 1995 caused the herniated disk" because of the delay between the reported injury and the reported symptoms. (Ex. 54-2). We have accepted claimant's explanation for the delay in seeking treatment after his injury. Inasmuch as Dr. Purtzer's changed opinion regarding causation is based solely on the delay in reporting, which we find reasonable under claimant's particular circumstances, we do not find Dr. Purtzer's ultimate conclusion persuasive.

In summary, we find the opinions of Drs. Campbell and Grant to be persuasive (and the contrary or ambiguous opinions of Drs. Marble, Rich, Young and Purtzer unpersuasive), as explained above. Accordingly, based on the opinions of Drs. Campbell and Grant, we conclude that claimant has established that his July 28, 1995 work injury was the major contributing cause of his subsequent need for treatment for an L4-5 disc condition. See ORS 656.005(7)(a)(B). Therefore, we reverse that portion of the ALJ's order that upheld the insurer's denial of claimant's L4-5 disc condition.

"Current Condition" Denial

We adopt and affirm the ALJ's opinion regarding the ineffectiveness of the December 26, 1995 partial "current condition" denial with respect to the accepted August 27, 1992 cervical/dorsal strain condition. Moreover, even assuming that there was an outstanding claim for mid-back treatment at the time of the denial, we would reach the same result.

In reaching this conclusion, we first note that the partial denial specifically provided that payment for medical services for the previously accepted conditions would continue. (Ex. 32). Second, claimant's attorney clearly understood that the "December 26, 1995 Denial of 'current need for treatment' issued in response to medical billings for low-back injury treatment." (Ex. 35-1, emphasis added). Under these circumstances (and the absence of contrary evidence), we conclude that the partial denial did not deny the accepted cervical/dorsal condition.

Eye Condition

Claimant was exposed to toxic chemicals when a sprayer hose broke at work on December 20, 1994. He sought treatment for his eyes on numerous occasions thereafter.

On February 15, 1995, the insurer denied claimant's injury claim for an eye condition (among other complaints). (Ex. 18). Claimant requested a hearing.

The ALJ upheld the denial, reasoning that claimant was not credible and finding a failure of medical proof. As we have explained herein, we do not find that claimant lacks credibility. However, we agree with the ALJ that claimant has not proven medical causation, because the medical evidence only supports a possibility that the chemical exposure caused claimant's eye problems (especially considering nonwork related potential causes). (See Exs. 12-14, 17, 24, 26, 27). Accordingly, this denial is upheld.

Attorney Fees

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

ORDER

The ALJ's order dated October 15, 1997 is reversed in part and affirmed in part. That portion of the order that upheld the insurer's denial of claimant's low back (L4-5 disc) condition is reversed. The denial of this condition is set aside and the claim is remanded to the insurer for processing according to law. Claimant is awarded a $4,000 attorney fee, payable by the insurer. The remainder of the order is affirmed.

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March 20, 1998 Cite as 50 Van Natta 450 (1998)

In the Matter of the Compensation of
**RICHARD TORRES, Claimant**
WCB Case No. 96-07210
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Baker's order that: (1) upheld the insurer's denials of his current low back condition; and (2) declined to assess penalties and attorney fees for the insurer's allegedly unreasonable denials.

On review, the issues are compensability and attorney fees. We affirm.

FINDINGS OF FACT

On December 28, 1995, claimant, a production worker, sustained a low back injury when he was caught between wood coming out of a ripsaw and a machine behind him. (Ex. 4). He had immediate pain in the low back and abdomen. He sought treatment from Dr. VanUchelen, who diagnosed a crush injury to the low back and abdominal region. (Id.) On January 2, 1996, Dr. Entena diagnosed a low back and abdomen contusion. (Ex. 5). He recommended physical therapy and prescribed medication. (Exs. 5, 6).

On January 12, 1996, claimant was examined by Dr. Jansen, chiropractor, who diagnosed lumbosacral sprain/strain, rule out disc pathology. (Ex. 11). Claimant continued to treat with Dr. Entena as well. (Exs. 14, 17).

Claimant was examined by Dr. Olson on February 1, 1996. (Ex. 20). In a later report, he interpreted an MRI as showing a ruptured disc at L4-5, pressing on the left side at the L5 root outlet zone. (Ex. 24). Dr. Olson referred claimant to Dr. Buza for a surgical consultation. (Ex. 27).

Dr. Buza diagnosed low back and left groin pain with musculoligamentous strain. (Ex. 30-3). He felt that claimant's pain represented an internal derangement of the disc and vertebral bodies more than a radicular type complaint. (Id.) He recommended continued conservative treatment. A pelvic and abdominal ultrasound on March 11, 1996 was negative. (Ex. 3a). A pelvic CT scan showed no significant abnormality in the area of the lumbosacral plexus. (Ex. 33).

The insurer accepted the claim for a disabling lumbosacral sprain on March 25, 1996. (Ex. 34).

On April 9, 1996, Dr. Buza reported that claimant had some radicular type complaints, but also had many muscle type complaints. (Ex. 39). On April 15, 1996, Dr. Buza reported that a myelogram demonstrated a bulge, but it was not a significant lesion for surgical intervention. (Ex. 43).

On April 23, 1996, claimant was examined by Dr. French, who diagnosed a "lumbar strain with groin strain or contusion likely as well." (Ex. 46-2). Dr. French reported on May 7, 1996 that claimant had "high pain behaviors." (Ex. 48). He diagnosed a lumbar strain with underlying degenerative disk disease and "[p]ain complaints and behavior, possible somatoform pain disorder." (Id.) One week later, Dr. French reported that claimant's objective findings were minimal. (Ex. 49). On May 23, 1996, Dr. French continued to refer to a somatoform pain disorder. (Ex. 50). He said that the "subjective findings significantly outweigh the objective findings at this point." (Id.) He released claimant to modified work. (Ex. 51). Dr. French reported on May 31, 1996 that claimant had tried working two hours per day with a 10 pound limit, but he "insisted this is way too much[.]" (Ex. 53).

On June 4, 1996, claimant was examined by Dr. Geist, orthopedic surgeon, Dr. Podemski, neurologist, and Dr. Quan, psychiatrist, on behalf of the insurer. (Ex. 56). Drs. Geist and Podemski reported that claimant felt he was "worse" than in January. (Ex. 56-4). They diagnosed a low back strain, by history, and "[p]sychological factors appear to be playing a very major role in the perpetuation of his symptomatology." (Ex. 56-5). They felt that the psychological problem was the major problem at that time. (Ex. 56-6). They did not believe claimant's disc abnormality at L4-5 was playing a significant role in his symptoms. (Ex. 56-7). There was so much functional overlay present that they were unable to adequately assess claimant low back situation. (Id.)

Dr. Quan diagnosed a pain disorder associated with psychological factors. (Ex. 57-4). He reported that the psychological factors preexisted claimant's employment and he said that the psychiatric disorder appeared to be "significantly impairing[.]" (Id.) Dr. Buza agreed with the reports from Drs. Geist, Podemski and Quan. (Ex. 71). Dr. French concurred with the report from Drs. Geist and Podemski, (Ex. 61), as did Dr. Olson. (Ex. 66).

On June 12, 1996, Dr. French continued to suspect a somatoform pain disorder. (Ex. 59). Dr. Olson reported that claimant had no objective findings on June 24, 1996, and he agreed that he should be returned to full activity. (Ex. 64-2).

The insurer issued a partial denial on June 27, 1996, stating that claimant's current condition and need for treatment was no longer related to his accepted condition. (Ex. 67).

The claim was closed by a July 1, 1996 Notice of Closure without a permanent partial disability award. (Ex. 68).

On July 8, 1996, Dr. Olson reported that there was nothing further he could do for claimant and he did not authorize palliative care. (Ex. 69).

Dr. Ballard, orthopedic surgeon, Dr. Brown, neurologist, and Dr. Sukin, orthopedic surgeon, performed a medical arbiter examination on August 24, 1996. Because of claimant's extreme pain behavior and some nonphysiologic physical findings, they did not feel that the physical examination was valid. (Ex. 73-4). They found no objective findings that would limit claimant's ability to repetitively use his spine. (Id.) The Notice of Closure was affirmed by an Order on Reconsideration dated October 3, 1996. (Ex. 75).

Claimant sought treatment from Dr. Doughton in November 1996. Dr. Doughton found extreme paraspinal muscle spasm on the left, a weak anal sphincter, abnormal straight leg raising on the left and right, and normal reflexes. Dr. Doughton opined that claimant originally had a crush injury to the

sacrum that had not been adequately treated. (Ex. 77). He felt claimant also had a lumbosacral strain that had probably cleared up months ago. (Id.) He referred claimant to Dr. Owen for chiropractic treatment and sent claimant to Dr. Whitton to determine whether any malingering was involved.

Dr. Whitton, chiropractor, examined claimant and diagnosed a chronic mild lumbar sprain/strain. (Ex. 81-3). He was unable to explain why claimant had ongoing symptoms and he found no organic or non-organic reason for his low back and left leg pain. (Id.) However, he did not doubt that claimant had low back and left lower extremity symptoms.

On February 28, 1997, Dr. Doughton reported that, after three months, he was sure that claimant had sustained a "sacral crushing injury" in the original work incident. (Ex. 88-1). He felt claimant had a direct injury to the psoas muscle that had not been addressed. He reported that claimant had been responding well to chiropractic treatments with Dr. Owen. (Ex. 88-2).

Claimant was examined by Dr. Fuller on March 25, 1997, who reported a straightforward evaluation with no pain behavior. (Ex. 90-9). Dr. Fuller diagnosed "[s]ubjective non-verifiable low back pain in the presence of normal studies, no evidence of 'sacral crush.'" (Id.)

On April 16, 1997, the insurer amended its denial, stating that claimant's request for treatment was for the same condition it had previously denied. (Ex. 91). Alternatively, the insurer stated that, even if the condition for which claimant was presently seeking treatment was not the same as the condition previously denied, it did not appear that it was compensably related to his accepted lumbosacral strain. (Id.) In addition, the insurer stated that the preponderance of medical evidence did not support the existence of a "crushing injury to the sacrum and coccyx[.]" (Id.)

Claimant requested a hearing on both denials.

## CONCLUSIONS OF LAW AND OPINION

On December 28, 1995, claimant sustained a low back injury when he was caught between wood coming out of a ripsaw and a machine behind him. (Ex. 4). The insurer accepted the claim for a disabling lumbosacral sprain on March 25, 1996. (Ex. 34). All the physicians, including Dr. Doughton, agreed that claimant's lumbosacral sprain condition has resolved. (Exs. 56, 61, 66, 73, 77, 90, 95, 96).

Claimant relies on Dr. Doughton's opinion to contend that he sustained a sacral crush injury as a result of the December 1995 incident. The ALJ was not persuaded by Dr. Doughton's opinion.

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

After the December 28, 1995 injury, claimant was treated by Drs. Entena, Jansen, Olson, Buza and French. In November 1996, Dr. Doughton became claimant's treating physician and he is the only physician to opine that claimant sustained a sacral crush injury as a result of the December 1995 incident. After reviewing the record, we find no reason to grant any particular deference to Dr. Doughton's opinion as compared to claimant's other treating physicians. Moreover, for the following reasons, we are not persuaded by Dr. Doughton's opinion.

Dr. Doughton first examined claimant on November 11, 1996, almost eleven months after the work injury. (Ex. 77). On February 28, 1997, Dr. Doughton reported that claimant had sustained a "sacral crushing injury" in the original work incident and a direct injury to the psoas muscle. (Ex. 88-1). He reported that claimant had been responding well to Dr. Owen's chiropractic treatments. (Ex. 88-2). Dr. Doughton concluded that the December 1995 injury was the major contributing cause of claimant's current low back and sacral and soleus muscle condition. (Id.) He said that the injury was apparent based on a defect in claimant's sacrum and very weak sphincter muscles. In a later report, Dr. Doughton explained:

> "[S]ince this man has improved considerably under Dr. Owen's and my care to the point where he has stopped using a cane, he has applied for a job for the first time in over a year, that the right diagnosis followed by right treatment is winding up with improvement in the patient and ought to be enough evidence of the correctness of my point of view." (Ex. 92-1; emphasis in original).

In reaching his conclusion, Dr. Doughton relied in part on the fact that claimant had originally been diagnosed with a crush injury to the lumbar and sacral spine. (Ex. 77, 88-3). Dr. Doughton did not agree that claimant had any psychological problems. (Exs. 88-2, 97).

None of the other physicians, including some of claimant's other treating physicians, agreed with Dr. Doughton that claimant had sustained a sacral crush injury. Dr. Fuller reported that it was medically improbable that claimant had a "sacral crush" because he verified that there were no skin abrasions to either claimant's abdominal wall anteriorly or lumbosacral area posteriorly, nor was there any bruising or hemorrhage. (Ex. 90-9). Dr. Fuller explained that, if there had been a sacral crush, "one might suppose that there would have been a bladder rupture or some internal evidence or abdominal acuity." (Id.) However, the record was negative in that respect. He felt that there would have been some signal change noted on the MRI had there been a sacral crush. (Ex. 90-10).

In a later report, Dr. Fuller explained further that if claimant had a severe crush injury to his sacrum, he would have expected a neuropraxia with immediate cessation of all activities of the sacral nerves. (Ex. 94-1). Claimant would have been unable to walk, would have had anal sphincter incontinence and would have lost control of his bladder. (Id.) Dr. Fuller pointed out that none of these events occurred. He felt it was impossible for Dr. Doughton's diagnosis to have occurred without severely injuring claimant's abdominal contents on the way to the sacral plexus. (Ex. 94-1, -2). He concluded that Dr. Doughton's opinion was highly speculative and was not borne out by the record. (Ex. 94-2). If claimant had decreased anal sphincter tone, Dr. Fuller said it would have shown up earlier because of fecal incontinence, but there was no such evidence in the record. (Id.) Dr. Fuller thought Dr. Doughton had overlooked claimant's malingering and he noted that it was not surprising that claimant became better, since patients who malinger can get better or worse as they choose. (Id.)

Dr. Buza, one of claimant's treating physicians, agreed with Dr. Fuller's conclusions. (Ex. 96). He also agreed with Drs. Geist, Podemski and Quan that claimant's current condition and need for treatment was related in major part to psychological factors. (Ex. 71-1).

Dr. French also concurred with Dr. Fuller's findings. (Ex. 95). He began treating claimant in April 1996. (Ex. 46). By May 7, 1996, he reported that claimant had "high pain behaviors" and a possible somatoform pain disorder. (Ex. 48). One week later, he commented that there were minimal objective findings. (Ex. 49). After reviewing subsequent medical records, Dr. French continued to believe claimant had a somatoform pain disorder. (Ex. 95). He felt that the initial diagnosis of a crush injury represented the mechanism of injury rather than underlying pathology. He opined that Dr. Doughton was relying heavily on subjective improvements of pain complaints as strongest proof of his diagnosis. Dr. French noted that it was well established that similar findings are found with somatoform pain disorders and he did not feel any diagnostic reliability could be inferred from such a therapeutic response. (Id.) Dr. French commented that a soft tissue crush or contusion was extremely unlikely without concomitant objective findings such as ecchymosis and bony injuries, which were not reflected in the record. (Id.)

We find that the opinions from Dr. Fuller and Dr. French are well-reasoned and persuasively explain why Dr. Doughton's "sacral crush" diagnosis was not appropriate. Based on Dr. Fuller's opinion, as supported by Drs. French and Buza, we are not persuaded that claimant sustained a sacral crush injury as a result of the December 1995 injury.

Furthermore, the persuasive medical evidence establishes that the compensable lumbosacral strain was not the major contributing cause of claimant's current low back condition. In June 1996, Drs. Geist and Podemski diagnosed a low back strain, by history, and "[p]sychological factors appear to be playing a very major role in the perpetuation of his symptomatology." (Ex. 56-5). They felt that the psychological problem was the major problem at that time. (Ex. 56-6). Dr. Quan, psychiatrist, diagnosed a pain disorder associated with psychological factors. (Ex. 57-4). He reported that the psychological factors preexisted his employment and he said that the psychiatric disorder appeared to be "significantly impairing[.]" (Id.)

In a later report, Dr. Geist agreed with Dr. Quan that there were significant psychological factors interfering with claimant's recovery. (Ex. 72-1). He felt that the physical injury was the initial source of disability, but the psychological problem later became more apparent. (Ex. 72-2). He concluded that the primary problem was psychological for several reasons, including the marked amount of pain behavior at the time of the examination. Dr. Geist explained:

> "He had an intermittent list to the right, which is more consistent with a non-organic problem, than an organic back problem.
>
> "The range of motion studies of his low back were totally invalid because of the marked amount of restriction.
>
> "He had a positive Waddell test, both components, and a strongly positive Marxer test. These are tests that are indicative of a non-organic problem.
>
> "In addition, he had diffuse tenderness throughout the entire lumbar area, on both sides, which is also strongly suggestive of a non-organic problem.
>
> "He did not exhibit any evidence of any objective physical signs to indicate a serious organic low back problem." (Id.; emphasis in original).

Dr. Buza agreed with the June 1996 reports from Drs. Geist, Podemski and Quan. (Ex. 71). Drs. Olson and French, also claimant's treating physicians, concurred with the June 1996 reports as well. (Exs. 61, 66). Dr. Fuller agreed that the compensable injury was no longer the major contributing cause of claimant's combined condition. (Ex. 90-11). In August 1996, the medical arbiter panel did not feel that claimant's physical examination was valid because of his extreme pain behavior and nonphysiologic physical findings. (Ex. 73-4).

In contrast, Dr. Doughton relied on the conclusion of Dr. Whitton, chiropractor, to determine that claimant was not malingering. (Ex. 88-1). Dr. Doughton explained that he had a prejudice against the MMPI and did not agree with Dr. Quan's conclusions. (Ex. 88-2). In his evaluation, Dr. Doughton found that claimant had "no more or no less neurotic tendencies than other people." (Id.)

Unlike Dr. Quan, there is no evidence that Dr. Doughton had special expertise in psychiatry, nor is there any evidence that Dr. Whitton had any such training. We are more persuaded by Dr. Quan's reports, as supported by Drs. Geist, Podemski, Olson, French and Fuller. We find that the persuasive medical evidence establishes that psychological factors were the major contributing cause of claimant's current low back condition. We conclude that claimant did not sustain his burden of proving compensability of his current low back condition.

Penalties

Claimant argues that he is entitled to a penalties and attorney fees for the insurer's unreasonable denials. However, 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 6, 1997 is affirmed.

In the Matter of the Compensation of
**DENNIS M. BLOOMFIELD, Claimant**
WCB Case Nos. 95-13056 & 95-08975
ORDER ON REVIEW
Bottini, Bottini & Oswald, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Bock and Hall.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) "froze" the evidentiary record as of January 13, 1997; (2) upheld the insurer's denial of claimant's occupational disease claim for right medial knee joint compartment arthritis; and (3) upheld the insurer's denial of claimant's October 1995 right knee injury claim for tendinitis. On review, the issues are compensability and the ALJ's evidentiary ruling. We reverse in part and affirm in part.

## FINDINGS OF FACT

Claimant compensably injured his right knee in 1982 while working for a previous employer (Miller Brands). In July 1982, claimant underwent right knee surgery to repair a medial meniscus tear. Claimant eventually received 30 percent scheduled permanent disability for the 1982 claim.

Claimant began working for his current employer (Paulson's) in 1988 as a floor-covering installer. The SAIF Corporation provided the employer's workers' compensation coverage at that time. On February 21, 1989, SAIF denied a right knee injury claim of December 27, 1988. (Ex. 9). The record does not indicate that the denial was appealed.

In April 1995, claimant sought treatment from his family physician, Dr. Knopf, reporting a two-week history of right knee pain.[1] Dr. Knopf diagnosed right knee pain, most likely a strain related to on-the-job trauma, and osteoarthritis related to an occupational disease and past surgery. (Ex. 11-3). Claimant filed an occupational disease claim based on his work activities at Paulson's. (Ex. 13).

Dr. Knopf opined on June 16, 1995 that claimant's work (being constantly on his knees) was the major contributing cause of his current knee condition. However, Dr. Knopf was unable to determine whether there had been a pathological worsening of the underlying knee condition. (Ex. 18). After an examining physician, Dr. Peterson, concluded that claimant's right knee symptoms were the long-term result of the 1982 injury and subsequent surgery, the insurer denied the right knee claim on July 21, 1995, on the ground that claimant's current condition was an aggravation or continuation of the 1982 injury. (Exs. 19, 20). Claimant was advised to file a claim with prior insurers. Id. Claimant requested a hearing.

In October 1995, claimant sought treatment from Dr. Knopf after noting sharp pain in the right inferior patella while kneeling at work on October 26, 1995. (Ex. 22A).[2] Prior to this, claimant had been performing his regular work and had not sought treatment from Dr. Knopf since June 16, 1995. (Ex. 17). Noting that claimant's patellar symptom was "new and different," Dr. Knopf diagnosed acute right knee pain, prescribed medication and suggested physical therapy. (Ex. 22A).

On November 15, 1995, claimant filed an injury claim based on the October 26, 1995 incident. (Ex. 22B). The insurer denied this claim on November 28, 1995. (Ex. 22C). Claimant requested a hearing from the denial.

The insurer issued another denial of the April 1995 claim on February 9, 1996, denying a list of diagnoses related to claimant's right knee condition. (Ex. 25). The insurer also issued another denial of the October 9, 1995 injury claim on February 9, 1996. (Ex. 26). Claimant requested a hearing from the former, but not the latter, denial.

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[1] At this time, an insurer (Lumberman's) associated with Kemper National Insurance Companies provided coverage for the employer.

[2] At this time, another insurer (American) associated with Kemper provided coverage of the employer. At the hearing, one counsel represented both Lumberman's and American.

Examining physicians, Drs. Farris, Fuller, and Gritzka, have evaluated claimant's right knee condition. (Exs. 22, 23, 24, 28). Dr. Neitling reviewed medical records on behalf of claimant. (Ex. 31).

CONCLUSIONS OF LAW AND OPINION

The hearing in this matter had been postponed on several occasions. On January 13, 1997, the hearing convened. An attorney hired shortly before the hearing represented claimant. The ALJ granted a postponement to allow new counsel to prepare for the hearing. However, the ALJ "froze" the documentary record as of the hearing date and further restricted any future hearing testimony to that of witnesses who were at the hearing or available and expected to testify at the January 13, 1997 hearing. After that ruling, claimant's counsel resigned. The case was continued under the conditions the ALJ prescribed.

Claimant later retained counsel and the hearing was reconvened on February 20, 1997.[3] The ALJ denied admission of several exhibits claimant's counsel submitted after January 13, 1997. (Exs. 31A, 33, 34, 35, 35A, 36, 37). Addressing the merits of claimant's injury and occupational disease claims, the ALJ first upheld the insurer's denial of the October 1995 injury claim, finding that the October 1995 incident did not require medical services or result in disability. The ALJ then set aside the insurer's denial of claimant's occupational disease claim with respect to a chondromalacia condition. However, the ALJ upheld the denial with respect to other listed conditions, including claimant's right knee medial joint compartment arthritis condition. The ALJ found that the medical evidence did not establish the compensability of any right knee conditions apart from chondromalacia.

On review, claimant first contends that the ALJ improperly froze the record as of January 13, 1997. Claimant requests that the case be remanded for admission of the excluded exhibits, as well as for the presentation of final rebuttal evidence either in the form of expert testimony or a rebuttal report. Claimant also asserts that he established the compensability of his right knee arthritis condition and his October 26, 1995 injury claim.

We need not address the evidentiary/remand issue. That is, based on the evidence the ALJ admitted, we conclude that claimant sustained his burden of proving both a compensable occupational disease claim (April 1995) for his right medial knee joint compartment arthritis and an accidental injury claim (October 1995).

Occupational Disease claim

Because this occupational disease claim is based on a worsening of a preexisting arthritic condition, claimant must prove that his employment conditions were the major contributing cause of the combined condition and pathological worsening of his right medial knee joint compartment arthritis condition. ORS 656.802(2)(b); Dan D. Cone, 47 Van Natta 1097, on recon 47 Van Natta 2220, on recon 47 Van Natta 2343 (1995). This claim presents a complex question of medical causation because of the preexisting right knee condition. We, therefore, require expert medical evidence for its resolution. Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985); Uris v. Compensation Department, 247 Or 420, 424 (1967). Medical opinions that are well-reasoned and based on complete and accurate histories are given greater weight. Somers v. SAIF, 77 Or App 259 (1986).

Numerous physicians have commented on the causation issues: Drs. Knopf, Peterson, Fuller, Farris, Gritzka, and Neitling. We ordinarily defer to the opinion of the attending physician, unless there are persuasive reasons to do otherwise or unless the causation issue concerns expert analysis rather than expert observation. See Allie v. SAIF, 79 Or App 284, 287 (1986) (where a case involves expert analysis rather than expert external observation, the status of "treating physician" confers no special deference); Weiland v. SAIF, 64 Or App 810 (1983). In this case, we find that, because claimant's knee condition arose many years before Dr. Knopf became the attending physician, this case involves expert analysis rather than external observation. For this reason, Dr. Knopf's status as the treating physician does not entitle his opinion to deference. Moreover, even if external observation were important in this case, we would find persuasive reasons not to defer to Dr. Knopf's opinion.

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[3] Dr. Farris was allowed to testify at the February 20, 1997 hearing because he had been present and available to testify at the January 13, 1997 hearing.

Dr. Knopf initially opined that claimant's employment at Paulson's was the major contributing cause of claimant's current knee condition. However, Dr. Knopf found it difficult to "speculate" as to whether there had been a pathological worsening of the underlying degenerative joint condition, although his "suspicion" was that there had been a symptomatic worsening. (Ex. 18). Dr. Knopf later concurred with the report of an examining physician, Dr. Peterson, who opined that there had been no pathological worsening of the degenerative joint condition due to claimant's work activity. (Exs. 19, 21). Dr. Peterson concluded that claimant's knee symptoms were the long-term result of claimant's compensable 1982 injury and subsequent surgery.

We give little weight to Dr. Knopf's opinion given his initial uncertainty on the issue of the pathological worsening. Although Dr. Knopf later concurred with Dr. Peterson's report, we find that unexplained concurrence to be of little benefit, not only because of the lack of reasoning, but also because we find the Peterson report, itself, to be conclusory. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980) (conclusory and unexplained medical opinion rejected). Accordingly, we look to the opinions of the other physicians in order to resolve the compensability issue.

Dr. Fuller reviewed x-ray films from 1982, 1989, and 1995 and interpreted them as showing no "flagrant" worsening or acceleration of claimant's medial compartment arthritis. (Ex. 28-8). Dr. Fuller concluded that claimant's employment at Paulson's had not made a major contribution to claimant's ongoing knee problems and that claimant's knee symptoms resulted from preexisting varus alignment that predisposed claimant to degenerative deterioration of the meniscus and from residuals of the 1982 menisectomy. (Ex. 28-9). According to Dr. Fuller, these two preexisting factors combined to cause medial compartment arthritis which was made only symptomatic by current activities. Id.

Dr. Farris issued written reports based on two examinations of claimant and testified at hearing. Dr. Farris placed the primary responsibility for claimant's right knee condition on the 1982 injury and related surgery. (Ex. 22-6). However, Dr. Farris conceded that claimant's work activity as a floor coverer (which requires substantial kneeling) would cause wear and tear on the knees "above and beyond the normal degenerative process." Id. Despite this conclusion, Dr. Farris maintained that the original 1982 injury was the major contributing cause of claimant's right knee condition. Id; (Exs. 23-6, 27-3); (Trs. II-41, 66, 69).

Dr. Gritzka agreed with Dr. Fuller that any activity could worsen or aggravate claimant's right knee condition. (Ex. 29). However, Gritzka believed that repetitive squatting or bending of the knees, particularly when carrying a load of flooring material or heavy tools, would place the medial compartment of the knee under stress. (Ex. 29-4). Dr. Gritzka further explained that kneeling on claimant's degenerated right medial femoral condyle pathologically worsened claimant's preexisting degenerative arthritis. Id. Dr. Gritzka concluded that claimant's work activity after December 1988 was the major contributing cause of a pathological worsening of the right knee arthritis condition. (Ex. 29-5).

Dr. Neitling, who performed a records review, agreed with Dr. Gritzka's assessment. (Ex. 31-1). Identifying not only post-traumatic arthritis involving the medial compartment of the right knee, but also a significant patello-femoral arthrosis, Dr. Neitling concluded that both conditions were due in major part to claimant's work activities. (Ex. 31-2). Dr. Neitling specifically disagreed with Dr. Fuller's assessment, noting that not all patients who have varus deformity and medial menisectomies develop degenerative changes in the knee. According to Dr. Neitling, chronic kneeling and other bent activities caused the progressive deterioration of the medial compartment of claimant's right knee. (Ex. 31-3).

Based on our review of the medical evidence in this record, we find that Drs. Gritzka and Neitling provided the most persuasive explanation of the etiology of claimant's current right knee condition. Therefore, based on the well-reasoned reports of Drs. Gritzka and Neitling, we conclude that claimant has sustained his burden of proving that his work activities for Paulson's were the major contributing cause of the combined right knee medial joint compartment arthritis condition and of its pathological worsening. Thus, we find that claimant sustained his burden of proving a compensable occupational disease claim for his right knee arthritis condition. Because the ALJ concluded otherwise, we reverse.

October 1995 Injury Claim

The parties agree and we find, that the compensability of the October 1995 injury claim is governed by ORS 656.005(7)(a)(B). That is, we find that the October 1995 injury (diagnosed as right knee pain/localized infrapatellar tendinitis) combined with the preexisting right knee condition. Thus,

claimant must prove that the October 26, 1995 incident was the major contributing cause of a need for treatment or disability for the combined right knee condition. The ALJ reasoned that claimant did not prove that he sustained a compensable injury because the alleged October 26, 1995 incident did not result in medical services or disability. We disagree.

At the time of the October 26, 1995 incident, claimant was not under active treatment, having last seen Dr. Knopf in June 1995. (Exs. 17, 22-3). After feeling sharp right knee pain on October 26, 1995, claimant again sought treatment from Dr. Knopf for a "new and different" symptom. Dr. Knopf diagnosed acute knee pain, most likely localized tendinitis to the infrapatellar area, and prescribed medication. (Ex. 22A). Accordingly, we conclude that the October 26, 1995 incident was the major contributing cause of a need for medical services for claimant's right knee tendinitis, however minimal those services may have been. Therefore, we find that claimant sustained his burden of proving a compensable injury.[4]

Attorney Fees on Review

Claimant's attorney is entitled to an assessed fee for services at hearing and on review regarding the compensability issues. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $5,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by the record and claimant's appellate brief), the complexity of the issues, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated April 19, 1997 is reversed in part and affirmed in part. Those portions of the ALJ's order that upheld the insurer's denial insofar as it denied claimant's occupational disease claim for medial knee joint compartment arthritis and the insurer's denial of his October 26, 1995 injury claim are reversed. Those denials are set aside and the claims are remanded to the insurer for processing in accordance with law. For services at hearing at hearing and on review, claimant's counsel is awarded an assessed fee of $5,000, to be paid by the insurer. The remainder of the ALJ's order is affirmed.

[4] We note that Dr. Farris opined that the October 26, 1995 incident resulted only in a mild symptomatic worsening of claimant's right knee condition. (Ex. 23-6). However, under ORS 656.005(7)(a)(B), a claimant need not prove a pathological worsening in order to establish a compensable injury claim. See Robert L. Hansen, 49 Van Natta 596, 598 (1997); Robert C. Train, 45 Van Natta 2329 (1993).

March 20, 1998 Cite as 50 Van Natta 458 (1998)

In the Matter of the Compensation of
**VERLA L. WARTHER, Claimant**
WCB Case No. 97-01631
ORDER ON REVIEW
Greg Noble, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Myzak's order which affirmed that portion of an Order on Reconsideration that reduced claimant's award of scheduled permanent disability for loss of use or function of the right forearm to 24 percent (36 degrees). On review, the issue is extent of scheduled permanent disability.

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

On review, claimant asserts that this matter should be remanded to the Director for promulgation of a temporary rule concerning loss of strength of her right arm. This issue was not raised at hearing and the ALJ did not address it. We have consistently held that we will not consider an issue raised for the first time on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991); Phyllis G. Nease, 49 Van Natta 195, 197 (1997). Accordingly, we decline to consider the late-raised remand issue in this case.

ORDER

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

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In the Matter of the Compensation of
**DARREN E. CONKLIN, Claimant**
WCB Case Nos. 96-11328 & 96-08469
ORDER ON REVIEW
Cole, Cary & Wing, Claimant Attorneys
Lundeen, et al, Defense Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Hall and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) upheld Liberty Northwest Insurance Corporation's denial of claimant's aggravation claim for a left inguinal hernia; (2) upheld the SAIF Corporation's denial of claimant's "new injury" claim for the same condition; and (3) did not award penalties for allegedly unreasonable or untimely denials. On review the issues are compensability, responsibility, and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings," with the following correction and exception.

"Finding" number 3 is corrected to read: "Claimant started working for SAIF's insured, Umpqua Lumber, in 1994."

We do not adopt the last sentence of "Finding" number 3.[1]

CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the facts pertinent to the case.

In 1992, claimant suffered a compensable right inguinal hernia while working as a choker setter for Liberty's insured.

On May 27, 1993, claimant injured his left groin while working at the same job. Claimant sought treatment and filed a claim. A left inguinal hernia was suspected.

On July 9, 1993, Liberty accepted the May 1993 claim as a nondisabling left groin strain.

Claimant stopped working for Liberty's insured and began working as a cantor operator for SAIF's insured in 1994. He did not receive treatment for his left groin injury from April 1994 through March 1996. Thereafter, claimant filed a "new injury" claim with SAIF.

Dr. Kremser repaired claimant's left inguinal hernia on May 10, 1996.

SAIF issued an August 9, 1996 responsibility denial. Claimant filed a September 1996 aggravation claim with Liberty. On December 18, 1996, Liberty denied compensability and responsibility. On March 27, 1997, SAIF denied compensability as well as responsibility. Claimant requested a hearing.

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[1] Dr. Kremser authored Exhibit 42, not Dr. Edwards.

Compensability, Aggravation, and Responsibility

The ALJ upheld Liberty's and SAIF's denials of compensability, reasoning that claimant's treating doctors were unwilling to say that claimant's May 1993 groin sprain was the major contributing cause of his 1996 need for surgery. We disagree.

Claimant has an accepted claim with Liberty for a left groin strain and he contends that the hernia is a worsening of the accepted condition. Accordingly, we first address whether claimant has proven a compensable aggravation. See Daryl J. Johnson, 46 Van Natta 1006 (1994), aff'd mem Dunbar v. Johnson, 138 Or App 188 (1995).

Liberty argues that the persuasive medical evidence establishes that claimant's left hernia was congenital and bound to protrude eventually with life stresses, of which the work injury could be but one. Thus, Liberty contends that claimant has not proven that the work injury was the major contributing cause of his recent need for surgery. Because Liberty does not contest the "worsening" prong of the claim under ORS 656.273, this is essentially a compensability dispute in the first instance.

Claimant concedes that he is subject to the major contributing cause standard of proof, because his left hernia condition is a combined condition involving a congenital predisposition and the May 1993 work injury. See ORS 656.005(7)(a)(B).

Considering the passage of time since the 1993 injury and the "combined" nature of the current condition, we find that the causation issue is a complex medical question which requires expert evidence for its resolution. See Barnett v. SAIF, 122 Or App 279 (1993). We generally rely on the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983); Argonaut Insurance Company v. Mageske, 93 Or App 698 (1988).

Dr. Kremser is the only physician who has examined and treated claimant since March 14, 1994. He performed claimant's May 10, 1996 left hernia surgery and he had a complete and accurate history.

Dr. Kremser has consistently opined[2] that the May 27, 1993 work injury was the major contributing cause of claimant's need for surgery for a left hernia. He acknowledged claimant's congenital predisposition, which combined with the injury to cause the hernia. However, considering claimant's history of no left groin problems before the 1993 injury and ongoing problems thereafter, the consistency of claimant's complaints, and the lack of additional inciting incidents, Dr. Kremser found the work incident more significant than the predisposition. (See Ex. 31). Dr. Kremser's opinion is consistent with claimant's history and clinical findings. Under these circumstances, we find no persuasive reason to discount Dr. Kremser's reasoning and conclusions.[3] See Somers v. SAIF, 77 Or App 259 (1986); Weiland, 64 Or App 810. Accordingly, based on Dr. Kremser's opinion, we conclude that claimant has established that his left hernia condition is compensable. In addition, because the "worsening" aspect of the claim is not disputed, we further conclude that claimant has proven his aggravation claim with Liberty under ORS 656.273. (See Ex. 31).

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[2] Liberty argues that Dr. Kremser was unable to state that the work injury was the major cause of claimant's hernia. Liberty also contends that Dr. Kremser's opinion changed without adequate explanation.

Dr. Kremser did say that he could not "prove" or be "certain" that the work injury caused the hernia. (See Ex. 38). However, once apprised that certainty is unnecessary, Dr. Kremser continued to opine that the work injury was the major cause of claimant's hernia. (See Exs. 31, 36, 38, 42). Because Dr. Kremser's opinion in this regard is consistent over time and well-reasoned, we find no persuasive reason to discount it. See McIntyre v. Standard Utility Contractors, Inc., 135 Or App 298 (1995) (medical probability, not certainty, is the required standard of proof); Donna Kuzelka, 49 Van Natta 775 (1997) (same).

[3] The remaining medical evidence regarding the etiology of claimant's left hernia is provided by Dr. James S. Edwards, Jr., former treating physician, and Drs. James Edwards (a different James Edwards) and Blumberg, file reviewers. Dr. James S. Edwards did not examine claimant after March 1994 and never saw him when the hernia was "full blown." Under these circumstances, Dr. J.S. Edwards was not in a particularly advantageous position to evaluate the etiology of the condition in question. See McIntyre, 135 Or App at 302 (A treating physician's opinion is less persuasive when he did not examine the worker at the relevant time). We agree with the ALJ that Dr. Blumberg's opinion is not persuasive because it is not based on a complete history. (See Ex. 35). Finally, we find the other Dr. Edwards' ultimate conclusion consistent with that of Dr. Kremser. (See Ex. 28).

Under ORS 656.308(1),[4] Liberty remains responsible for claimant's compensable left groin condition, unless a "new injury" during SAIF's later coverage was the major contributing cause of his left hernia. See SAIF v. Drews, 308 Or 1 (1993); Liberty Northwest Ins. Corp. v. Senters, 119 Or App 314, 317 (1993). Because we find no evidence that claimant's work for SAIF's insured contributed to his hernia, we conclude that responsibility remains with Liberty.

Penalties and Attorney Fees

Claimant seeks penalties on numerous bases. We first consider his contention that Liberty's December 13, 1996 denial of compensability was unreasonable.

Penalties may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(11)(a). The reasonableness of a carrier's denial of compensation must be gauged based upon the information available to the carrier at the time of its denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988); Price v. SAIF, 73 Or App 123, 126 n. 3 (1985). A carrier's "refusal to pay is not unreasonable if it has a legitimate doubt about its liability." International Paper Co. v. Huntley, 106 Or App 107, 110 (1991) (citing Castle & Cook, Inc., v. Porras, 103 Or App (1990)).

Liberty's denial stated:

> "The information currently contained in your file does not establish or substantiate a relationship between your condition and your employment with [Liberty's insured]." (Ex. 34-1).

Liberty argues that the denial was reasonable because claimant's left hernia was not diagnosed (only suspected) in 1993 and the present aggravation claim was filed almost three years after its initial acceptance. We disagree.

At the time of Liberty's December 26, 1995 denial of compensability (Ex. 32), the medical evidence unanimously related claimant's left hernia to the compensable 1993 work incident. (See Exs. 28, 30, 31). Under these circumstances, we find that Liberty did not have a legitimate doubt regarding its liability and a penalty is appropriate. See Karen L. Lewis, 45 Van Natta 1079, 1080 (1993) (where the evidence available to the insurer should have prompted pre-denial investigation, the insurer did not have legitimate doubt regarding its liability without such investigation); Kenneth A. Foster, 44 Van Natta 148, 151, 152, aff'd mem, SAIF v. Foster, 117 Or App 543 (1992) (same).

Claimant also seeks a penalty based on Liberty's allegedly unreasonable and untimely processing of claimant's aggravation claim. However, because we agree with the ALJ that the record does not indicate when Liberty received the claim, we cannot say that the denial was untimely. Claimant also argues that Liberty's denial was unreasonable because it inaccurately referred to a right hernia (rather than a left hernia) and did not address the aggravation claim specifically. Because we find no indication that the inaccurate reference or the alleged omission delayed claimant's compensation (or that they constituted unreasonable claim processing for which a penalty would be warranted), we award no penalty or penalty-related attorney fee on these bases.

In addition, claimant seeks a penalty based on SAIF's allegedly unreasonable denial of compensability. (See Ex. 40). However, because SAIF had medical evidence supporting a legitimate doubt at the time of its denial, (Ex. 35), we conclude that the denial was not unreasonable.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review regarding compensability is $4,000, payable by Liberty. In reaching

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[4] Liberty argues that responsibility should be assigned with SAIF under the successive injury rule or the last injurious exposure rule. However, because the persuasive medical evidence in this case establishes that claimant's current left hernia condition "involves" the "same condition" as his "Liberty" claim (see Exs. 4, 8, 28, 30, 31, 36, 37, 41-13-14, -21, 42), responsibility is determined under ORS 656.308. See Smurfit Newsprint v. DeRossett, 118 Or App 368 (1993).

this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's counsel's statement of services, 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.

Finally, claimant's counsel is also entitled to an attorney fee for services at hearing and on review for finally prevailing over Liberty'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). Claimant neither asserts nor do we find "extraordinary circumstances" warranting an attorney fee in excess of the statutory maximum $1,000 attorney fee. See Jack L. Barbee, 48 Van Natta 1855, 1858 (1996). Therefore, claimant's counsel is awarded a $1,000 attorney fee for services at hearing and on review regarding the responsibility issue, payable by Liberty.

ORDER

The ALJ's order dated August 21, 1997 is reversed in part and affirmed in part. That portion of the order that upheld Liberty Northwest Insurance Cooperation's denial is reversed. Liberty's denial is set aside and the claim is remanded to Liberty for processing according to law. Claimant is awarded a penalty equal to 25 percent of amounts due at the time of hearing as a result of this order, payable to Liberty in equal parts to claimant and claimant's attorney. In addition, claimant is awarded $5,000 in attorney fees, payable by Liberty. The remainder of the order is affirmed.

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March 23, 1998 Cite as 50 Van Natta 462 (1998)

In the Matter of the Compensation of
**CELIA BARRERA, Claimant**
WCB Case No. 97-04872
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Kekauoha's order affirming an Order on Reconsideration that declined to award unscheduled permanent partial disability for a left shoulder and back condition. On review, the issues are evidence and extent of unscheduled permanent disability.

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

Claimant's brief on review references the Appellate Unit's April 2, 1997 medical arbiter examination appointment confirmation letter. SAIF objects to claimant's reliance on that letter, which is not part of the record developed at hearing. We treat this reference to the Appellate Unit's letter as a motion to take administrative notice of the letter and/or a motion for remand for admission of this letter into the record. We deny both motions because our consideration of the Appellate Unit's letter would not effect our ultimate disposition in this case.

ORDER

The ALJ's October 31, 1997 order is affirmed.

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In the Matter of the Compensation of
**PEDRO FRIAS, Claimant**
WCB Case No. 97-03188
ORDER ON REVIEW
Lavis & Dibartolomeo, 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) Mills' order that directed it to recalculate claimant's rate of temporary disability benefits. On review, the issue is rate of temporary disability. We affirm.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

Claimant's temporary disability rate was originally calculated based upon a regular $12 an hour, 40-hour work week. In March 1997, SAIF audited claimant's temporary disability benefits based upon his actual income during his weeks of employment and concluded that claimant's average weekly wage should be $294.30. This recalculated to a new temporary disability rate of $196.21, whereas the prior rate at which claimant had been paid was $320.02. The recalculation was based upon claimant having worked 31.6 weeks with gross earnings during that period of $9,300. The 31.6 weeks included two gaps in claimant's employment from May 25, 1996 through July 4, 1996 and from September 7 through September 22, 1996. After the hearing, SAIF agreed that three weeks of claimant's first gap in employment should be excluded from the temporary disability rate calculation because claimant was on vacation during that time period and work would have been available to him.

Applying OAR 436-060-0025(5)(a)(A) (WCD Admin. Order 96-070), the ALJ found 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 Board review, SAIF argues that the ALJ was mistaken in stating that the version of OAR 436-060-0025(5)(a)(A) which is applicable here 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). The ALJ relied on a footnote to Kollen, which indicated that where a claimant was employed less than 52 weeks, it was unnecessary to determine whether an "extended gap" existed because that portion of the rule was inapplicable. Kollen involved former OAR 436-60-025(5)(a), a prior version of 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 * * *."

We agree with SAIF that the version of the administrative rule applicable to this case is different than the rule used in Kollen. SAIF argues 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."

Assuming, without deciding, that SAIF's interpretation of this 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 base our conclusion on the following reasoning.

In Hadley v. Cody Hindman Logging, 144 Or App 157 (1996), the court rejected an interpretation of the phrase "extended gaps" in former OAR 436-60-025(5)(a)[1] that required a change in employment for the "extended gaps" exception to apply. The court did not otherwise define the phrase "extended gaps," but explained simply that it would be improper to require more than a hiatus in employment to establish an "extended gap." 144 Or App at 161-62.

On remand, we held that 16-1/2 weeks of unemployment in a 26-week period constituted "extended gaps." Earin J. Hadley, 49 Van Natta 1101, 1103 (1997). Finding no guidance for a definition of "extended gaps" in the Director's rules or rule adoption documents, we turned to the dictionary, which defines "extended" as "drawn out in length *** esp. in length of time[.]" Webster's Third New Int'l Dictionary 804 (unabridged ed. 1993). 49 Van Natta at 1102. We reasoned that whether a gap in employment is "drawn out in length" depends on the particular circumstances of each case. We noted, however, that, pursuant to the court's instructions, we would not consider whether a change in the work relationship had occurred in determining whether there was an "extended gap" in employment. Under the circumstances of the Hadley case, we concluded that an unemployment period that 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.

Here, claimant had 4.8 weeks of unemployment during the 31.6-week period of his employment. The period of unemployment consisted of two gaps of 2.2 and 2.6 weeks. Considering that claimant was unemployed for 4.8 weeks preceding his injury, or 15 percent of 31.6 weeks, we conclude that claimant's period of unemployment constituted an "extended gap" within the meaning of OAR 436-060-0025(5)(a). See 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 436-060-0025(5)(a), the gaps in claimant's employment constitute "extended gaps" which are excluded from the rate calculation.

Inasmuch as SAIF requested review, and we have not disallowed or reduced claimant's compensation, claimant would normally be entitled to an attorney fee pursuant to ORS 656.382(2). However, claimant did not file a brief; therefore, no attorney fee shall be awarded. Shirley M. Brown, 40 Van Natta 879 (1988).

## ORDER

The ALJ's order dated August 13, 1997 is affirmed.

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[1] Former OAR 436-60-025(5)(a) provided:

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

In the Matter of the Compensation of
**SHARRON D. LEMLEY, Claimant**
WCB Case Nos. 96-07170 & 96-07169
ORDER ON REVIEW
Ronald A. Fontana, Claimant Attorney
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that upheld the self-insured employer's partial denial of claimant's injury claim for a neck condition (C4-5 herniated disc). On review, the issue is compensability and, if compensable, a penalty and attorney fee for allegedly unreasonable claims processing. We affirm.

## FINDINGS OF FACT

Claimant was compensably injured on October 10, 1993, when she was punched in the face by a customer. (Ex. 24). X-rays revealed degenerative disc disease at C4-5 and C5-6. (Ex. 26).

On February 17, 1994, Dr. Brett, neurosurgeon, evaluated claimant's persistent left-sided pain in the neck and shoulder, with radiation into the left arm and dyesthesia in the left hand. Brett noted no complaints in the right upper extremity. (Ex. 30). The employer accepted, inter alia, a cervical strain and herniated discs at C5-6 and C6-7. (Exs. 27, 36). Subsequent to fusion surgery at C5-6 and C6-7, a November 22, 1994 Notice of Closure awarded 10 percent unscheduled permanent disability for the neck. (Ex. 57).

Meanwhile, on September 19, 1994, claimant experienced the sudden onset of pain in the right shoulder while moving tables at work. (Ex. 56). The employer accepted a right shoulder strain. (Ex. 63).

On April 4, 1995, Drs. Bald and Klecan evaluated claimant's right shoulder injury and psychological condition. (Ex. 72). Dr. Bald found that claimant had no objective signs of impingement syndrome, rotator cuff tear, or weakness in the right shoulder or right upper extremity warranting further treatment. Dr. Bald also noted active limitation of motion, but with considerable inconsistencies, opining that claimant had a considerable psychogenic component to her ongoing pain complaints. He declared her medically stationary. (Ex. 72-5). Dr. Klecan also found claimant to be medically stationary. Klecan opined that, given claimant's extensive life-long history of somatic displacement, it was medically probable that the degree and chronicity of her shoulder symptoms were partially magnified by psychological processes. (Ex. 73-12). On August 9, 1995, Dr. Brenneke, claimant's attending physician for her shoulder, declared claimant medically stationary. (Ex. 75).

On February 12, 1996, claimant sought treatment from Dr. Engstrom for increasing neck pain with radicular pain down the left arm. (Ex. 81). Cervical films revealed an anterior defect at C4-5, secondary to posterior spondylotic spurring, and without herniation. No involvement of the left side was noted. (Exs. 86, 87). Dr. Brett opined that claimant's C7 nerve root had chronic injury, with the onset of ephaptic transmission into the left arm. (Exs. 88, 93).

On June 10, 1996, claimant sought evaluation from Dr. Long regarding chronic neck, right shoulder, and right arm pain, with tingling in the left ulnar hand and the left forefoot. (Ex. 95). Dr. Long diagnosed a C4-5 disc lesion. (Ex. 96A-2). On June 24, 1996, claimant requested amendment of the Notice of Acceptance to include the herniated disc at C4-5. (Ex. 98).

On September 17, 1996, Dr. Rosenbaum, neurosurgeon, evaluated claimant's neck condition for the employer. (Exs. 100, 101, 102).

On September 13, 1996, Dr. Mawk evaluated claimant for a cervical syndrome. (Exs. 99B, 102A).

On March 5, 1997, the employer partially denied claimant's C4-5 disc bulge/herniation on the basis that it was not compensably related to either the 1993 or 1994 injury. (Ex. 107).

CONCLUSIONS OF LAW AND OPINION

Relying on the opinions of Dr. Brett and Dr. Rosenbaum, the ALJ concluded that claimant failed to prove that her October 1993 and/or September 1994 work injuries were the major contributing cause of a pathological worsening of her preexisting C4-5 neck condition. Claimant contends that Dr. Long's opinion is more persuasive than those of Dr. Brett and Dr. Rosenbaum, and that she has carried her burden to prove compensability of her C4-5 herniated disc as either a direct or consequential result of her 1993 and/or 1994 injuries. We disagree.

Claimant was injured in October 1993, when she was assaulted in the face while on the job. X-rays revealed degenerative disc disease (DDD) at C4-5 and C5-6. Claimant was subsequently diagnosed with herniated discs at C5-6 and C6-7, for which Dr. Brett performed fusion surgery. Claimant's claim was closed on November 22, 1994. Meanwhile, in September 1994, claimant injured her right shoulder while moving tables at work. The employer accepted a right shoulder strain.

On February 12, 1996, claimant sought treatment from Dr. Engstrom for increasing neck pain with radicular pain down the left arm. (Ex. 81). Cervical films revealed an anterior defect at C4-5, secondary to posterior spondylotic spurring and without herniation. No involvement of the left side was noted. Dr. Brett opined that claimant's C7 nerve root had been chronically injured, with the onset of ephaptic transmission into the left arm.

On June 10, 1996, claimant sought evaluation from Dr. Long regarding complaints of chronic neck, right shoulder, and right arm pain, and tingling in the left ulnar hand and the left forefoot. (Ex. 95). Dr. Long diagnosed a C4-5 disc lesion.

Claimant contends that her herniated disc at C4-5 is either a direct or consequential result of the 1993 and/or 1994 compensable injuries. Claimant has the burden to prove compensability by a preponderance of the evidence. ORS 656.266; Hutcheson v. Weyerhaeuser, 288 Or 51 (1980). Because claimant has been diagnosed with DDD that preexisted and combined with her 1993 injury (Exs. 26, 98; Tr. 77), she must prove that the major contributing cause of her C4-5 herniated disc was the 1993 injury, the 1994 injury, or both injuries. ORS 656.005(7)(a).

Because of the number of causes and the passage of time, this case is sufficiently complex that medical causation must be established by expert medical opinion. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). Because resolution of the matter involves expert analysis rather than expert external observation, we do not give special deference to evidence from the treating physician. See Allie v. SAIF, 79 Or App 284 (1986).

Here, claimant relies on the opinions of Dr. Long (Exs. 99, 107B, 107C; Tr. 44-115), and Dr. Mawk (Exs. 99A, 99B, 102A, 108, 110, 111). The employer relies on the opinions of Dr. Brett (Exs. 103, 106) and Dr. Rosenbaum (Exs. 100, 101, 102, 104; Tr. 117-203).

Dr. Brett, neurosurgeon, who performed fusion surgery for claimant's herniated discs at C5-6 and C6-7 after the 1993 injury, reviewed chartnotes and reports from Dr. Engstrom, Dr. Long, Dr. Mawk and Dr. Rosenblum. Dr. Brett opined that the extra-dural defect at C4-5 was due to spondylotic change and a bone spur, rather than a herniation, and, as such, did not require attention, whereas there had been significant nerve impingement at C5-6 and C6-7, which required surgery. Dr. Brett also explained that the [central right] disc pathology would not cause the discomfort radiating into claimant's left arm or dysesthesia in the ulnar aspect of the left hand. Finally, Dr. Brett opined that neither the 1993 or 1994 work injuries resulted in or worsened the pathology at C4-5. (Ex. 99).

In a subsequent deposition, Dr. Brett provided additional reasoning in support of his opinion that it was not medically probable that the disc protrusion at C4-5 on the right was a result of the 1993 work injury, explaining that the myelogram prior to surgery showed that the injury had not resulted in any nerve impingement and a disc bulge of that size would often be considered a normal finding. He also explained that, with the type of injury claimant experienced in 1993, it was extremely unlikely that she would injure discs at three levels. (Ex. 103-8, -9, -10). Additionally, Dr. Brett explained that, based on his examination of claimant in October 1994, her right arm complaints were related to her right shoulder, as neither her subjective complaints nor subsequent myelogram or CT scans confirmed new neck pathology. (Id.)

Dr. Rosenbaum, neurosurgeon, examined claimant and reviewed her records. in September 1996. He opined that it was highly unlikely that claimant had cervical radiculopathy, explaining that she did not have symptoms or signs of right C5 nerve root compression and that scans of the C4-5 level did not evidence nerve root involvement. (Exs. 100, 101). In deposition, Dr. Rosenbaum explained that claimant had relatively diffuse complaints of pain, which did not substantiate neck pathology. (Ex. 104-35). He also noted claimant's functional overlay on examination, and opined that the 1994 injury did not result in any injury to claimant's neck. (Ex. 104-40 through -53).

In contrast, Dr. Long opined that, although claimant had degenerative changes at C4-5 prior to the 1993 injury, the central right C4-5 disc bulge revealed by a March 1996 MRI was the result of a disc injury in 1993 and was progressively worsened by the effects of the fusion surgery and claimant's heavy work, as well as the 1994 injury when claimant was moving heavy tables. (Ex. 107C; Tr. 76, 77). Dr. Long also "suspected" that claimant's shoulder condition, which had been persistent in spite of extensive physical therapy, was neurogenic rather than musculoskeletal or glenohumeral. (Ex. 96A-2). Finally, in weighing the various factors affecting claimant's C4-5 disc, Dr. Long opined that the 1993 and 1994 work injuries were the major contributing cause of claimant's C4-5 nerve root problem in 1996 and 1997. (Tr. 80). Basically, Dr. Mawk concurred with Dr. Long's opinion. (Exs. 108, 109, 110).

We find Dr. Brett and Dr. Rosenbaum's opinions more persuasive than those of Dr. Long and Dr. Mawk, as they are well-reasoned and based on an accurate and complete history. Somers v. SAIF, 77 Or App 259, 262 (1986).

As noted above, Dr. Long, who began treating claimant in June 1996, opined that claimant's C4-5 disc lesion was a direct result of her October 1993 injury. However, as discussed by Dr. Brett, her treating physician for the 1993 injury, the disc bulge at that time was minimal and there was no evidence of nerve root involvement. Moreover, after reviewing the June 1996 MRI and comparing it with March 1994 films, Dr. Brett opined that the central right C4-5 impingement on the dural sac was not symptomatic and was due to arthritic change consistent with claimant's age. (Ex. 103-13, -14, -15).

Like Dr. Brett, Dr. Rosenbaum opined that the C4-5 defects revealed by x-rays and MRIs were due to osteoarthritis. Dr. Rosenbaum also concluded that it was highly unlikely that claimant had cervical radiculopathy, as he found no symptoms or signs of right C5 nerve root compression and that scans of the C4-5 level did not evidence nerve root involvement. He also noted that claimant's diffuse pain complaints, which he related to claimant's functional overlay, did not support a diagnosis of a neck problem.[1]

Absent medical evidence of nerve root involvement in 1993, we are not persuaded by Dr. Long's opinion that the C4-5 disc lesion was a direct result of claimant's 1993 neck injury. Consequently, Dr. Long's opinion that claimant's C4-5 disc lesion was progressively worsened as a result of the fusion, her heavy work, and the 1994 injury, is unpersuasive.

In sum, after our de novo review of the record, we conclude that claimant has failed to carry her burden to prove that the major contributing cause of her C4-5 herniated disc was the 1993 injury, the 1994 injury, or both.[2]

## ORDER

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

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[1] We note that Dr. Rosenbaum's findings regarding functional overlay are supported by the findings by Dr. Bald of a considerable psychogenic component to claimant's ongoing pain complaints, and the report of Dr. Klecan, who recorded an extensive, life-long history of somatic displacement, and opined that the chronicity of claimant's shoulder symptoms was partially magnified by psychological processes. (Exs. 73, 75).

[2] We note that there is no medical evidence that claimant's C4-5 disc condition arose directly or consequentially from the 1994 injury.

In the Matter of the Compensation of
**TERESA MARION, Claimant**
WCB Case No. 97-07463
ORDER DENYING MOTION TO DISMISS
Hornecker, Cowling, et al, Defense Attorneys

Claimant, pro se, has requested Board review of Administrative Law Judge (ALJ) Peterson's order that dismissed her request for hearing. Contending that claimant's request for review was untimely filed, the self-insured employer has moved the Board for an order dismissing claimant's review request for lack of jurisdiction. We deny the motion.

## FINDINGS OF FACT

The ALJ's order issued on January 5, 1998. The order recited that copies had been mailed to claimant, the employer, its claims administrator, and its attorney.

On February 6, 1998, the Board received claimant's February 4 request for review of the ALJ's order. The request, which was sent by certified mail and was contained in an envelope bearing a postmark date of February 4, 1998, indicated that copies were mailed to the employer, its claims administrator, and its 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. ORS 656.289(3). Requests for Board review shall be mailed to all parties to the proceeding before the ALJ. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed, or actual notice received, within the statutory period. Argonaut Insurance v. King, 63 Or App 847 (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). All parties to the ALJ's order must be served or receive notice, even if the appealing party makes no claim as to the excluded party. Kelsey v. Drushella-Klohk NCE, 128 Or App 53, 57 (1994); Mosley, 113 Or App at 237.

The employer contends that we lack jurisdiction to consider claimant's appeal because it "was filed untimely." We disagree. The 30th day after the ALJ's January 5, 1998 order was February 4, 1998. Although the Board did not receive claimant's review request until February 6, 1998, the request was contained in an envelope that was sent by certified mail and bears the postmark date of February 4, 1998. Because the request was mailed, by certified mail, within 30 days of the ALJ's January 5 order, we conclude that the request was timely filed. ORS 656.289(3), 656.295(2); OAR 438-005-0046(1)(a), (b).

We also conclude that notice of claimant's appeal was timely served on all parties to the ALJ's order. Claimant's review request indicates that copies were mailed to all parties. That representation is uncontested and is supported by the employer's acknowledgment that claimant's review request was "received." Furthermore, although the employer alleges that it did not actually "receive" claimant's review request until February 6, 1998, it does not allege that the request was untimely mailed, i.e., mailed after February 4, 1998. Inasmuch as our rules provide that "[s]ervice by mail is complete upon mailing," OAR 438-005-0046(2)(a), and there is no allegation that copies of claimant's review request were not timely mailed to all parties on February 4, 1998, we are persuaded that claimant provided timely notice of her appeal to the other parties to this proceeding. See ORS 656.295(2).

Accordingly, we deny the motion to dismiss. In light of these circumstances, the briefing schedule shall be revised as follows. Claimant's appellant's brief (her written argument explaining why she disagrees with the ALJ's decision and what action she wants the Board to take) must be filed within 21 days from the date of this order. (A copy of her brief should also be mailed to the employer's attorney.) The employer's respondent's brief must be filed within 21 days from the date of mailing of claimant's brief. Claimant's reply brief must be filed within 14 days from the date of mailing of the employer's brief. Thereafter, this case will be docketed for review.

IT IS SO ORDERED.

In the Matter of the Compensation of
**RICK L. MATHIESEN, Claimant**
WCB Case Nos. 96-11242 & 95-13316
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Ronald W. Atwood, et al, Defense Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) upheld the denial of Liberty Northwest Insurance, on behalf of Consolidated Sawmill Machinery, Inc. (Liberty/CSMI), of claimant's bilateral carpal tunnel syndrome; and (2) upheld the denial of Liberty, on behalf of Schnitzer Steel (Liberty/Schnitzer), for the same condition. On review, the issues are compensability and responsibility.

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

In upholding the carrier's denials, the ALJ found that claimant failed to prove that his work activities at Liberty/CSMI (between June 1993 and January 1994) or at Liberty/Schnitzer (between March 1995 and June 1995) were the major contributing cause of his bilateral carpal tunnel syndrome. On review, claimant asserts that his bilateral carpal tunnel syndrome is compensable because he has shown that his work activities, taken as a whole, are the major contributing cause of his condition. We disagree.

Claimant has the burden of proving that his bilateral carpal tunnel syndrome condition is compensable by the preponderance of the medical evidence. ORS 656.266. Because of the multiple potential causal factors, the causation issue is a complex medical question which must be resolved on the basis of expert medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986).

In this case, four physicians have addressed the causation of claimant's condition: Dr. Canepa (claimant's attending physician), Drs. Williams and Wilson (who examined claimant at Liberty/CSMI's request), and Dr. Rosenbaum (who reviewed claimant's records at the request of Liberty/Schnitzer). All of these medical experts essentially agree that claimant's bilateral carpal tunnel syndrome had developed by June 14, 1993, when he compensably injured his left ring finger while working for Liberty/CSMI. (See, e.g. Exs. 24-4, 33-3, 35, and 36 at pp. 13-16). Drs. Williams and Wilson reported that although claimant's employment activities prior to June 1993 likely contributed to his condition, the exact cause of his bilateral carpal tunnel syndrome is "unknown." (Ex. 24-4). Dr. Rosenbaum concluded that claimant's right carpal tunnel syndrome is probably related to a previous right wrist fracture in 1972 and that his left carpal tunnel syndrome is probably a long-standing idiopathic condition. (Ex. 33). Because neither of these opinions identify claimant's work activities as the major contributing cause of his bilateral carpal tunnel condition,[1] they are insufficient to sustain claimant's burden of proof.

Dr. Canepa initially concurred with the report of Drs. Williams and Wilson. Later, in his deposition, Dr. Canepa explained that he did not take a detailed history of claimant's work activities nor did he attempt to determine which employer was responsible for claimant's condition. He testified that although he presumed that claimant's carpal tunnel syndrome was caused by repetitive activity, he had no specific history of claimant's work exposures.[2] (Ex. 36, pp. 23-26). Dr. Canepa also admitted that he could not identify the major contributing cause of claimant's carpal tunnel condition. Id. at 13. Finally, Dr. Canepa noted that he had no history of an old navicular injury to claimant's right wrist. Id. at 29.

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[1] Under the major contributing cause standard, the persuasive medical opinion must evaluate the relative contribution of different causes and explain why work exposure or injury contributes more to the claimed condition than all other causes or exposures combined. See, e.g., Dietz v. Ramuda, 130 Or App 397, rev den 321 Or 416 (1995).

[2] Dr. Canepa testified that he never took a history of claimant's work activity and that the only information he had about claimant's more recent employment activities was provided to him by counsel. (Ex. 36-21; see also Exs. 32, 35).

We also find Dr. Canepa's testimony insufficient to establish that claimant's bilateral carpal tunnel syndrome was caused in major part by his work activities as a whole. Indeed, Dr. Canepa did not give any indication that he was familiar with claimant's work activities prior to June 1993. In the absence of a complete and accurate history of claimant's work activities (especially his work exposure prior to June 1993), Dr. Canepa's assumption that claimant's condition is work-related is unpersuasive. See, e.g., Moe v. Ceiling Systems, 44 Or App 429 (1980) (rejecting conclusory medical opinion); Miller v. Granite Construction Co., 28 Or App 473, 476 (1977) (medical opinion that is not based on a complete and accurate history is unpersuasive).

Consequently, on this record, we agree with the ALJ that claimant has failed to prove the compensability of his bilateral carpal tunnel syndrome by a preponderance of the evidence.

ORDER

The ALJ's order dated October 13, 1997 is affirmed.

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March 23, 1998 Cite as 50 Van Natta 470 (1998)

In the Matter of the Compensation of
**ANITA R. RIOS, Claimant**
Own Motion No. 97-0224M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE

Claimant requests review of the self-insured employer's January 29, 1998 Notice of Closure which closed her claim with an award of temporary disability compensation from May 13, 1997 through January 14, 1998. The employer declared claimant medically stationary as of January 14, 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 he/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 29, 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 employer has advised that it is withdrawing its January 29, 1998 Notice of Closure. The employer took this action relying on a February 2, 1998 chart note from Dr. Ballard, claimant's treating physician, wherein he opines that "as far as being medically stationary, meaning that she [claimant] is probably as good as she [claimant] will get without something further being done, that will probably occur in May. I would like to see her [claimant] back in May." Inasmuch as the employer has withdrawn its January 29, 1998 Notice of Closure, we do not find that claimant's compensable left knee condition was medically stationary on January 29, 1998, the date of claim closure.

Accordingly, we set aside the employer's January 29, 1998 Notice of Closure and direct it to resume payment of temporary disability compensation commencing on January 14, 1998. When appropriate, the claim shall be closed by the employer pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**ORVILLE L. BAUMGARDNER, Claimant**
WCB Case No. 95-12230
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Steven Maher, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Hoguet's order that declined to grant permanent total disability benefits. On review, the issue is permanent total disability.

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

ORS 656.206(1)(a) provides that a claimant is permanently totally disabled if he or she is permanently incapacitated from "regularly performing work at a gainful and suitable occupation." Claimant contends that he is entitled to permanent total disability (PTD) because he is physically disabled from working or, alternatively, because he satisfies the requirements of the "odd lot" doctrine.

We agree with the ALJ that claimant has not established that he is unable to work based solely on medical considerations. (See Exs. 192-2, 217; see also Ex. 206).

We also agree that claimant has not proven entitlement to PTD compensation under the "odd lot" doctrine. We offer the following supplementation on this issue.

Under the "odd lot" doctrine, a disabled person with some residual physical capacity may still be permanently and totally disabled 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). However, unless 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). Even if 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).

Here, even assuming that claimant has otherwise established that he is incapacitated from regularly working under the "odd lot" doctrine, we would nonetheless conclude that he has not proven entitlement to permanent total disability benefits because there is no persuasive evidence that he is "willing to work" within the meaning of ORS 656.206.

Claimant has had a long history of hard physical work as a carpenter. He has also had a long history of low back problems and three low back surgeries. He returned to carpentry work after each surgery. This history is evidence of claimant's work ethic and his desire to keep working, before his mid-1994 worsening. (See Ex. 163). However, after claimant's mid-1994 worsened back problems, Dr. Thomas recommended retirement and claimant eventually did retire without seeking work again. (Exs. 178, 181, 184, 192, 200, 202, 217).

Dr. Thomas believed that attempting to return to work would be an "effort in frustration" for claimant. (Ex. 183). Dr. Thomas stated that he was aware of no jobs which would accommodate claimant's physical restrictions and acknowledged that his opinions about claimant's employability were based on social and vocational factors as well as medical impairment. (Exs. 217, 238; see Exs. 192, 206).

There is no evidence that evaluation of employability on non-medical bases is within the scope of Dr. Thomas' expertise. Accordingly, in the absence of qualified supporting evidence, we find Dr. Thomas' conclusions regarding matters beyond his training and expertise (i.e., social and vocational factors affecting claimant's employability) to be unpersuasive. See Larry R. Ruecker, 45 Van Natta 933, 934 (1993) (opinion regarding vocational matters beyond physicians' expertise and therefore unpersuasive). Under these circumstances, we cannot say that it would be futile for claimant to seek work on this record. Finally, because the record does not establish that claimant made reasonable efforts to obtain employment or that he was "willing to work" within the meaning of ORS 656.206, we conclude that his claim for permanent total disability compensation must fail. See Barbara Johnson, 49 Van Natta 871, 873 (1997).

ORDER

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

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March 24, 1998 Cite as 50 Van Natta 472 (1998)

In the Matter of the Compensation of
**ROBIN L. CARRILLO, Claimant**
WCB Case Nos. 97-02524 & 97-00061
ORDER ON REVIEW
Malagon, et al, Claimant Attorneys
Zimmerman, et al, Defense Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that: (1) upheld the SAIF Corporation's denial of claimant's aggravation claim for a current low back condition; (2) upheld EBI Companies' denial of claimant's "new injury" or occupational disease claim for the same condition; and (3) declined to award interim compensation for periods before December 23, 1996. On review, the issues are compensability and, if the claim is compensable, responsibility, aggravation, and interim compensation. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the relevant facts.

Claimant performed heavy repetitive work activities for at least 14 years. He has had chronic low back problems since a July 30, 1991 work injury which SAIF accepted. He had L5-S1 surgery on September 21, 1991 and returned to his regular work on the green chain in February 1992.

Claimant's 1991 injury claim was closed with a total unscheduled permanent disability award of 32 percent for his low back and a 5 percent scheduled award for lost left foot sensation.

Claimant had ongoing low back problems. He treated conservatively on numerous occasions between 1991 and 1996. Most of these occasions involved work incidents.[1]

EBI, rather than SAIF, covered the employer beginning in 1994.

Claimant's low back problems continued. After a week of difficulties in September 1996, an MRI revealed not only the old L5-S1 laminectomy defect, but also a new left-sided L4-5 herniated disc.

Claimant was referred to Dr. Miller, neurosurgeon, who first examined claimant on October 4, 1996.

Claimant filed an aggravation claim with SAIF and a "new" injury or occupational disease claim with EBI. The claims were denied and claimant requested a hearing.

Compensability/Responsibility

The ALJ found that claimant failed to prove his aggravation claim with SAIF because Dr. Miller, treating physician, was unable to say that claimant's current problems arose from the accepted L5-S1 condition.

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[1] Claimant also experienced temporary low back problems associated with shoveling gravel and moving a piano off work. He treated conservatively and returned to his regular work in each case.

SAIF does not contest the compensability of the accepted L5-S1 condition; it merely denies that the L5-S1 condition has worsened. SAIF also argues that no evidence relates any L4-5 condition which claimant may have to his work during its coverage.

EBI contends that it should escape liability because SAIF has not denied the L5-S1 condition and no persuasive evidences indicates that claimant's current problems arise from his L4-5 disc.[2]

Claimant argues that his current problems represent a worsening of his accepted L5-S1 condition. We agree that claimant's current condition is compensably related to the condition accepted by SAIF,[3] noting that SAIF does not deny compensability.

Accordingly, because claimant's current condition involves SAIF's accepted condition, SAIF remains responsible unless claimant suffered a new injury during EBI's coverage. ORS 656.308(1). Because we find no persuasive evidence that claimant's current disability and need for treatment for his low back arises from work injury or exposure with EBI, we conclude that responsibility does not shift from SAIF.

Aggravation

Claimant argues that his accepted L5-S1 condition has worsened since the initial claim closure, based on lost lumbar range of motion and work restrictions. We disagree.

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." In SAIF v. Walker, 145 Or App 294 (1996), the court determined that the term "actual worsening" was not intended to include a symptomatic worsening. Rather, the court concluded that there must be medical evidence that the symptoms have increased to the point that it can be said that the compensable condition has worsened. SAIF v. Walker, 145 Or App 294; see Russell D. Parker, 49 Van Natta 83 (1997).

In this case, Dr. Miller suspected that claimant has additional ligamentous and annular disruptions at the L5-S1 level. (Ex. 40-2). However, none were demonstrated by MRI. Accordingly, based on Dr. Miller's opinion that "no significant changes occurred" at L5-S1, we conclude that claimant has not established an actual worsening of his compensable condition. (Id). Consequently, claimant's aggravation claim must fail. See ORS 656.273.

Interim Compensation

We adopt the ALJ's opinion and conclusions regarding this issue. Specifically, we agree that claimant has not established that SAIF received medical evidence supported by objective findings that the claimant has suffered a worsened condition attributable to the compensable injury before December 10, 1996, when SAIF concedes that all the elements necessary to trigger payments of interim compensation were in place. (See Exs. 27-37). Thus, because SAIF's denial issued on December 23, 1996 denial, less than 14 days after the claim was perfected, SAIF was not required to pay interim compensation under ORS 656.273(3) and (6). See Laura D. Girard, 49 Van Natta 1417 (1997).

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[2] EBI also argues that we should not address an L5-S1 claim against it because claimant indicated at hearing that no claim was asserted against EBI with respect to the L5-S1 condition. (See Tr. 2-3). We agree. (See claimant's Reply Brief, p.1).

[3] Dr. Miller, treating physician, opined that claimant's L5-S1 condition was the primary cause of his current problems, "[u]ntil proven otherwise." (Ex. 40-3). He stated:

> "Given the previous surgery at L5-S1, his previous [1991] work injury, and the type of work he does, I think it is actually more likely that he is having continued pain and problems due to the L5-S1 level rather than new pain from the L4-5 level." (Ex. 40-1).

See John J. Rice, on remand, 46 Van Natta 2528, 2529 (1994) (claim compensable where preexisting degenerative disease worsened by years of traumatic work exposure, an accepted low back strain, and multiple work injuries).

ORDER

The ALJ's order dated October 13, 1997 is affirmed.

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In the Matter of the Compensation of
**PATRICIA A. CLARKE, Claimant**
WCB Case No. C800354
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Brownstein, Rask,, et al, Claimant Attorneys
VavRosky, et al, Defense Attorneys

Reviewed by Biehl and Haynes.

On February 17, 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 CDA, as amended by the parties' addendum.

The CDA received on February 17, 1998, provided, in part:

> "Pursuant to ORS 656.236, in consideration of the release of employer's remaining third party lien in the amount of $11,113 (after partial payment of $7,000 to employer via third party settlement pursuant to ORS 656.576 et. seq.), [claimant] hereby releases her rights to the following workers' compensation benefits * * *."

On February 26, 1998, we wrote the parties requesting further information regarding the third party settlement. Specifically, we requested an addendum giving the amount of the settlement, the attorney fee and costs and claimant's share of the settlement. We requested this information to assist us in ascertaining the value of the consideration flowing to claimant under the CDA. See Kenneth Hoag, 43 Van Natta 991 (1991) (Board generally disapproves CDAs in which the consideration consists of the carrier's reduction of a third party 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).

On March 13, 1998, we received the parties' addendum containing the requested information regarding the settlement. The total amount of the third party settlement was $23,500 and the carrier's total lien was $18,113. The addendum recites that the consideration for the CDA is the carrier's waiver of $11,113 of its $18,113 lien; i.e., the carrier agrees to accept $7,000 out of the third party settlement in satisfaction of its lien. An attorney fee of $7,825.50 and costs of $425 would also be paid out of the $23,500 settlement. Claimant would receive a total of $8,249.50 from the settlement.

In accordance with the statutory scheme for the distribution of proceeds from a third party settlement, the consideration for the CDA (the carrier's partial waiver of its third party lien) would be less than that described in the CDA addendum. Our reasoning for that conclusion is as follows.

When the costs and attorney fees totaling $8,250.50 are deducted from the $23,500 settlement, as allowed by ORS 656.593(1)(a), the remaining balance is $15,674.50. From that amount, claimant's statutory 33 1/3 percent ($5,083.12) is deducted leaving a remaining balance of $10,166.38. See ORS 656.593(1)(b). It is from this remaining balance which the carrier can recover its lien. ORS 656.593(1)(c). The carrier's total lien is $18,113. Thus, the carrier would not be able to recover its total lien from the balance of the settlement. Instead, the carrier could only recover $10,166.38. The carrier has agreed to reduce its lien to $7,000. After deducting this $7,000 from the $10,166.38 remaining balance of the third party settlement proceeds, the remainder is $3,166.38. This amount will be paid to claimant in addition to the $5,083.12 she is otherwise entitled to under ORS 656.593(1)(b). ORS 656.593(1)(d).

Accordingly, we find that the actual value of the consideration for the CDA is the difference between the amount the carrier could have statutorily recovered from the third party settlement ($10,166.38) and the amount that it agreed to receive from the settlement ($7,000). Thus, we find that the actual consideration for the agreement is $3,166.38, rather than the $11,113 figure represented in the parties' addendum.

Notwithstanding this clarification, we do not find the proposed CDA to be unreasonable as a matter of law. Consequently, we find that the agreement, as amended by the addendum and clarified by this order, is in accordance with the terms and conditions prescribed by the Board. See ORS 656.236(1). Accordingly, the parties' claim disposition agreement 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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March 24, 1998 Cite as 50 Van Natta 475 (1998)

In the Matter of the Compensation of
**CAROLYN S. CROSS-PRINCE, Claimant**
WCB Case No. 96-10291
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Michael Johnson's order that: (1) found that a prior stipulation did not preclude the SAIF Corporation from denying claimant's current low back condition; and (2) upheld SAIF's denial of claimant's current low back condition. On review, the issues are whether the prior stipulation precludes the denial of claimant's current condition and, if the denial is not precluded, compensability. We affirm.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of the fifth paragraph on page 3 of the ALJ's order. We replace that paragraph with the following paragraph:

> "On November 16, 1995 an ALJ approved a stipulation and order in which the parties agreed that the January 10, 1995 denial of the October 18, 1994 injury claim would remain in full force and effect. In addition, SAIF agreed to pay the outstanding medical bills from the October 18, 1994 injury claim under the accepted March 22, 1993 claim. (Ex. 9A)."

We summarize the relevant findings of fact as follows. Claimant compensably injured her low back on March 22, 1993. SAIF accepted the claim as a nondisabling "low back muscle strain." Claimant was treated by Dr. Springer, a family practice physician. On October 18, 1994, claimant again hurt her back while at work. SAIF denied the October 18, 1994 claim on January 10, 1995.

In November 1995, the parties entered into a stipulation in which they agreed that the denial of the October 18, 1994 injury would remain in full force and effect. The stipulation also provided that SAIF would pay the outstanding medical bills that were currently in the October 18, 1994 claim under the accepted March 22, 1993 claim.

In March 1996, Dr. Springer referred claimant to orthopedist, Dr. Peterson, for consultation regarding claimant's back condition.

## CONCLUSIONS OF LAW AND OPINION

### Preliminary Matter

The ALJ identified the exhibits admitted into evidence as 1 through 16 and 9A. However, SAIF argues that Exhibits 3, 9, 11 and 12 were withdrawn at the commencement of the hearing. Claimant does not object to SAIF's assertion. The transcript of the hearing confirms that Exhibits 3, 9, 11 and 12 were withdrawn and that claimant's counsel raised no objection to the withdrawal of these exhibits. (Tr. 1- 5). We also note that both parties and the ALJ cite to Dr. Springer's deposition, Exhibit 17. The

deposition was apparently taken after the date of the hearing and was intended by the parties and the ALJ to be part of the record. Accordingly, we conclude that Exhibit 17 was admitted into the record. Under such circumstances, we find that Exhibits 1 and 2, 4 through 8, 10, 13 through 17 and 9A were admitted by the ALJ into the record.

Effect of the November 16, 1995 Stipulation and Order.

The ALJ found that the November 1995 stipulation did not bar SAIF from denying claimant's current condition. On review, claimant argues that, under the stipulation, SAIF agreed to process claimant's then-current low back condition as "part and parcel of her accepted March 1993 work injury." (App. Br. at 3). Claimant argues that the condition has not changed since the date of the stipulation and that SAIF is therefore barred from denying the current condition. SAIF argues that the November 1994 stipulation does not constitute a formal acceptance of claimant's 1994 condition as part of the 1993 claim. SAIF argues that it agreed in the stipulation and order only to pay outstanding medical bills which were in the October 1994 claim at the time of the stipulation. SAIF asserts that it did not agree to pay for ongoing or future treatment of claimant's condition and is not barred from denying the current condition.

The November 1995 stipulation provides, in pertinent part:

"The parties agree to settle all issue(s) raised or raisable at this time as follows:

"The hearing request in Claim No. 7208732A, WCB Case No. 95-01031, is hereby dismissed with prejudice. The January 10, 1995 Denial shall remain in full force and effect. SAIF Corporation will pay the outstanding medical bills that are currently in Claim No. 7208732A from Claim No. 7778991K."

Whether an acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449 (1992). In the stipulation, the parties agreed that SAIF would pay the outstanding medical bills which were currently in the denied October 1994 claim under the accepted March 22, 1993 claim. SAIF did not agree to formally accept claimant's then-current low back condition and did not agree to pay any medical bills other than those that were "currently" in the October 1994 claim file.

Pursuant to ORS 656.262(10), merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability. Based on the clear language of the stipulation, we find that SAIF agreed to pay the existing medical bills for the denied claim under the March 22, 1993 claim, but did not formally accept the 1994 back condition. Thus, we do not find that the stipulation barred SAIF from denying claimant's current low back condition. Accordingly, because SAIF's denial was not precluded by the stipulation, we turn to the merits of the compensability issue.

Compensability

Two physicians address the cause of claimant's current low back condition. Dr. Springer is a family practice physician who has treated claimant since the March 22, 1993 compensable injury. Dr. Peterson is a specialist in orthopedics to whom Dr. Springer referred claimant for consultation in 1996.

Dr. Peterson's assessment was that claimant's current symptoms were unrelated to the 1993 compensable injury. Dr. Peterson based his opinion on the fact that claimant indicated that her current symptoms did not develop until 1994 and that diagnostic studies demonstrated a lytic spondylolisthesis of L5 on S1 which was a congenital condition. Dr. Peterson also indicated that claimant's history included no specific event since the onset of her current symptoms, which would represent a significant aggravation of the underlying condition. In addition, Dr. Peterson stated that claimant's symptoms were consistent with her lytic spondylolysis of L5 and Grade 1 spondylolisthesis of L5-S1.

Dr. Springer concurred with Dr. Peterson's diagnoses, findings, tests, medically stationary date, work release and opinions. Dr. Springer also gave deposition testimony regarding his opinion. Dr. Springer indicated that claimant had a low back strain as a result of the March 22, 1993 injury and continues to have the same condition. Based on the fact that claimant still has a low back strain, Dr. Springer agreed that the 1993 injury appeared to be "a major cause" of claimant's current condition. Dr. Springer also indicated that he tended to defer to Dr. Peterson, an orthopedic specialist, regarding claimant's orthopedic condition.

Claimant argues that Dr. Peterson has an incorrect history in that he believes claimant's symptoms began in 1994, whereas claimant has had symptoms since the 1993 compensable injury. However, even if we found Dr. Peterson's opinion unpersuasive, we would find Dr. Springer's opinion insufficient to carry claimant's burden of proof. We reach this conclusion for the following reasons.

Dr. Springer deferred to Dr. Peterson's opinion as an orthopedic specialist that claimant had preexisting conditions in her spine which contributed to claimant's current condition. Dr. Springer acknowledged that those preexisting conditions were outside of his area of expertise as a family practice physician. Thus, we are not persuaded that Dr. Springer was able to evaluate the contribution from claimant's preexisting spinal conditions and weigh them against the contribution from the 1993 compensable injury to determine which cause was the major contributing cause of claimant's current condition. Under these circumstances, we do not find Dr. Springer's opinion persuasive. 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). Based on this record, claimant has not established compensability of her current condition.

ORDER

The ALJ's order dated October 3, 1997 is affirmed.

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March 24, 1998 Cite as 50 Van Natta 477 (1998)

In the Matter of the Compensation of
**KENNETH C. FELTON, Claimant**
Own Motion No. 96-0005M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
EBI Companies, Insurance Carrier

Claimant requested reconsideration of our December 9, 1997 Own Motion Order Reviewing Carrier Closure, in which we upheld the insurer's July 3, 1997 Notice of Closure. With his request for reconsideration, claimant indicated that he would be submitting additional medical records from Dr. Walker, the surgeon who had performed his right total knee arthroplasty.

On January 8, 1998, we abated our order to allow claimant to obtain the additional medical records from Dr. Walker and allow the insurer time to file a response to claimant's motion. Subsequently, claimant submitted a January 30, 1998 report from Dr. Walker. The insurer responded to claimant's motion for reconsideration and submitted copies of several chart notes from Dr. Walker, including a January 16, 1998 chart note that had not been submitted previously. Having received the parties' submissions and responses, we proceed with our review of the record. After further consideration, we replace our prior order with the following.

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. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12, (1980).

On July 25, 1973, claimant compensably injury his right knee and has subsequently undergone several knee surgeries. Claimant's aggravation rights regarding his right knee injury claim expired on December 31, 1979. By Own Motion Order dated January 31, 1996, as reconsidered on April 2, 1996, we authorized reopening claimant's claim to provide temporary disability compensation beginning December 19, 1995, the date claimant underwent arthroscopic debridement of the lateral compartment of his right knee. Subsequently, in December 1996, claimant underwent a right total knee arthroplasty, which was performed by Dr. Walker, treating orthopedist. At that time, claimant resided in Boise, Idaho. On January 7, 1997, Dr. Walker examined claimant regarding the right total knee arthroplasty.

Thereafter, claimant relocated to Arizona, where Dr. Russo, treating orthopedist, provided follow-up care regarding claimant's right knee condition. In a May 21, 1997 chart note, Dr. Russo noted that claimant complained of "continuing pain which, in [Dr. Russo's] opinion, is outside what appears to be objectively evident." Dr. Russo also noted that claimant's complaint of looseness with side-to-side movements represented "slight laxity of varus/valgus which, at this time, appears to be of no functional concern." Dr. Russo also stated that claimant was interested in having a larger spacer put in his right knee. However, Dr. Russo opined that this "is not indicated, since there is inadequate functional laxity to warrant such surgery." Instead, in Dr. Russo's opinion, claimant needed only "simple observation following the surgeries performed previously" and recommended that claimant return in six months for repeat standing x-rays regarding both knees.

On June 17, 1997, in response to the insurer's inquiries, Dr. Russo indicated that, as of May 21, 1997, claimant was medically stationary, meaning that "no further material improvement would reasonably be expected from medical treatment or the passage of time." On July 3, 1997, the insurer closed claimant's claim with a medically stationary date of May 21, 1997.

On July 30, 1997, claimant sought treatment from Dr. Little, M.D.; however, Dr. Little provided no opinion regarding claimant's medically stationary status at claim closure.

In an August 14, 1997 letter, Dr. Russo responded to a FAX sent by claimant. Dr. Russo noted that he had "encouraged [claimant] to improve the function of [his] knee, as the instability [claimant] describe[s] is related to persistent lack of strengthening, and there has been no objective evidence of [claimant's] voluntary participation in carrying out my recommendations." Dr. Russo also noted that he had "reassured [claimant] that the size of the spacer in [claimant's] knee is not contributing to any perceived instability and is not in need of revision." Finally, Dr. Russo requested that claimant find another physician for his continued orthopedic care.

Although continuing to reside in Arizona, claimant subsequently traveled to Boise, where he was examined by Dr. Walker on November 14, 1997. Dr. Walker noted that claimant had weakness of the right quadriceps and suggested that claimant work on a strengthening program, which he recommended be provided in the form of formal physical therapy. (Letter to insurer dated November 18, 1997). He provided claimant with prescriptions for physical therapy and a cane. Regarding the issue of whether claimant "is medically stationary from his last operation," Dr. Walker opined that claimant would not improve his range of motion; however, "his strength should improve and his functional ability should continue to improve if he is able to work on a quality strengthening program. (November 14, 1997 chart note). Nonetheless, Dr. Walker's November 1997 chart note and letter provide no opinion as to claimant's medically stationary status at claim closure.

However, claimant subsequently returned to Boise where he was examined by Dr. Walker on January 16, 1998. Dr. Walker noted that claimant's knee was "essentially unchanged" compared to his November 14, 1997 examination. (January 16, 1998 Chart Note). He again opined that physical therapy would improve claimant's right knee condition. Furthermore, we find that Dr. Walker's January 1998 opinion persuasively related claimant's need for physical therapy back to the time of claim closure. We make this finding based on the following.

In his November 1997 and January 1998 examinations, Dr. Walker found that claimant showed a significant amount of atrophy in the quadriceps muscle of the right leg which results in considerable weakness. Based on these findings, he opined that claimant's leg strength had never recovered since his total knee arthroplasty because claimant was not able to participate in a structured physical therapy program. (January 30, 1998 letter). Dr. Walker also explained:

> "[Claimant] was previously judged to have reached medical stability as of 5/21/97 by the opinion of Dr. Russo. I did not have the opportunity to examine [claimant] at that point in time and was only able to examine his knee in November 1997. However, at that time, he was quite weak and it is my estimation that this weakness had persisted from the time of his operation because of his inability to participate in a physical therapy program, the circumstances of which I am not completely sure. I do, however, believe that [claimant's] medical condition could be improved though further strengthening of his leg through a physical therapy program." (Id.).

Considering these circumstances, Dr. Walker further concluded that "[claimant] is currently not medically stable following his total knee arthroplasty and I do not believe he has ever been medically stable since his operation." (Id.).

Both Drs. Walker and Russo served as claimant's treating orthopedists. Although Dr. Russo was claimant's treating physician at claim closure, Dr. Walker provides the more thorough examinations and reasoning in explaining why claimant has not yet become medically stationary. Furthermore, Dr. Walker performed claimant's right total knee arthroplasty, which places him in a good position to judge claimant's recovery. Therefore, based on Dr. Walker's January 1998 opinions, we find that claimant has met his burden of proving he was not medically stationary at claim closure.

Accordingly, we set aside the insurer's July 3, 1997 Notice of Closure as premature. The insurer is ordered to recommence the payment of temporary disability compensation in this claim, beginning the date the insurer previously terminated these benefits. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

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March 24, 1998 Cite as 50 Van Natta 479 (1998)

In the Matter of the Compensation of
**DONALD J. FENDRICH, Claimant**
WCB Case No. 96-11512
ORDER ON REVIEW
Black, Chapman, Webber & Stevens, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Baker's order that upheld the insurer's denial of claimant's current low back and cervical condition. On review, the issue is compensability.

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

The ALJ found that the medical opinions relied on by claimant were not persuasive because they were conclusory, were rendered without a demonstrated awareness of all the material facts and without a showing of a weighing of the relative contributions of the industrial and non-industrial factors. We agree that claimant has not sustained his burden to prove that his current condition is compensable.

On Board review, claimant relies on the medical opinions of Dr. Bert and Dr. Neiling to establish the compensability of his current condition.

Dr. Bert conceded at his deposition that he lacked a history of the mechanism of the 1985 injury, but noted that claimant feels that it involved an injury or series of injuries to his neck. (Ex. 83-5). Dr. Bert further indicated that there have been no changes in claimant's compensable C4-5 disc condition or in the levels above and below C4-5. (Ex. 83-4,5). Dr. Bert acknowledged that claimant's somatic over-focus makes it difficult to identify the source of claimant's complaints. Based on his medical opinions in the record, Dr. Bert has not distinguished between the contribution from claimant's noncompensable conditions and his compensable conditions to determine the major contributing cause of claimant's current condition.

Although Dr. Bert has opined that the 1985 injury and surgical treatment are the major cause of claimant's present condition, he has not explained what claimant's current condition is or how it continues to be causally related to the 1985 compensable injury. Given the complex nature of claimant's claim, including the multiple denied conditions, the passage of time since the 1985 compensable injury and claimant's somatic over-focus, we find Dr. Bert's causation opinion to be lacking in explanation and analysis. See Moe v. Ceiling Systems, Inc., 44 Or App 429 (1980). Under such circumstances, we find Dr. Bert's opinion to be unpersuasive.

Dr. Neiling examined claimant apparently for the purpose of determining the contribution to his current condition of an October 1996 noncompensable motor vehicle accident and a June 17, 1996 injury. Dr. Neiling diagnosed chronic cervical and lumbar strains. Dr. Neiling indicated that claimant's motor vehicle accident in October 1996 was not the cause of any permanent injury. In Dr. Neiling's view, claimant sustained a strain to the soft tissues which would resolve. Dr. Neiling opined that the chronicity of claimant's symptoms would relate, with reasonable medical probability, to his previous industrial injuries and the residuals of those injuries.

To the extent that Dr. Neiling's opinion can be said to support a causal relationship between claimant's current condition and the 1985 compensable injury, we find it unpersuasive. In this regard, Dr. Neiling's report indicates that the doctor had no medical records earlier than the early 1990's. Based on his report, Dr. Neiling was only able to obtain minimal details regarding the 1985 industrial injury. Under such circumstances, we find Dr. Neiling's opinion to be based on inadequate information regarding the 1985 injury. Furthermore, in rendering his opinion, Dr. Neiling did not differentiate between or discuss the contribution from claimant's noncompensable conditions. See Dietz v. Ramuda, 130 Or App 397 (1994) (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). Under such circumstances, we find Dr. Neiling's report to be conclusory and based on insufficient information.

Dr. Bufton has offered an opinion regarding the relationship of claimant's current condition to the accepted C4-5 condition. Dr. Bufton could not reach a firm neurologic diagnosis because of claimant's diffuse pain complaints and his "non-anatomic exam." However, Dr. Bufton did not think that the current complaints of diffuse pain were specifically related to the accepted C4-5 condition.

Based on this record, we find no persuasive medical evidence which relates claimant's current condition to the 1985 industrial injury. Under such circumstances, we affirm the ALJ's order.

ORDER

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

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March 24, 1998 Cite as 50 Van Natta 480 (1998)

In the Matter of the Compensation of
**DONALD L. HALVORSEN, JR., Claimant**
WCB Case No. 97-02909
ORDER ON RECONSIDERATION
Pozzi, Wilson, et al, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

The self-insured employer requests reconsideration of our February 24, 1998 Order on Review that reversed the Administrative Law Judge's determination that its request for reconsideration of a November 5, 1996 Determination Order was timely. Contending that our order improperly placed the burden of proving a timely reconsideration request on the employer and that we relied on an inaccurate factual finding, the employer asserts that we should have found that its request for reconsideration was timely. For the following reasons, we do not find the employer's arguments persuasive.

First, we disagree with the employer's reading of our order. We did not place the burden of proof on the employer. Rather, we determined that, based on our review of the record, the employer's reconsideration request was not timely. In other words, regardless of which party had the burden of proof, we would reach the same conclusion.

Second, we reject the employer's contention that our order rested on a factual error. We stated that, while the reconsideration request was dated January 3, 1997 (which would have been timely), the record did not establish when the request was mailed. Inasmuch as the reconsideration order stated that the employer requested reconsideration on January 7, 1997 (which was more than 60 days after the November 5, 1996 Determination Order), we were not persuaded that the filing of the employer's reconsideration request was timely.

Citing Madewell v. Salvation Army, 49 Or App 713 (1980) (presumption that a writing is truly dated), the employer asserts that the Madewell presumption should work in its favor because the reconsideration request stated that its "mailing date" was January 3, 1997. However, Madewell holds that there is no presumption that a letter is mailed on the date that it is dated. 49 Or App at 716. Thus, we decline to presume that the reconsideration request was in fact mailed on the "mailing date" listed on the document, particularly in light of the express statement in the reconsideration order that reconsideration was not requested until January 7, 1997. Consequently, we continue to find that the record does not establish a timely reconsideration request.

Accordingly, we withdraw our February 24, 1998 order. On reconsideration, as supplemented herein, we adhere to and republish our order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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March 24, 1998 Cite as 50 Van Natta 481 (1998)

In the Matter of the Compensation of
**MYLO L. LUPOLI, Claimant**
WCB Case No. 97-04471
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock, and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order that upheld the insurer's denial of his aggravation claim for a low back condition. On review, the issue is aggravation.

We adopt and affirm the ALJ's order.

ORDER

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

**Board Member Biehl dissenting.**

In adopting and affirming the ALJ's order, the majority concludes that claimant's current low back condition was not caused in major part by the compensable low back condition or by his work activities. The ALJ and the majority find that claimant's current condition resulted in major part from his July 1994 motor vehicle accident along with possible contributions from a preexisting non-compensable degenerative low back condition. Because I believe that claimant's work activities for the employer were the major contributing cause of his current low back condition, including a herniated disc at L5-S1, I respectfully dissent.

Claimant began working as a roofer around the beginning of 1990. He had no back problems before working for the employer. In December 1992, he began experiencing persistent low back pain with intermittent left leg symptoms and occasional right leg symptoms. On February 14, 1994, the claim was accepted as a disabling lumbosacral strain. (Ex. 14). A Determination Order awarded 22 percent unscheduled permanent disability, which included 5 percent impairment for a chronic low back condition. (Ex. 33).

In December 1996, claimant sought to reopen his claim because of severe back pain. (Ex. 54). An MRI on December 5, 1996 showed a ventral left disk herniation at L5-S1 and a ventral right annulus bulge at L4-5. (Ex. 55). Dr. Brett performed a left L5-S1 diskectomy on June 17, 1997. (Ex. 71D).

Dr. Brett's opinion on causation is persuasive because it is well-reasoned and based on complete information. See Somers v. SAIF, 77 Or App 259 (1986). He opined that claimant's work activities as a roofer, not the July 1994 motor vehicle accident, were the major contributing cause of his current low back condition. Dr. Brett first examined claimant on March 14, 1997 and reported that claimant had a sequestered disc herniation on the left at L5-S1 with left SI radiculopathy. (Ex. 60). He referred to a previous lumbar CT scan from December 1993, which showed "some calcification in an annular area of

injury on the left at L5-S1, with some superimposed disc herniation and lateral recess compromise on the left at L5-S1 as well as diffuse annular bulging at L4-5." (Ex. 61-1). Dr. Brett noted that subsequent magnetic imaging showed similar findings, but more clear-cut sequestration of disc material. (Id.) Dr. Brett believed that claimant's work as a roofer, with many years of heavy and repetitive lumbar exertion and twisting, was the major contributing cause of development of the disc pathology at L5-S1. (Ex. 60-1, 61-2).

Based on claimant's history, his examination of claimant and his review of medical records, Dr. Brett found "no significant new symptomatology precipitated by [claimant's] motor vehicle accident of July 18, 1994 with regard to his nerve root impingement" and he did not believe the July 1994 accident contributed in any meaningful way to claimant's current condition. (Exs. 65, 67). Dr. Brett explained that claimant had continued to have intermittent left leg radicular pain since March 1993, with known disc pathology on the left at L5-S1, as documented on CT imaging. (Ex. 67). He concluded that, based on claimant's history and the previous lumbar imaging, claimant's 1993 work "injury" remained the major contributing factor in his current condition. (Id.)

Based on Dr. Brett's opinion, I believe that claimant's work activities for the employer were the major contributing cause of his current low back condition, including a herniated disc at L5-S1. See ORS 656.802(2)(a). As the treating surgeon, he was in the unique position to observe claimant's low back pathology during surgery. For that reason, I defer to his opinion regarding the nature and causation of claimant's current low back condition. See Argonaut Insurance Company v. Mageske, 93 Or App 698, 702 (1988). Moreover, to the extent that the claim is based on a worsening of a preexisting disease or condition, I believe that claimant has established that his employment conditions were the major contributing cause of the combined condition and pathological worsening of the preexisting disease. See ORS 656.802(2)(b).

In contrast, the majority and the ALJ erroneously rely on Dr. Gray's opinion. His opinion on causation is not persuasive because it is inconsistent with his own medical records and he did not have an accurate history of claimant's leg symptoms before the July 1994 motor vehicle accident.

Dr. Gray's testimony that claimant's current condition was caused in major part by the July 1994 motor vehicle accident is not persuasive, because his own medical records from treating claimant for that injury are inconsistent with his conclusion. During Dr. Gray's treatment of claimant for the motor vehicle accident, his chart notes focused on a large hematoma over the L5 region, as well as a questionable fracture at L5 that he later ruled out. (Exs. 25, 29, 31, 38, 40, 43A, 45, 73-9, -10). Although the October 28, 1994 chart note referred to paresthesias in the right leg and right toes that was not especially painful (Ex. 40), Dr. Gray's chart notes following the July 1994 accident do not mention left leg symptoms or a possible disk herniation. By August 8, 1994, the hematoma was 50 percent resolved. (Ex. 29). On August 17, 1994, Dr. Gray said that the hematoma seemed to cause most of the pain. (Ex. 31-1). On the same date, claimant was able to return to light duty, although he did not have a job at that time. By September 1994, Dr. Gray was recommending that claimant look for work. (Ex. 38). The hematoma had resolved by January 1995. (Ex. 45). On February 17, 1995, Dr. Gray reported to claimant's previous attorney that, other than an occasional ache or pain, he did not expect any permanent sequelae from the injury. (Ex. 45A).

Although Dr. Gray did not anticipate any permanent impairment from the July 1994 motor vehicle accident, he subsequently testified that the accident was the major contributing cause of the L5-S1 herniation. Because Dr. Gray did not explain his inconsistent opinions, his conclusion regarding causation of claimant's current condition is not persuasive.

Furthermore, Dr. Gray did not have an accurate history of claimant's leg symptoms prior to the motor vehicle accident. On July 1, 1997, Dr. Gray opined that, if claimant had a lumbar disk herniation when he first examined him in March 1994, he would have expected primarily left-sided symptoms, rather than bilateral symptoms. (Ex. 72). Dr. Gray relied on claimant's March 1994 pain diagram that showed pain down both legs. (Ex. 15A-3). In a deposition, however, Dr. Gray said that he had only recently reviewed previous medical records that indicated claimant had left-sided sciatica. (Ex. 73-9). The medical records before the July 1994 accident indicated that claimant had primarily left-sided symptoms before and after the accident. A January 1993 chart note referred to "occasional tingling sensation at the back of left knee, thigh at times." (Ex. C). A report on December 1, 1993 said claimant had "radiation and numbness to his left calf for the past two weeks[.]" (Ex. 1B). A CT scan on the same date indicated that the reason for the scan was low back pain and "decreased strength on the left side." (Ex. 3). Physical therapy notes referred to episodes of pain down the left leg to the calf, as well

as pain down the right posterior thigh. (Ex. 7). Chart notes beginning December 20, 1993 referred to left radicular symptoms. (Exs. 10A, 10B, 10C, 10D). A December 27, 1993 report indicated claimant had returned to full duty work and had a flare-up of pain on the left side of the low back. (Ex. 10F). On December 29, 1993, Dr. Corrigan referred to claimant's "intermittent radiation of pain into the posterolateral left calf." (Ex. 11).

Based on the medical records before the July 1994 motor vehicle accident, it is clear that claimant had primarily left-sided symptoms, rather than bilateral symptoms. Although Dr. Gray relied on claimant's March 1994 pain diagram in concluding that claimant had primarily bilateral symptoms, he did not review the previous medical records until shortly before the August 1997 deposition. (Ex. 73-9). In light of Dr. Gray's opinion that if claimant had a lumbar disk herniation in March 1994, he would expect primarily left-sided symptoms, his July 1, 1997 report actually supports claimant's position that he had a lumbar disk herniation in March 1994, before the motor vehicle accident. (Ex. 72).

Finally, although Dr. Gray agreed with Dr. Corrigan's December 1993 report that the CT scan showed a degenerative bulge, rather than a true herniation (Exs. 73-12, 11-3), I am more persuaded by Dr. Brett's conclusion that the December 1993 lumbar CT scan showed "some calcification in an annular area of injury on the left at L5-S1, with some superimposed disc herniation and lateral recess compromise on the left at L5-S1 as well as diffuse annular bulging at L4-5." (Ex. 61-1). When Dr. Brett performed the left L5-S1 lumbar diskectomy, he reported that there "some adherence of the S1 nerve root to the underlying focal disk protrusion with careful neurolysis performed and this was in keeping with [claimant's] long-standing symptoms since his work injury of 03/01/93." (Ex. 71D-1).

In conclusion, I would find that claimant established compensability of his current low back condition. Accordingly, I would reverse the ALJ's order and set aside the insurer's denial.

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March 24, 1998 Cite as 50 Van Natta 483 (1998)

In the Matter of the Compensation of
**ALAN L. OLSON, Claimant**
WCB Case Nos. 97-07697 & 96-06515
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Snarkis, et al, Defense Attorneys
Judy C. Lucas (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: (1) set aside its denial of claimant's "new injury" claim for a low back condition; and (2) upheld Industrial Indemnity Insurance's denial of claimant's aggravation claim for the same condition. Claimant cross-requests review of that portion of the ALJ's order that upheld SAIF's denial of claimant's injury claim for a cervical condition. On review, the issues are compensability and responsibility. We affirm.

## FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" with the exception of the finding on page three that "[o]n October 18, 1990, claimant experienced the sudden onset of neck pain while driving a truck for Gordon Trucking." We, instead, find that claimant felt his neck snap when he ran over a dip in the highway on that date, but he did not experience any neck pain until the following day.

## CONCLUSIONS OF LAW AND OPINION

We adopt the and affirm the ALJ's order as supplemented and modified below.

Low Back Condition.

On review, SAIF challenges the ALJ's ruling that it is responsible for claimant's current low back condition based on a finding that his September 1996 work injury with SAIF's insured is the sole cause of that condition. In reaching this decision, the ALJ relied on the opinion of the treating physician, Dr.

Winans, that: the September 1996 SAIF injury occurred "in the face of pre-existing degenerative change but without combining or intertwining with those changes"; the September 1996 SAIF injury is the major contributing cause of claimant's current low back treatment and disability; claimant's present need for low back treatment "is based on soft tissue injury" resulting from the September 1996 injury; and the preexisting degenerative changes in claimant's lumbar spine were not significant enough to play a major role in claimant's discomfort and need for treatment.

We agree with the ALJ's deference to Dr. Winans for the reasons explained by the ALJ. We recognize that Dr. Winans initially concurred with the contrary opinion of SAIF's examiner, Dr. Tsai, neurosurgeon, who opined that the preexisting degenerative changes in claimant's lumbar spine are the major contributing cause of his current low back treatment. Nevertheless, we conclude that the change in Dr. Winans' opinion is logically explained by the more complete history he obtained from claimant on May 8, 1997. In addition, we note that the record does not establish that the contrary opinion of Dr. Tsai is based on an accurate history of claimant's driving activity for SAIF's insured in September 1996.

Thus, we conclude that responsibility for claimant's current low back condition still rests with SAIF because Dr. Winans' persuasive opinion establishes that the September 1996 SAIF injury is at least the major contributing cause of the current low back treatment and disability. See ORS 656.308(1).

Accordingly, claimant's attorney is entitled to an attorney fee for services on review regarding his low back claim. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the low back claim is $1,500, 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.

Cervical Condition.

On review, claimant challenges the ALJ's ruling that claimant has not established a compensable claim with SAIF for a March 12, 1996 cervical injury. Claimant contends that the ALJ erred in rejecting the opinion of Dr. Winans that the March 1996 SAIF injury was the major contributing cause of claimant's current cervical treatment. Claimant also relies on the opinion of Dr. White, neurosurgeon, who examined claimant for SAIF. Dr. White opined that the March 1996 SAIF injury resulted in a strain that combined with claimant's preexisting degenerative changes, that the work injury was the major cause of the need for treatment for approximately three months, and that the preexisting degenerative changes were the major cause thereafter.

The ALJ declined to defer to Dr. White based, in part, on a finding that he did not have an opportunity to review an August 1996 MRI. We instead conclude that Dr. White did review that MRI. Nevertheless, the fact that Dr. White did not review a follow-up CT scan in September 1996 is, itself, a persuasive basis for discounting his opinion. In addition, we give less weight to Dr. White's opinion because he neither reviewed nor addressed the contrary position of Dr. Tsai that the preexisting degenerative changes were the major contributing cause of claimant's current need for cervical treatment.

We also agree with the ALJ's conclusion that Dr. Winans' opinion is not persuasive because it is based on an inaccurate history of the "sudden onset" of claimant's cervical symptoms. In addition, we are persuaded by SAIF's argument on review that Dr. Winans' opinion does not satisfy the requirements discussed in Dietz v. Ramuda, 130 Or App 397, 401 (1994), rev den 321 Or 416 (1995). In particular, Dr. Winans' analysis does not explain why the March 1996 SAIF injury is the primary cause of claimant's cervical treatment and disability, as distinct from the precipitating cause. In addition, Dr. Winans' opinion does not address the relative contribution of the preexisting degenerative changes demonstrated on claimant's August 1996 MRI and September 1996 CT scan.

## ORDER

The ALJ's order dated October 10, 1997 is affirmed. For services on review regarding claimant's low back claim, his counsel is awarded a $1,500 assessed attorney fee, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
**JOHN H. ANDREWS, Claimant**
WCB Case No. 97-02299
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes, Bock and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Crumme's order that assessed a penalty for an allegedly unreasonable denial. On review, the issue is penalties. We reverse.

## FINDINGS OF FACT

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

## CONCLUSIONS OF LAW AND OPINION

The ALJ decided that claimant proved compensability of a low back strain condition and, after finding that SAIF's denial was unreasonable, assessed a penalty. SAIF challenges only that portion of the order concerning the penalty, contending that it had a legitimate doubt concerning its liability and, thus, a penalty is not warranted.

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.

As the ALJ found, after working on November 19, 1996, claimant went home feeling no symptoms. After laying on a couch for an hour or two, claimant's back felt stiff and sore. When claimant attempted to lift his young son, he felt sharp pain and spasming in his back.

At hearing, claimant testified that he telephoned the employer on the morning of November 20, 1996, and left a message saying that he was not coming to work because he was not "feeling well." (Tr. 18). On the evening of November 24, 1996, claimant called his supervisor, Larry Gilbertson. According to claimant, he told Mr. Gilbertson "what the problem was," and Mr. Gilbertson told him that, if he was claiming a work injury, claimant needed to file a Form 801. (Id. at 20). Claimant responded that he wanted to see a doctor before filing a claim. (Id.) Claimant also stated that, during this conversation, Mr. Gilbertson asked claimant if he had hurt his back at work "and I said yes, it had to have been at work because I hadn't done anything else to -- that would make it hurt." (Id. at 38).

Mr. Gilbertson also testified about the November 24, 1996 telephone conversation. Specifically, Mr. Gilbertson stated that claimant told him that "his back was bothering him and he was going to see the doctor and I told him to come by the job and pick up a -- an accident form before going to the doctor." (Id. at 49). Mr. Gilbertson further testified that claimant told him his back began hurting when he got up from the couch at home "but he didn't say specifically that it was at work. He indicated it might have been at work." (Id. at 49, 53, emphasis added).

Claimant saw a physician the next day, on November 25, 1996. On the Notice of Claim form, in the "Worker's Statement of Cause" portion, claimant wrote: "Don't know exactly[.] I just know when I got home After work my back started Hurting really bad." (Ex. 2). The doctor's chartnote diagnosed "Left SI joint strain post on-the-job injury 6 days ago." (Ex. 3).

On December 4, 1996, claimant filed the 801 form. In box 17 ("Describe accident fully"), claimant wrote:

> "I went to work as normal[.] [W]e were sheeting a post & beam with 1 1/8 plywood. I was packing it to where it had to go[.] It was windy & rainy. I felt fine when I went home But later that night I was laying on the couch it started hurting." (Ex. 4).

The next chartnote from claimant's doctor diagnosed "lumbar strain, OJI 11-19-96." (Ex. 7).

On January 20, 1997, SAIF issued its denial, stating that "there is insufficient evidence" that claimant's injury was caused by work. (Ex. 10).

On this record, we find that SAIF had a legitimate doubt as to its liability when it issued its January 20, 1997 denial. As of that date, during the conversation with Mr. Gilbertson and on the Notice of Claim form and 801 form, claimant indicated only that his back began hurting after work and that he was unsure as to the cause of his condition. Such information would raise only a possibility that claimant sustained a work injury. Although claimant's physician referred to an "OJI" (on the job injury), absent from his chartnotes is a history of claimant's condition; instead, the only information available to the doctor apparent from the record is the "Notice of Claim" form where claimant wrote only that he "didn't know" how he was injured and that onset of symptoms was after he worked.[1] Thus, the chartnotes, by themselves, provide an insufficient basis for the physician's reference to "OJI," such as the particular kind and duration of claimant's work duties. Under these circumstances, we find that a mere reference to "OJI," in the context of claimant's indications that his condition could be due to an off-work incident, is not enough to destroy legitimate doubt.

We also disagree with the dissent that the April 7, 1997 report caused the continuation of the denial to be unreasonable. As we discussed in Marilyn A. Hodges, 50 Van Natta 234 (1998), corrected 50 Or App 245 (1998), a medical opinion supporting compensability generated after a denial does not necessarily destroy all legitimate doubt when assessment of the persuasiveness of the opinion will be at issue at the hearing. In the face of claimant's delay in filing an injury report and his vague and uncertain information concerning the occurrence of an injury, SAIF was not unreasonable in questioning the history contained in the report. Consequently, because SAIF had grounds for challenging the reliability of the report, the continuation of its denial was not unreasonable.

In short, we conclude that SAIF had a legitimate doubt as to its liability at the time of the denial. We further conclude that subsequent evidence did not destroy all legitimate doubt. Consequently, we conclude that SAIF's denial was not unreasonable and no penalty is warranted.

## ORDER

The ALJ's order dated July 11, 1997 is reversed in part and affirmed in part. That portion of the ALJ's order assessing a penalty is reversed. The remainder of the order is affirmed.

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[1] On April 7, 1997, claimant's doctor wrote to claimant's attorney that claimant related a history of repetitively carrying plywood at work on November 20, 1996 in windy and rainy weather. (Ex. 13). Although this report tends to show that claimant related a specific history to his physician, because the report was generated after SAIF's denial, we do not find it relevant to determining whether SAIF had a legitimate doubt at the time of the denial. See Brown, 93 Or App at 591.

**Board Member Biehl dissenting.**

I disagree with the majority that SAIF had a "legitimate doubt" of its liability at the time it issued its denial. As the majority explains, claimant expressed uncertainty concerning the cause of his low back condition when he spoke to Mr. Gilbertson and when filling out the "Notice of Claim" and 801 Forms. Claimant's physician, however, did not share claimant's uncertainty; he unambiguously stated that claimant's condition was a "post on-the-job injury" and "OJI." The record developed up to the date of the denial shows that claimant's doctor had available to him the information contained on the "Notice of Claim" form. That is, claimant's physician knew what claimant had told his employer and what he testified at hearing--that claimant worked and then went home and developed low back symptoms. For this reason, I disagree with the majority that claimant's doctor "merely referred" to an "OJI"; the doctor knew enough about the circumstances of claimant's injury that his statement of "post on-the-job injury" should be taken at face value. Thus, because the record shows that claimant sustained a work injury at the time SAIF issued its denial, it lacked legitimate doubt as to its liability.

Furthermore, even if I agreed that SAIF had a legitimate doubt when it issued its denial, the April 7, 1997 report from claimant's physician destroyed any legitimate doubt. See Brown, 93 Or App at 592 (after a carrier reasonably denies a claim, continuation of that denial in the light of new medical evidence becomes unreasonable if the new evidence destroys any legitimate doubt about liability). In this report, the doctor states that claimant related a history of repetitive work on November 20, 1996

and, after work, he had the onset of low back pain; the report also states that claimant's condition was a "direct result of the work activities[.]" (Ex. 13).

Unlike Marilyn A. Hodges, to which the majority cites, there is no contrary medical evidence which would undermine this report. Instead, the report is entirely consistent with the information provided by claimant concerning the circumstances of his injury. The record also contains no indication that claimant's history was suspect; claimant consistently reported the history of his condition and there is no evidence that claimant sustained an off-work injury. In other words, there is no evidence, and SAIF does not allege, that claimant is not credible.

What this case really holds is that a carrier may continue to deny a claim, even though the entire record supports compensability, on the chance that claimant will testify differently at hearing, thereby providing a basis for discounting the medical evidence. In my opinion, that possibility does not equate with legitimate doubt.

Because I believe SAIF lacked a legitimate doubt as to its liability, whether at the time it issued its denial or after receipt of the April 7, 1997 report, I would affirm the ALJ's imposition of a penalty.

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March 25, 1998 Cite as 50 Van Natta 487 (1998)

In the Matter of the Compensation of
**JANICE D. BUSH, Claimant**
WCB Case No. 97-02445
ORDER ON REVIEW
Rasmussen, Tyler, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Bock and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that upheld the SAIF Corporation's denial of her consequential condition claim for a left arm 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 left lateral epicondylitis condition, which allegedly resulted from "overuse" of the left arm as a consequence of claimant's compensable right arm injury. The ALJ determined that, even assuming that claimant developed her left arm condition because of restricted use of the right arm, such condition did not flow "directly and inexorably" from the compensable injury and, thus, that her left lateral epicondylitis was not a compensable consequential condition under ORS 656.005(7)(a)(A).[1]

On review, claimant contends that her left arm epicondylitis should be found compensable as a consequential condition resulting from her compensable right arm condition. Claimant asserts that she has met her burden of proving that her compensable right arm condition was the major contributing cause of her left arm condition. We agree.

In 1994, claimant developed right arm and shoulder symptoms as a result of her employment as a grocery checker. She filed a workers' compensation claim, which SAIF accepted for right lateral epicondylitis and right shoulder tendonitis. Claimant received 12 percent scheduled permanent disability for loss of use or function of the right arm and 17 percent unscheduled permanent disability for her right shoulder.

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

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

After the initial claim closure in October 1994, claimant entered a vocational training program in January 1995 in office procedures and accounting. This involved the use of a single-handed, left-handed keyboard, called a "Maltron" keyboard. After she began to operate the Maltron device, claimant began to develop left arm symptoms. The vocational program ended in October 1996. Claimant used the Maltron device at home between October 1996 and January 1997, where she typed resumes and letters for about four hours a day.

Claimant returned to her treating physician, Dr. Lorish, in January 1997 for treatment of her left arm symptoms. Dr. Lorish diagnosed mild left lateral epicondylitis, noting claimant's report that she was not using her right arm, but rather her left arm to perform keyboard, computer and "mouse" work. (Ex. 4). Dr. Lorish opined that claimant's left-sided problems were caused at least in part by increased repetitive forces due to not using her right side. Id.[2]

After an examining physician, Dr. Button, opined that claimant had no objective diagnosis relative to either upper extremity, SAIF denied the compensability of the diagnosed left lateral epicondylitis condition on March 17, 1997. Claimant requested a hearing.

If a condition arises directly, even if belatedly, from a work incident, then the material contributing cause standard applies to establish compensability. Albany General Hospital v. Gasperino, 113 Or App 411 (1992). If a condition is not directly related to the work incident, but is a consequence of the injury that had necessitated vocational rehabilitation, then the condition would be compensable if the injury is the major contributing cause of the consequential condition. See id.; Kephart v. Green River Lumber, 118 Or App 76 (1993), rev den 317 Or 272 (1993) (upholding the denial of compensation for a shoulder injury the claimant suffered when he fell from a truck in the course of vocational rehabilitation for a compensable hand injury because the fall from the truck was the major contributing cause of shoulder injury).

In this case, claimant began experiencing left arm symptoms during a vocational rehabilitation program. However, unlike Kephart, where the claimant's injury did not occur as a direct result of a physical problem connected with a compensable injury, we find that Dr. Lorish's opinion establishes that claimant's condition here was the result of overuse due to compensating for the compensable right arm and shoulder conditions.[3] Thus, while claimant's left arm condition developed during a vocational rehabilitation program, we find that the compensable injury is the major contributing cause of claimant's consequential left arm condition. See Linda D. Lunow, 46 Van Natta 1120, 1121 (1994) (low back condition compensable when condition developed as a result of an altered gait due to compensable knee injury).

SAIF argues, however, that Gaylynn Grant, 48 Van Natta 141 (1996), is controlling. In Grant, the claimant sustained multiple compensable injuries. She subsequently entered a vocational rehabilitation program where she developed left hand numbness and pain while performing typing and computer work. The attending physician opined that the claimant's ulnar nerve condition was a result of the training program, not the compensable injury. Relying on the attending physician's opinion, we found that the ulnar nerve condition was not compensable. 48 Van Natta at 142.

SAIF's contentions notwithstanding, we do not find Grant controlling. While claimant developed a left arm condition during a vocational training program, the persuasive medical evidence from Dr. Lorish establishes that the original compensable injury, not the vocational program, was the major contributing factor in the development of the epicondylitis condition. Unlike Grant, where there was no connection between the original compensable physical condition and the subsequently developed condition, apart from the fact that the compensable injury necessitated the vocational program during

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[2] Dr. Lorish later agreed that claimant's compensable right arm condition and resulting overuse of her left arm were the major contributing cause of the left lateral epicondylitis. (Ex. 10-2).

[3] In evaluating medical opinions, we rely on those that are both well-reasoned and based on an accurate and complete history. Somers v. SAIF, 77 Or App 259, 263 (1986). Absent persuasive reasons to the contrary, we generally defer to the opinion of the treating physician. See Weiland v. SAIF, 64 Or App 810 (1983). Here, we find no reason not to defer to Dr. Lorish's opinion regarding the cause of claimant's epicondylitis.

which the disputed condition developed, there is a direct connection between the compensable injury and claimant's epicondylitis in this case (the left lateral epicondylitis developed as a result of restricted use of the right arm). Under these circumstances, we conclude that claimant established a compensable consequential condition pursuant to ORS 656.005(7)(a)(A).[4]

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review 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 August 29, 1997 is reversed. SAIF's March 17, 1997 denial is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $3,500, to be paid by SAIF.

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[4] SAIF also contends that the use of the "Maltron" keyboard alone is the cause of the epicondylitis condition. SAIF cites claimant's testimony that she believed that use of the Maltron device caused the left arm problems. (Tr. 20). However, causation of the left arm condition is a complex question of medical causation. See Uris v. Compensation Dept., 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986). Therefore, we rely on the expert medical evidence from Dr. Lorish. Claimant's testimony, while probative, is not determinative of the causation issue. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980).

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March 25, 1998 Cite as 50 Van Natta 489 (1998)

In the Matter of the Compensation of
**MARTIN CAM, Claimant**
WCB Case No. 96-01462
ORDER ON REVIEW
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Garaventa's order that found that his low back injury claim was not prematurely closed. Claimant has submitted additional documents with his request for review. We treat claimant's submission as a motion for remand. See Judy A. Britton, 37 Van Natta 1262 (1985). On review, the issues are remand and premature claim closure.

We deny the motion for remand and, on the merits, adopt and affirm the ALJ's order.

The documents submitted by claimant are copies of a February 27, 1997 "interval note" by Dr. Grewe and a June 4, 1997 letter from the nurse case manager for CareMark Comp, the managed care organization. The February 27 interval note by Dr. Grewe was already received into evidence as Exhibit 43; therefore, remand is unnecessary for receipt of that document. In addition, after reviewing the June 4, 1997 letter from CareMark Comp, we find that consideration of the letter is not reasonably likely to affect the outcome of this case. For these reasons, we conclude that there is no compelling reason to remand this matter to the ALJ under ORS 656.295(5). See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986). Accordingly, the motion for remand is denied.

ORDER

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

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In the Matter of the Compensation of
**RICHARD L. OLSEN, Claimant**
WCB Case Nos. 97-01039 & 96-08724
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Bock, Biehl, and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) upheld the SAIF Corporation's denial of claimant's right shoulder injury claim; and (2) upheld SAIF's denial of claimant's occupational disease claim for a right shoulder condition. On review, the issues are timeliness of claim filing and, potentially, compensability. We affirm in part and reverse in part.

## FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" and provide the following summary.

In late February or early March 1996, claimant felt the onset of right shoulder pain while moving heavy beams at work. Over the next several months, claimant's symptoms waxed and waned depending on the manner in which he worked. (Tr. 7). After staining a new floor at work in July 1996, claimant sought medical treatment for his right shoulder. (Id. at 8-9). On August 15, 1996, claimant filed a Form 801 for his right shoulder condition.

## CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that the medical evidence was insufficient to prove a compensable injury or compensable occupational disease. Claimant challenges this order, contending that his claim is for an injury and that he carried his burden of proof. SAIF responds that the ALJ correctly concluded that the medical opinions do not reflect an accurate history and, consequently, the record lacks persuasive medical evidence that work activities caused claimant's need for treatment. SAIF also argues that, if we find that claimant proved a compensable injury, his claim should be barred because he did not timely give notice of the "accident" under ORS 656.265.

The physicians who give opinions concerning causation in this case consist of Dr. McCallum, claimant's family physician, and Dr. Edelson, orthopedic surgeon, both of whom treated claimant's right shoulder condition. According to Dr. McCallum, claimant's condition "was indeed due to lifting heavy wooden beams at work in March, 1996." (Ex. 27).

Dr. Edelson first reported that "the major contributing cause of [claimant's] need for treatment was his work activities, lifting heavy beams weighing between 600-700 pounds." (Ex. 28). Dr. Edelson added that it "would be quite rare for a 37 year old to have any significant form of rotator cuff tearing or severe tendinitis without a specific injury, which he clearly has in this case." (Id.)

Dr. Edelson then concurred with a "check-the-box" report from claimant's attorney stating that claimant "developed shoulder pain following a pop in his shoulder in March of 1996" and that, after this incident, claimant "continued working repetitively using his arms and gradually over time, the symptoms became worse and worse, requiring him to seek medical treatment in July of 1996." (Ex. 29). Dr. Edelson then reported to SAIF that the "major cause of [claimant's] shoulder problem is the repetitive use on the job, which stems from an initial strain to the shoulder." (Ex. 29A).

In determining the appropriate standard for analyzing compensability, we focus on whether claimant's right shoulder 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). The phrase "sudden in onset" refers to an injury occurring during a short, discrete period, rather than over a long period of time. Donald Drake Co. v. Lundmark, 63 Or App 261, 266 (1983), rev den 296 Or 350 (1984).

Here, claimant's condition is most appropriately categorized as an "ongoing condition or state of the body" rather than an "event." Although, as the dissent states, there was a diagnosis of a strain or rotator cuff tear, the ultimate opinion from Dr. Edelson shows that claimant's condition was rotator cuff tendonitis. (Ex. 28). The onset of symptoms for this condition did not coincide with a specific event but was over a long period of time while claimant performed repetitive work. (Id.) Consequently, we analyze the claim as one for occupational disease.

In proving an occupational disease compensable, claimant must show that employment conditions are the major contributing cause of the disease. ORS 656.802(2). Because Dr. Edelson's opinion satisfies this standard and there is no contrary opinion, we further conclude that claimant carried his burden of proof.[1]

Finally, we note that SAIF's timeliness argument is limited to finding that claimant proved a compensable injury claim. Thus, there is no contention that claimant did not timely file an occupational disease claim under ORS 656.807. Furthermore, because claimant filed his claim in August 1996, less than a year after February or March 1996, when he first felt symptoms, and July 1996, when he first sought treatment, claimant timely filed his claim. See ORS 656.807(1)(a), (b).

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $4,500, 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 May 28, 1997 is reversed in part and affirmed in part. SAIF's denial of claimant's occupational disease claim is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $4,500, to be paid by SAIF. The remainder of the order is affirmed.

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[1] We reject SAIF's argument that Dr. Edelson's opinion should be discounted on the ground that it was not based on an accurate history. Claimant testified that, after feeling a "pop" in his shoulder while moving heavy beams at work in late February or early March 1996, his symptoms waxed and waned according to the demands of his work. (Tr. 7). Finally, in July 1996, after staining a new wood floor, his pain was so great that he sought medical treatment. (Id. at 8-9). Although Dr. Edelson did not specifically refer to the floor staining activity, he based his opinion on a history that claimant initially injured his shoulder while moving heavy beams and then subsequent repetitive work activities worsened the shoulder condition. We find such history sufficiently accurate to render Dr. Edelson's opinion reliable.

**Board Member Haynes dissenting.**

I disagree with the majority that this claim should be analyzed as an occupational disease. The record shows that claimant's symptoms coincided with a specific event; that is, claimant felt a "pop" and pain while lifting heavy beams at work on a particular day in late February or early March. Claimant was diagnosed with a right rotator cuff strain and rotator cuff tendonitis; both conditions "stemmed" from the injurious event. (Exs. 27, 28). Consequently, claimant's condition is most appropriately considered an "event" rather than an "ongoing condition or state of the body." See Mathel, 319 Or at 240. The fact that claimant's condition progressively worsened following the injurious event does not mean that the onset of symptoms was "gradual in onset." See Lundmark, 63 Or App at 266.

Because the claim qualifies as an "injury," claimant must satisfy ORS 656.265 in filing the claim. That statute provides:

> "(1) Notice of an accident resulting in an injury or death shall be given immediately by the worker or a dependent of the worker to the employer, but not later than 90 days after the accident. * * *
>
> "* * * * *
>
> "(4) Failure to give notice as required by this section bars a claim under this chapter unless the notice is given within one year after the date of the accident and:
>
> "(a) The employer had knowledge of the injury or death[.]"

Here, it is undisputed that claimant did not give notice of his right shoulder condition until August 1996, when he filed the Form 801. Thus, claimant did not give "notice of an accident" within 90 days after the late February or early March 1996 accident. The issue then becomes whether the claim is barred under subsection (4).

When interpreting a statute, our task is to discern the legislature's intent. This task begins with an examination of the text and context of the statutory provision. PGE v. Bureau of Labor and Industries, 317 Or 606, 610-11 (1993). Text and context includes prior judicial interpretation of the statute. See State v. King, 316 Or 437, 445-46 (1993) (when the Supreme Court interprets a statute, that interpretation becomes part of the statute as if written into it at the time of its enactment). If the legislature's intent is clear from those inquiries, further inquiry is unnecessary. PGE, 317 Or at 611.

According to its language, if "notice is given within one year," the claim is not barred when the "employer had knowledge of the injury or death[.]" This provision, however, does not provide a specific time period within which the employer must have knowledge of the injury.

The entire statute is organized as first stating the requirements for giving notice and then, in subsection (4), providing the penalty for not following the requirements. Although the statute clearly provides that "notice" must be given within 90 days of the accident and that a claim is barred if there is no "notice" within one year of the accident, the statute provides no time period for the employer to have "knowledge of the injury or condition."

Based on the context of the statute, I would conclude that an employer must have "knowledge of the injury or condition" within 90 days of the accident in order for the claim not to be barred. Any other construction essentially would eliminate the requirement of giving notice within 90 days provided in subsection (1). That is, if subsection (4)(a) was construed as providing that a claim is not barred if "notice" is within one year of the accident and the employer has "knowledge of the injury or condition" within that time period, there would be no purpose for requiring a worker to give "notice" within 90 days. Because we must give effect to all statutory provisions, I would construe subsection (4)(a) as barring a claim unless "notice" is given within one year of the accident and the employer has "knowledge of the injury or condition" within 90 days of the accident.

As noted above, construction to text and context includes judicial interpretation of the statute.[1] By case law, the employer's "knowledge of the injury" had to be sufficient to meet the purposes of prompt notice of an accident or injury. E.g., Wilson v. Roseburg Forest Products, 113 Or App 670, 673 (1992). That is, the employer had to be aware that there may have been an injurious event and that a condition might be work-related. Id. at 674. By construing subsection (4)(a) uniformly with the time period provided in subsection (1), prior interpretation of subsection (4)(a) remains uniform.

Here, according to claimant's testimony, the employer did not have knowledge of the beam moving incident that occurred in late February or early March until an August 1996 meeting. (Tr. 9-10). Consequently, although claimant gave "notice" of the accident within one year, the employer did not have "knowledge of the injury or condition" within 90 days of the accident. Thus, I would conclude that claimant's claim is barred. See ORS 656.265(4)(a).

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[1] ORS 656.265 was amended in 1995; prior to that time, the worker had 30 days to give notice of "an accident resulting in injury or death." Former ORS 656.265(1). Subsection (4) in relevant part provided:

"Failure to give notice as required by this section bars a claim under this chapter unless

"(a) The employer had knowledge of the injury or death, or the insurer or self-insured employer has not been prejudiced by failure to receive the notice[.]"

In the Matter of the Compensation of
**ALBERT S. OLSON, Claimant**
Own Motion No. 98-0073M
OWN MOTION ORDER
Bennett, Hartman, et al., Claimant Attorneys

The insurer has submitted claimant's request for temporary disability compensation for claimant's compensable post L4-5 fusion. Claimant's aggravation rights expired on March 12, 1980. The insurer opposes authorization of temporary disability compensation, contending that: (1) claimant's current condition is not causally related to the accepted condition; (2) the insurer is not responsible for claimant's current condition; (3) surgery or hospitalization is not reasonable and necessary for the compensable injury; and (4) claimant was not in the work force when the current condition worsened.

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

On February 11, 1998, the insurer submitted its recommendation to deny claimant's request for own motion relief. The insurer disputed the compensability of and responsibility for claimant's current condition alleging that these issued had been previously litigated. The insurer further contended that claimant was not in the work force at the time of the current disability. The Board wrote to both the insurer and claimant requesting further clarification of the insurer's recommendation and requesting a copy of the denial if one had issued. The claimant responded by letter dated February 20, 1998 addressing only the work force issue.[1] No response has been received from the insurer.

Thus, the issue of whether claimant's current need for surgery for his severe left L3-4 and L4-5 lateral recess stenosis with nerve root entrapment syndrome is related to his accepted post L4-5 fusion 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 1974 injury claim for the payment of temporary disability benefits. See ORS 656.278(1)(a). Should claimant's circumstances change, and the surgery subsequently be determined to be compensably related to the accepted condition in the 1974 claim, 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] The Board sent a second letter dated March 6, 1998 to all parties requesting that they submit the requested information regarding the compensability and responsibility issues. To date, no response has been received from either party.

In the Matter of the Compensation of
**GAIL L. RUSSELL, Claimant**
WCB Case No. 97-03655
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Baker's order that affirmed an Order on Reconsideration that awarded no unscheduled permanent disability for claimant's back injury. On review, the issue is unscheduled permanent disability.

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

The ALJ determined that claimant had no permanent impairment due to the compensable April 16, 1996 back injury, accepted as a thoracic and lumbar strain. Thus, the ALJ affirmed the Order on Reconsideration that awarded no permanent disability.

On review, claimant contends that she should be awarded unscheduled permanent disability based on permanent impairment due to reduced range of motion as documented by Dr. Laycoe, the medical arbiter. We disagree.

Dr. Laycoe noted in his report that claimant did not meet the straight leg raising validity test. (Ex. 21-2, 7). Based on this test and claimant's voluntary guarding due to pain, Dr. Laycoe concluded that his range of motion findings were not valid for rating permanent impairment. (Ex. 21-4).

Claimant asserts that Dr. Laycoe should not have discounted range of motion measurements due to voluntary guarding because it is not a proper criterion for validity testing. However, even if we assumed claimant's argument is correct, guarding was not the only basis for Dr. Laycoe's conclusion that his range of motion findings were invalid. As previously noted, Dr. Laycoe also reported that claimant did not meet the straight leg raising validity test. (Ex. 21-4). In light of Dr. Laycoe's unambiguous statement that his range of motion measurements were invalid, and his accompanying explanation, we reject claimant's contention. See Manuel Villa-Gallegos, 49 Van Natta 1386 (1997) (the claimant failed to prove impairment where the medical arbiter stated range of motion measurements did not satisfy straight leg raising validity criteria); Harvey Clark, 47 Van Natta 136, 137 (1995) (where the medical arbiter found the claimant's range of motion findings invalid, the claimant failed to prove impairment); Cf. Justeen L. Parker, 49 Van Natta 334 (1997) (arbiter's range of motion (ROM) measurements rated as impairment when arbiter did not identify the validity standards that were not satisfied, nor did he provide a written explanation of why the ROM measurements did not meet validity standards). Moreover, Dr. Laycoe's opinion is consistent with that of claimant's attending physician, Dr. Altrocchi, who reported that claimant had no residual abnormalities from her injury. Accordingly, we affirm.

ORDER

The ALJ's order dated November 25, 1997 is affirmed.

In the Matter of the Compensation of
**SEVEDIOUS H. SIMINGTON, Claimant**
WCB Case No. 97-05066
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Herman's order that: (1) found that claimant had failed to timely raise the issue of premature claim closure; and (2) affirmed an Order on Reconsideration which did not award any unscheduled permanent disability for a left shoulder and neck injury. On review, the issues are whether claimant is precluded from raising the issue of premature closure, and extent of unscheduled permanent disability.

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

Assuming *arguendo* that claimant could raise the issue of premature claim closure, the doctrine of issue preclusion would bar claimant from relitigating the premature claim closure issue. Under the doctrine of issue preclusion, if an issue of fact of law is actually litigated and determined by a valid and final judgment and the determination is essential to the judgment, the determination is conclusive in a subsequent action between the parties, whether on the same or a different claim. Drews v. EBI Companies, 310 Or 134, 139-140 (1990). A stipulation approved by an Administrative Law Judge has the finality and effect of a judgment. See Fimbres v. Gibbons Supply Co., 122 Or App 467 (1993).

The issue of premature claim closure is determined by whether claimant's compensable condition was medically stationary at the time of claim closure. ORS 656.268(1); Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). Here, in the December 16, 1996 stipulation, claimant agreed that his condition was medically stationary as of June 27, 1996. There is no evidence establishing that claimant's condition changed between the date of the stipulation and the January 21, 1997 Notice of Closure. The December 16, 1996 stipulation is a valid and final judgment concerning claimant's medically stationary status at that time. Because there is no evidence that claimant's condition changed, claimant is precluded from relitigating his medically stationary status, which necessarily includes the issue of whether his claim was prematurely closed by the January 21, 1997 Notice of Closure.

ORDER

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

In the Matter of the Compensation of
**DONNA L. BIERER, Claimant**
WCB Case No. 97-00410
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

The self-insured employer requests review of Administrative Law Judge (ALJ) Neal's order that set aside its partial denial of claimant's injury claim for a current right shoulder condition. On review, the issue is compensability. We reverse.

## FINDINGS OF FACT

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

## CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the pertinent facts.

Claimant fell at work on June 19, 1996, injuring her right shoulder. She treated conservatively.

The employer accepted claimant's claim for a nondisabling right shoulder strain.

On November 14, 1996, the employer denied claimant's current right shoulder condition. Claimant requested a hearing.

The ALJ set aside the employer's denial based on the opinion of Dr. Rivas, treating physician. The ALJ reasoned that Dr. Rivas' opinion (relating claimant's ongoing right shoulder problems to the work injury) is persuasive because it is consistent with claimant's credible testimony regarding her symptoms. We disagree.

Claimant initially treated with Dr. Heidinger, but the medical evidence concerning causation is provided by Dr. Rivas and Dr. Farris, examining physician. We generally rely on the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983). In this case, we find such reasons.

Claimant sought treatment for right shoulder symptoms, "present for the last one month," on June 7, 1996 (before her work injury). At that time, Dr. Heidinger noted "tenderness just superior to the bicipital groove. Patient points to the area of the rotator cuff or glenoid rim." (Ex. 1-1).

On June 21, 1996, claimant again sought treatment and reported her June 19, 1996 fall at work.[1]

On July 22, 1996, Dr. Rivas examined claimant and reported that her pain was "localized at the AC joint, right in the bicipital groove." He diagnosed right shoulder tendinitis. (Exs. 4-1).

Dr. Farris examined claimant on September 13, 1996 and noted her complaints of intermittent pain over the anterior aspect of her right shoulder. He reported claimant's history of right shoulder problems beginning "around January of 1996." (Ex. 5-1, emphasis added). Right shoulder x-rays revealed "mild arthrosis of the acromioclavicular joint and a mild Type II acromium." (Ex. 5-6). Dr. Farris diagnosed a resolved right shoulder strain and mild intermittent bicipital and rotator cuff tendinitis. (Id). He concluded that claimant had no injury-related impairment and any treatment she received more than 6 weeks after the June 19, 1996 incident was due to her preexisting condition rather than the work injury. (Id).

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[1] Dr. Heidinger diagnosed "Infraspinatus muscle strain and associated strains." Physical examination revealed tenderness "over the posterior aspects" of the right shoulder as well as along the medial border of the scapula, in the triceps muscle, and in the distal portion of the pectoralis. There was no significant tenderness over the areas of the rotator cuff, along the trapezius muscle, or along the cervical spine. (Ex. 3).

By October 25, 1996, claimant had "no tenderness anywhere" and excellent shoulder range of motion. (Ex. 4-5).

On October 30, 1996, Dr. Rivas signed a concurrence letter indicating agreement with Dr. Farris' September report. (Ex. 7).

On September 26, 1997, Dr. Rivas examined claimant and reported:

> "This patient has not had a previous injury to this area and the day when she fell at work was the first time that has had any symptoms in this area, and prevails to this day. . . . [Today she is] still complaining of discomfort over the bicipital groove and the medial aspect, also of the right arm. The examination is unchanged from my previous exams. . . . [P]rior to this injury there were no problems, therefore it is 100% due to her injuries at work." (Ex. 11).

Claimant testified that her complaints before the work injury were in her back, not in her shoulder, and that she had not had right shoulder problems in the current location before her fall at work. (Tr. 7-8, 19; see Tr. 16-17). She specifically stated that her prior problems had been in her back, "further than where I can reach," in the back, not the shoulder. (Tr. 20).

We do not find claimant's testimony to be consistent with her pre-injury medical records. On June 7, 1996, Dr. Heidinger specifically recorded right shoulder pain, including tenderness "just superior to the bicipital groove," with claimant pointing to the area of the rotator cuff groove or glenoid rim. (Ex. 1-1). Nothing in the contemporaneous record suggests that these pre-injury complaints were anywhere other than claimant's right shoulder.[2] (See Ex. 1-2). Consequently, we cannot say that Dr. Rivas' understanding that claimant had "no problems" before her work injury is accurate. (See Ex. 11). Because Dr. Rivas' ultimate opinion regarding causation is expressly based on the absence of prior problems, we also cannot say that his conclusions are based on an accurate history. (Id).

Moreover, Dr. Farris opined that claimant's injury-related strain condition had resolved (by the time of his examination) and Dr. Rivas concurred with Dr. Farris' report without reservation. (Exs. 5, 7). Thus, Dr. Rivas' subsequent opinion relating claimant's September 1997 condition "100%" to the work injury amounts to an unexplained change. See Moe v. Ceiling Systems, 44 Or App 429 (1980). Under these circumstances, we find Dr. Farris' opinion (which is well reasoned and based on an accurate history) more persuasive than that of Dr. Rivas. Accordingly, the ALJ's order must be reversed.[3]

## ORDER

The ALJ's order dated October 1, 1997 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

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[2] The medical records variously describe claimant's prior and current symptoms as occurring in her shoulder, or more specifically, e.g., "over the bicipital groove." (See Exs. 1, 11). Dr. Rivas loosely refers to claimant's problem in "this area." On this record, we cannot say that claimant's problems are in a different place now than they were before. Moreover, in light of Dr. Rivas' unlimited concurrence with Dr. Farris' opinion, we find Dr. Rivas' opinion unpersuasive, as explained herein.

[3] We need not determine whether claimant is subject to the "major contributing cause" standard of proof under ORS 656.005(7)(a)(B), because the evidence supporting the claim is unpersuasive. In other words, claimant has not carried her burden, even if the standard is only "material cause" under ORS 656.005(7)(a).

In the Matter of the Compensation of
**ORESTE A. CHORNEY, Claimant**
WCB Case No. 97-05937
ORDER ON REVIEW
Gary L. Tyler, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Tenenbaum's order that upheld the self-insured employer's partial denial of claimant's claim for a current low back condition. On review, the issues are claim preclusion and compensability. We affirm.

## FINDINGS OF FACT

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

We do not find that the present claim is based on the same factual transaction as the claim denied in August 1996 (or that the basis for the present claim existed at the time of the prior claim).

We do not find that the April 15, 1997 dismissal order "finally litigated" the compensability of claimant's L4-5 disc condition.

## CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for a February 1994 lumbar strain. That claim was closed in September 1994 with a five percent unscheduled permanent disability award.

Claimant also has degenerative disc and joint disease in his low back, which preexisted his 1994 injury. Claimant's current low back problems involve his preexisting disease.

On August 23, 1996, the employer denied claimant's aggravation claim, based in part on a contention that claimant's preexisting condition was the major cause of his then-current need for treatment. Claimant requested a hearing and then withdrew his request. An April 15, 1997 dismissal order dismissed claimant's hearing request.

On May 23, 1997, the employer issued a partial denial of claimant's current low back condition on claim preclusion and causation grounds. Claimant requested a hearing.

The ALJ found claimant's current claim for a low back condition (including an L4-5 herniated disc) precluded by the April 15, 1997 dismissal order. (See Ex. 46). The ALJ reasoned that the compensability of the current condition could have been litigated previously because claimant has the same condition now as he had at the time of the prior dismissal.

However, on October 3, 1997, Dr. Puziss opined that claimant's condition "worsened considerably over the past year." (Ex. 52-1). Because his opinion in this regard is uncontradicted, we cannot say that claimant's condition has not changed since the April 15, 1997 dismissal order. Under these circumstances, the current claim is not completely precluded. See Liberty Northwest Ins. Corp. v. Bird, 99 Or App 560 (1989) (when a previously denied claim is reasserted, the question is whether the condition has changed so as to have created a new set of operative facts that previously could not have been litigated); Popoff v. J.J. Newberry's, 117 Or App 242 (1992) (a previously denied claim is precluded when the denial becomes final); Douglas L. Tugg, 48 Van Natta 1590 (1996).

However, even though the entire claim is not precluded, that does not aid claimant's cause. Claimant's then-current low back condition was not compensable as of the August 23, 1996 denial, because the denial became final without being challenged.[1] There is no medical evidence indicating that

[1] Claimant withdrew his hearing request from that denial and a dismissal order issued on April 15, 1997. Thus, the denial became final as if it had not been challenged.

cognizable work-related factors (i.e., not including claimant's noncompensable preexisting degeneration or his condition as it existed at the time of the August 23, 1996 denial) are the major contributing cause of claimant's current low back condition. ORS 656.005(7)(a)(B). Accordingly, the employer's May 23, 1997 denial is properly upheld.

ORDER

The ALJ's order dated November 4, 1997 is affirmed.

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March 26, 1998 Cite as 50 Van Natta 499 (1998)

In the Matter of the Compensation of
**BRENT HARPER, Claimant**
WCB Case No. 97-05103
ORDER ON REVIEW (REMANDING)
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Peterson's order that dismissed his request for hearing. On review, the issue is the propriety of the dismissal order. We vacate and remand.

FINDINGS OF FACT

Claimant filed a request for hearing on June 24, 1997. A hearing was set for September 16, 1997. On that date, claimant did not appear in person or through an attorney.

At the hearing, the ALJ advised the insurer's attorney that claimant had called the ALJ's office and left a message that he would not be able to appear at the hearing because he could not find a baby-sitter and did not have transportation. (Tr. 3). Claimant also reportedly had not made copies of the exhibits. After addressing claimant's reasons for not attending the hearing, the insurer's attorney moved for dismissal on the ground that claimant had abandoned his request for hearing.[1] (Tr. 5). The ALJ granted the insurer's motion.

On September 23, 1997, the ALJ issued an Order of Dismissal which stated that claimant failed to appear and that "[n]o reasonable excuse for the claimant's non-appearance was forthcoming...." However, the ALJ's order also provided that the matter could be reinstated, if, within 30 days, claimant set forth a "good and sufficient explanation of his failure to appear at the date and time specified in the Notice of Hearing."

On October 27, 1997, the Board received an October 21, 1997 letter from claimant, explaining that he did not attend the hearing because his daughter was sick and he had no care provider. Claimant also noted that he did not have transportation or money to provide copies of the exhibits.

CONCLUSIONS OF LAW AND OPINION

An ALJ shall dismiss a request for hearing if claimant or his attorney fail to attend a scheduled hearing, unless "extraordinary circumstances" justify postponement or continuance of the hearing. OAR 438-006-0071(2). Here, the ALJ stated on the record that the Hearings Division had received a phone call from claimant regarding his inability to find a baby-sitter, his lack of transportation, and his inability to make copies of exhibits. In response, the insurer contended that claimant's reasons for not attending the hearing were inadequate. After considering the matter, the ALJ dismissed the hearing request, concluding that claimant had not provided a reasonable excuse for his failure to appear at the hearing. We interpret the ALJ's order as denying a request for postponement of the hearing.

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[1] The insurer's counsel alleged that claimant's reasons for not attending the hearing were inadequate because claimant's excuses were inconsistent, his oldest child should have been old enough to baby-sit his siblings, and there was no need for claimant to make copies of exhibits because the insurer would be supplying them.

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 (1997).

Because the insurer 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).[2] Thus, we find a compelling reason to remand this case for further development of the record regarding claimant's postponement request.[3]

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 his 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 September 23, 1997 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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[2] In reaching this conclusion, the record does not establish when claimant's baby sitter and transportation problems arose. Had they arisen several days before the hearing, it may have been reasonable to assume that alternative measures would have been available to enable claimant to attend the scheduled hearing. On the other hand, if these problems arose shortly before the hearing, such alternative arrangements may not have been possible.

In light of these considerations, the appropriate response from the ALJ may well have been to attempt to develop the record by sending claimant a "show cause" order. Thereafter, assuming that claimant timely responded, the ALJ could then have ruled on the postponement request based on a more fully developed record. Alternatively, in the absence of a timely response from claimant, the ALJ could then have issued an order dismissing claimant's hearing request based on a denial of the postponement request, as well as a failure to respond to the "show cause" order.

We acknowledge that the ALJ's dismissal order included a paragraph in which claimant was also advised that, within 30 days, he could provide the ALJ with "good and sufficient explanation" of his failure to appear. This "combined order" ("show cause" and "dismissal") may well be useful when a party has not appeared at a scheduled hearing and no communication regarding the non-appearance has been received (except that the "show cause" period should probably be reduced from 30 to 15 days to avoid confusion and conflict with the 30 day appeal period). Nevertheless, where, as here, a communication "explaining" the reason(s) for a party's nonappearance at hearing has been made, the issuance of a standard "show cause" order may have been warranted. Although this latter approach may result in the issuance of two separate orders (i.e., a "show cause" order and subsequent "order of dismissal"), it has the desirable effect of potentially further developing the record for appellate review.

[3] We note that claimant's October 21, 1997 letter provided an additional reason for his failure to appear at the hearing (his daughter's illness) and requested reinstatement of his hearing request. In other words, claimant was responding to the ALJ's request to provide a "good and sufficient explanation" of his failure to attend the hearing. Inasmuch as claimant provided his explanation within the time parameters established by the ALJ's order, we find a compelling reason to remand to the ALJ to further consider/develop the record regarding claimant's postponement request.

In the Matter of the Compensation of
**DANNY L. HERNANDEZ, Claimant**
WCB Case No. 96-10053
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorneys
Stoel Rives, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Michael Johnson's order that awarded 5 percent (9.6 degrees) scheduled permanent disability for a loss of use or function in each arm, whereas an Order on Reconsideration awarded no scheduled permanent disability. Claimant cross-requests review of that portion of the order that declined to assess a penalty or attorney fee for the insurer's allegedly unreasonable failure to provide timely discovery. On review, the issues are extent of 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, which we briefly recap as follows.

On October 1, 1995, claimant sustained a compensable neck injury when a large wrench fell from a height of 17-20 feet off a crane and cracked his safety helmet. The insurer accepted disabling cervical, thoracic and right trapezius strains. (Exs. 21, 69).

On February 7, 1996, claimant was examined by his attending physician, Dr. Nelson, physiatrist and rehabilitation specialist. On March 18, 1996, a physical capacities evaluation (PCE) indicated that claimant was restricted from repetitive use of both arms. (Exs. 50, 61). These findings were confirmed by Dr. Nelson, who also indicated that upper extremity goiniometry might be necessary. (Ex. 51).

On April 30, 1996, Dr. Nelson declared claimant medically stationary and recommended measurement of range of motion (ROM) of claimant's neck by inclinometer, which was done. (Exs. 55, 58). On July 26, 1996, Dr. Nelson performed a closing examination regarding claimant's cervical strain, in which he agreed with the earlier ROM findings for the neck. (Ex. 65). On August 5, 1996, Dr. Nelson concurred with the findings in the March 18, 1996 PCE, indicating that they were permanent and should be used for reference in claimant's claim closure process. (Ex. 66).

A September 13, 1996 Determination Order awarded 25 percent unscheduled permanent disability for claimant's neck and 5 percent scheduled permanent disability for a chronic condition restricting repetitive use of each arm. Claimant requested reconsideration, raising the sole issue of temporary disability dates. An October 22, 1996 Order on Reconsideration reduced claimant's unscheduled permanent disability award to 16 percent and each scheduled award to zero, based on Dr. Nelson's July 26, 1996 closing report. Claimant 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 address the insurer's arguments.

The ALJ awarded 5 percent scheduled permanent disability for the loss of use and function of each arm, relying on the attending physician's (Dr. Nelson) concurrence with the March 1996 physical capacities evaluation (PCE) that found limitations in the frequency with which claimant could use each arm.

Citing William L. Fischbach, 48 Van Natta 1233 (1996), the insurer argues that, because there were no symptoms, impairment or conditions in claimant's arms, claimant is not entitled to a chronic condition award for each arm. The insurer also argues that claimant is not entitled to chronic condition awards because certain movements merely irritate his accepted neck and trapezius conditions. We disagree with both arguments.

In Fischbach, the ALJ found that the claimant was entitled to a 5 percent scheduled permanent disability award for a chronic condition in his left arm, in addition to the 8 percent unscheduled permanent disability awarded for his left shoulder condition. In so finding, the ALJ relied upon Foster v. SAIF, 259 Or 86 (1971), and Alvena Peterson, 47 Van Natta 1331 (1995), which held that a claimant is entitled to separate permanent disability awards where an injury to an unscheduled body part, such as a shoulder, also produces a loss of use or function to a scheduled body part, such as the arm.

On review, we found that the medical arbiter did not report any arm symptoms flowing from the claimant's left shoulder injury. Rather, the arbiter explained that the claimant experienced uncomfortable snapping in the left shoulder with awkward motions and difficulty using his left arm overhead because of easy shoulder fatiguability. We noted that the arbiter did not identify any symptoms causing loss of function to the claimant's left arm. Under those circumstances, we concluded that the claimant was not entitled to a separate scheduled permanent disability award for a chronic condition of a scheduled member. 48 Van Natta at 1234.

This case, however, is more analogous to Alvena Peterson than to Fischbach. Here, the restrictions placed on the repetitive use of claimant's arms are not simply positional problems created by his neck impairment. Rather, Dr. Nelson, claimant's attending physician, indicated specifically that claimant's arms were permanently restricted body parts.

Claimant's accepted conditions are cervical, thoracic and right trapezius strains. In response to the insurer's query, Dr. Nelson concurred with the March 18, 1996 PCE, which found that claimant was restricted to "light repetitive work" in the use of each arm, and indicated that these restrictions were permanent. (Exs. 50, 61, 66). There is no attribution in the PCE of claimant's restrictions on the use of his arms to positional problems, or avoidance of symptoms, reinjury, or exacerbation, or recurrence of symptoms. Therefore, we conclude that Dr. Nelson specifically indicated that claimant's arms were permanently restricted body parts.

Penalty

The ALJ concluded that claimant had not received a copy of Dr. Nelson's July 26, 1996 closing examination report prior to the issuance of the Order on Reconsideration. The ALJ nevertheless declined to award penalties or attorney fees, reasoning that claimant's possession of the medical report would have had no effect on the Department's sua sponte reassessment of claimant's permanent disability awards. Concluding that claimant was not damaged by not having the document in his possession, the ALJ declined to assess a penalty against the insurer.

On review, claimant contends that he is entitled to penalties and attorney fees for the insurer's failure to timely provide the document. We agree that a penalty-related attorney fee is warranted.

Relying on the sworn affidavit of its claims adjuster, the insurer asserts that it provided the document to claimant's attorney along with the Form 1503 dated August 27, 1996 requesting claim closure. (Ex. 71). We adopt that portion of the ALJ's opinion,[1] which concludes that claimant did not receive a copy of Dr. Nelson's July 26, 1996 closing report (Ex. 65) at any time prior to the issuance of the Order on Reconsideration.

However, we disagree with the ALJ's conclusion that the insurer's failure to provide the document timely was harmless. Even though claimant's request for reconsideration was limited to the issue of the dates of entitlement to temporary disability, the Director reduced the Determination Order's award of 25 percent unscheduled permanent disability for claimant's cervical condition to 16 percent and the award of 5 percent scheduled permanent disability for a chronic condition in each arm to zero, based on Dr. Nelson's July 26, 1996 closing report. At hearing, claimant maintained that, had he been timely provided a copy of Dr. Nelson's report, he would have offered additional medical evidence at reconsideration. (Tr. 2).

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[1] Specifically, the last paragraph on page 7, with the exception of the first three sentences, through the first sentence of the first full paragraph on page 8 which begins: "I conclude * * * ."

Upon receiving notice of a worker's request for reconsideration of a Determination Order, the insurer is required to furnish to the worker, within six working days of the mailing date of the reconsideration request, copies of any documents supplemental to the Determination Order as well as other documents as requested by the Department or the worker. Former OAR 436-30-135(4)(b). Moreover, all information submitted to the Department by any interested party during the reconsideration process must be copied to all interested parties and be accompanied by certification that it has been provided to all interested parties. Former OAR 436-30-135(1)(d).

Here, the record indicates that claimant's first notice of the attending physician's July 26, 1996 closing examination did not occur until claimant's attorney requested copies of the record from the insurer after claimant filed his hearing request.[2] Consequently, in light of the statutory requirement that no additional evidence is admissible after reconsideration, ORS 656.262(7)(g), claimant was denied the opportunity to generate a rebuttal report to submit at reconsideration, as provided under former OAR 436-30-125(1)(g) and (h).[3] Moreover, although the insurer did not object to the Determination Order at the reconsideration proceeding, both at hearing and on review the insurer asserted that claimant's scheduled permanent disability award should be reduced. We accordingly conclude that the insurer's claims processing was an unreasonable resistance to the payment of compensation.

Although there is no evidence that compensation was due at the time of the August 27, 1996 discovery violation, an attorney fee award pursuant to ORS 656.382(1) does not depend on amounts "then due." See Eastmoreland Hospital v. Reeves, 94 Or App 698, 702 (1989); Janice Talevich, 48 Van Natta 2318 (1996). Inasmuch as the insurer gave insufficient reason for its failure to timely provide discovery, we conclude that an attorney fee should be assessed under ORS 656.382(1).

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for the insurer's discovery violation is $500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, and the value of the interest involved.

Attorney Fee/Board Review

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the permanent disability issue is $1,000, 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. Claimant is not entitled to an attorney fee for his counsel's services in seeking an attorney fee award. See Amador Mendez, 44 Van Natta 736 (1992).

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[2] Thus, claimant was also unable to request abatement to give him an opportunity to respond to Dr. Nelson's report. See former OAR 436-030-0135(1)(e), which provides:

"When a party does not discover until after the reconsideration order has issued that additional documents were not provided by the opposing party in accordance with [OAR 436-030-0135], the Order on Reconsideration may be abated and withdrawn to give the party an opportunity to respond to the new information."

[3] Former OAR 436-40-125(1) provides in pertinent part:

"Pursuant to this section, a 'completed reconsideration request' shall include, but not be limited to:

" * * * * *

"(g) any information and documentation deemed necessary to correct or clarify any part of the claim record the party believes to be erroneous; and/or

"(h) any medical evidence that should have been but was not submitted at the time of the claim closure including clarification or correction of the medical record based on the examination(s) at or before claim closure[.]"

ORDER

The ALJ's order dated April 16, 1997 is reversed in part and affirmed in part. That portion of the ALJ's order that declined to award a penalty-related attorney fee is reversed. Claimant is awarded an assessed fee of $500 for its discovery violation, payable by the insurer to claimant's counsel. The remainder of the ALJ's order is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, payable by the insurer.

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March 26, 1998 Cite as 50 Van Natta 504 (1998)

In the Matter of the Compensation of
**MARTY HOLBERT, Claimant**
WCB Case No. 97-05525
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Lane, Powell, et al, Defense Attorneys

Reviewed by Board Members Bock and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Kekauoha's order that set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation regarding a disputed factual finding.

The ALJ determined that claimant had sustained his burden of proving that his employment activities were the major contributing cause of his bilateral carpal tunnel condition. In so doing, the ALJ found that the probe card repair work claimant performed, and which the ALJ identified as causative of claimant's condition, began in April 1996. The employer, however, contends that the record establishes that this work did not begin until September 1996 and, thus, that a panel of examining physicians had an accurate history when they concluded that claimant's employment was not the major contributing cause of his carpal tunnel condition.

Claimant's testimony regarding the commencement of his probe card repair work was inconsistent in that he agreed at one point that it began in April 1996 (Tr. 16) and, at another, in September 1996. (Tr. 38). However, claimant conceded that he was not good with dates. (Ex. 5). Moreover, we note that there is a May 16, 1996 chart note from Dr. Rung indicating that claimant had already returned to light duty from a prior back injury in August 1995. (Ex. 1; See also Ex. 2-2). This light duty was apparently the probe card work to which claimant subsequently attributed his carpal tunnel condition. (Tr. 5). In light of this evidence, we agree with the ALJ's finding that the probe card work began in April 1996.[1]

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

ORDER

The ALJ's order dated October 28, 1997 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] We acknowledge the existence of a September 1996 emplyment transfer/change form which the employer asserts establishes that claimant transferred to the probe card position on September 6, 1996. (Ex. 2Aa). However, the document is ambiguous and certainly does not rule out claimant having begun the probe card repair work in April 1996, especially in light of the above contemporaneous medical records.

In the Matter of the Compensation of
**ROBERT D. MOORE, Claimant**
Own Motion No. 98-0130M
ORDER POSTPONING ACTION
ON OWN MOTION REQUEST
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 L3-4 disc herniation injury. Claimant's aggravation rights expired on December 4, 1995. SAIF recommended that the Board authorize the reopening of claimant's 1989 claim for the payment of temporary disability compensation.

In addition, SAIF advises that claimant has an August 5, 1997 accepted lower thoracic and lumbar strains claim through SIMS (Claim No. 000309-011235-WC01) and that SIMS has issued a February 18, 1998 responsibility denial regarding the L3-4 hardware removal.

Even though SAIF has accepted responsibility for L3-4 hardware removal, there is litigation pending regarding the responsibility for claimant's current low back condition. Because that litigation will necessarily address the issue of whether claimant's need for surgery is causally related to the 1989 injury or a subsequent injury, we conclude that it would be in the best interest of the parties to postpone action on this own motion matter until the pending litigation has been resolved.

Therefore, we defer action on this request for own motion relief and request that Administrative Law Judge (ALJ) Podnar, who is scheduled to conduct the hearing in WCB Case No. 98-01619 on May 18, 1998, submit a copy of the hearing order to the Board. In addition, if the matter is resolved by stipulation or disputed claim settlement, the ALJ is requested to submit a copy of the settlement document to the Board. After issuance of the order or settlement document, the parties should advise the Board of their respective positions regarding own motion relief.

IT IS SO ORDERED.

In the Matter of the Compensation of
**NANCY L. SABIN, Claimant**
WCB Case No. 97-00982
ORDER ON REVIEW
Black, Chapman, 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) Stephen Brown's order that upheld the SAIF Corporation's denial of her neuroma of the proximal phalanx of the second digit of her right foot. On review, the issue is compensability. We reverse.

## FINDINGS OF FACT

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

On October 27, 1995 claimant was compensably injured when she slipped and fell off a counter stool. She landed on her buttocks and back. She sought treatment the next day, and Dr. Kleeman reported complaints of headache, right-sided low back pain, right wrist pain and right knee pain. SAIF subsequently accepted contusion and abrasion, left knee, low back contusion and contusion and abrasion, right wrist.

On November 14, 1996, claimant saw Dr. Novak, who documented complaints of low back pain, right leg pain, right toe pain and left calf fullness. Dr. Novak treated only the low back and left calf complaints. Claimant also complained of right toe pain to the physical therapist and to Dr. Novak in January 1996.

Dr. Novak referred claimant to Dr. Laubengayer in February 1996 for her back and right leg complaints. On February 13, 1996, Dr. Laubengayer found, among other things, that claimant had some hypesthesia over the dorsum of the foot near the 2nd and 3rd toes, but no pain with motion of the toes and no tenderness of the metatarsals.

Claimant again complained of right toe pain when she saw Dr. Novak in July 1996 for a closing examination. He referred claimant to Dr. Hoyal for a podiatric evaluation. Dr. Hoyal diagnosed a neuroma and abnormally healed fracture of the proximal phalanx of the second digit of the right foot.

In October 1996, at the request of SAIF, Dr. McKillop reviewed claimant's medical records with regard to her right foot complaints. He opined that claimant had an interdigital neuroma likely as a result of trauma to the toes of the right foot. Because the contemporaneous medical records did not document pain, edema and discoloration immediately following the October 27, 1995 incident, Dr. McKillop did not relate claimant's right toe condition to that incident. Dr. Hoyal concurred with Dr. McKillop's report.

Dr. Novak initially opined that claimant's right toe problems were not related to her October 27, 1995 fall. He later reviewed his chart notes, documenting a complaint of toe pain in November 1995, and opined that claimant indeed may have injured her toe in the fall. He explained that her right toe complaints may have been missed in light of all the other problems resulting from her fall.

Claimant testified that the front of her right shoe was bent under as a result of her fall from the counter stool and that afterwards, she experienced pain and swelling in the toes of her right foot. She also testified that she noted some discoloration (slight bruising) on her second toe and that she had not injured the second toe of her right foot prior to the October 1995 incident.

Claimant's husband testified that claimant experienced pain and swelling in the second toe of her right foot after her fall. He also testified that claimant's right foot has continued to bother her since the fall, and that he was present during some of her medical examinations and heard her complain to her doctors about right foot pain.

## CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant failed to prove the compensability of her right foot neuroma by a preponderance of the evidence. On review, claimant argues that her credible testimony, read in conjunction with the expert opinions of Drs. Novak and McKillop, persuasively establishes that her right foot neuroma is causally related to her October 27, 1995 fall. We agree.

The ALJ expressly found claimant's testimony credible. We find no reason to dispute this determination. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987) (unless the substance of the witness' testimony and other inconsistencies in the record raise such doubt that we are unable to conclude that the material testimony is credible, we will generally defer to the ALJ's finding that the witness is credible).

Claimant testified that the October 27, 1995 fall caused the top of her right shoe to turn under to such an extent that she was concerned that she had ruined her shoe. (Tr. 10). She testified that, after the fall, she experienced pain, swelling and some discoloration in her second toe. She also reported that her right foot pain continued and that she repeatedly complained of such pain to her doctors, even though Dr. Novak did not treat the problem until July 1996, when he referred claimant to Dr. Hoyal.[1] (Tr. 11).

In his records review, Dr. McKillop found that claimant's neuroma of the proximal phalanx of the second digit was probably related to some past trauma to that part of her right foot. He explained that trauma to the forefoot could occur if the toe was badly stubbed against some object, or if the foot was severely stepped on or struck with some object, thereby creating blunt trauma to the second toe that would fracture the toe and force the MP joint into acute extension or some other deformed position. (Ex. 16-4). Dr. McKillop also concluded that claimant's neuroma is probably "a consequential condition secondary to past trauma to the toe area," but declined to relate this condition to the October 27, 1995 fall because the contemporaneous chart notes did not refer to symptoms or findings consistent with trauma to the right toes. He explained that "if the trauma to the foot had occurred on October 27, 1995, then one would have expected pain and possibly edema and discoloration." (Ex. 16-3).

Finally, as noted above, when Dr. Novak reviewed his chart notes on claimant in March 1997, he reported that he had actually documented a complaint of right toe pain on November 14, 1995, the second time he saw claimant following the October 27, 1995 incident. He admitted that claimant may have injured her toe in the fall, but that this injury "just became lost in light of all the other problems."

Unlike the ALJ, we find, based on claimant's credible testimony (i.e., that she bent under her right shoe during the October 27, 1995 fall from the counter stool and that she thereafter experienced pain, swelling and some discoloration in the second toe of her right foot) and the expert medical analyses of Drs. Novak and McKillop, that it is more likely than not that claimant suffered trauma to the second toe of her right foot in her October 27, 1995 fall off the counter stool which resulted in a fracture of the proximal phalanx of that toe. We are further persuaded that this traumatic injury to the second toe was, in turn, the major contributing cause of the later diagnosed neuroma of the proximal phalanx. Consequently, we find claimant's neuroma compensable as a consequential condition under ORS 656.005(7)(a)(A).

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

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[1] The contemporaneous medical records document complaints of numbness or pain of the right foot or toe on November 14, 1995, January 18, 19 and 24, 1996, February 13, 1996 even though claimant was not referred to Dr. Hoyal until her July 1996 closing examination. (Exs. 5, 6A, 7, 8).

ORDER

The ALJ's order dated September 24, 1997 is reversed. SAIF's denial of claimant's neuroma of the proximal phalanx of the second digit of the right foot 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 an assessed fee of $4,000, payable by SAIF.

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In the Matter of the Compensation of
**NANCY L. SABIN, Claimant**
WCB Case No. 97-03260
ORDER ON REVIEW (REMANDING)
Black, Chapman, 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) Stephen Brown's order that affirmed the Order on Reconsideration that rescinded the Notice of Closure. On review, the issue is premature claim closure. We reverse and remand.

FINDINGS OF FACT

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

On October 27, 1995, claimant was compensably injured when she slipped and fell off a counter stool. SAIF accepted a contusion and abrasion, left knee, low back contusion and contusion and abrasion, right wrist.

Dr. Novak saw claimant on July 12, 1996 for a closing examination. He found, among other things, chronic low back pain, presently stable, a resolved and stable head contusion, and knee pain, basically stable. (Ex. 4). In subsequent correspondence, Dr. Novak indicated that claimant's accepted conditions were all medically stationary on July 12, 1996, that she was capable of returning to her regular work and that she suffered no permanent impairment as a result of the accepted conditions. (Ex. 5).

On January 6, 1997, SAIF issued a Notice of Closure which awarded temporary disability through July 12, 1996 but no permanent disability. On March 4, 1997, claimant requested reconsideration and a medical arbiter examination.

The Department did not schedule an arbiter's examination. Instead, on March 25, 1997, it issued an Order on Reconsideration finding inadequate closing information and rescinding the Notice of Closure. SAIF requested reconsideration of the Order on Reconsideration asserting that Dr. Novak specifically found claimant to be medically stationary without permanent impairment. On reconsideration, the Appellate Reviewer declined to correct or amend the March 25, 1997 Order on Reconsideration.[1]

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[1] Specifically, the Appellate Reviewer explained the Department's position as follows:

"[T]here is insufficient information to determine impairment, and thus, the claim was prematurely closed in accordance with OAR 436-030-0020(1) through (4). A physician's response to a "check-the-box" type document is not considered sufficient information to determine impairment. Dr. Novak has failed to provide any objective findings in which to determine impairment. Additionally, a statement that he believes the worker has not suffered any permanent impairment as a result of the accepted conditions, without supporting documentation, is deficient." (Ex. 11).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that the Appellate Reviewer was correct in setting aside the Notice of Closure because Dr. Novak's closing examination did not describe findings of impairment due to the compensable injury. On review, SAIF argues that the Department and the ALJ lacked the authority to rescind the Notice of Closure based on inadequate closing information where claimant's attending physician indicated that all accepted conditions were medically stationary on July 12, 1996 and that claimant was capable of performing her regular job duties. We agree with SAIF.

Subsequent to the ALJ's order, we held in Estella M. Rogan, 50 Van Natta 205 (1998), that the Department is not authorized to set aside a carrier's closure notice as premature on the basis that the insurer did not obtain adequate closing information pursuant to OAR 436-030-0020(1) through (4). There, the carrier closed the claimant's claim by Notice of Closure based on the attending physician's declaration that the claimant's condition was medically stationary without permanent residuals. On reconsideration, the Department rescinded the closure notice reasoning that, because no closing examination had been performed, the carrier did not obtain adequate closing information. The ALJ affirmed the Order on Reconsideration. On review, we reversed, finding that neither the statutes nor the rules require a closing examination report as a prerequisite for issuance of a carrier's closure notice.

In reaching this conclusion, we explained that ORS 656.268(4)(a) sets forth only two prerequisites for a carrier's claim closure. The claim may be closed when: (1) the worker's condition has become medically stationary and the worker has returned or been released to work; or (2) the accepted injury is no longer the major contributing cause of the worker's combined or consequential condition. We reasoned that because a closing examination report is not a condition precedent to issuance of a closure notice, the absence of such a report was not grounds for setting aside a closure notice as "premature." We also noted that, to the extent OAR 436-030-0020(4)(a) could be read to require a closing examination prior to issuance of a valid closure notice, the rule exceeds the terms of ORS 656.268 and should be given no effect. 50 Van Natta at 205.

Here, it is undisputed that claimant's attending physician, Dr. Novak, declared her accepted conditions medically stationary and released her for regular work prior to SAIF's issuance of the Notice of Closure. Thus, the statutory conditions precedent to issuance of the closure notice have been satisfied in this case.[2] See ORS 656.268(4)(a); see also OAR 436-030-0020(3). Because SAIF's Notice of Closure was authorized by statute, it shall be reinstated.

Unlike Rogan, however, claimant has also challenged other aspects of the Notice of Closure, including the impairment findings used to rate disability, and has specifically requested a medical arbiter examination.[3] For reasons not apparent from the record (but likely because it found the claim had been prematurely closed), the Department did not appoint a medical arbiter. While we lack the authority to remand this matter to the Department for appointment of a medical arbiter, see Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993), claimant is statutorily entitled to a medical arbiter report because she timely disagreed with the impairment findings used to rate her disability. See ORS 656.268(7)(a); see also Juan Ramirez, 49 Van Natta 2117 (1997); Linda M. Cross, 45 Van Natta 2130 (1993). Accordingly, as we did in Ramirez and Cross, we must fashion a remedy which accommodates both the Pacheco-Gonzalez decision and claimant's statutory right to a medical arbiter's report.

Under the circumstances of this case, we conclude that the best remedy is to remand the case to the ALJ for deferral pending receipt of a medical arbiter's report pursuant to ORS 656.268(6)(e). The parties shall be responsible for contacting the Director to make arrangements for the appointment of a medical arbiter and preparation and submission of a medical arbiter's report. When the parties are ready to proceed to hearing on claimant's other challenges to the Notice of Closure (including consideration of the medical arbiter's report), they shall contact the ALJ. Thereafter, the ALJ shall conduct further proceedings in any manner that achieves substantial justice.

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[2] Although bound by principles of stare decisis to follow the Board's holding in Estella M. Rogan, Member Hall disagrees with that decision as a matter of law. Under the factual circumstances of this case, however, Member Hall agrees that remand for a medical arbiter examination is an appropriate remedy.

[3] Claimant checked "yes" objecting to every aspect of the Notice of Closure. (Ex. 8).

ORDER

The ALJ's order dated September 24, 1997 is reversed. The Order on Reconsideration's rescission of the Notice of Closure is reversed. The ALJ's attorney fee award is also reversed. This case is remanded to ALJ Stephen Brown for further proceedings consistent with this order.

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March 26, 1998 Cite as 50 Van Natta 510 (1998)

In the Matter of the Compensation of
**RAY SEAMSTER, Claimant**
WCB Case No. 97-02904
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock, and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Neal's order that upheld the insurer's denial of claimant's claim for a vascular disease condition on the ground that the claim was barred by res judicata. On review, the issue is res judicata.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated July 25, 1997 is affirmed.

**Board Member Hall dissenting.**

I realize that by adopting and affirming the ALJ's order, the majority's decision has no precedential value. However, I feel compelled to dissent because I find that the ALJ committed an error of law in determining that claimant is barred by claim preclusion from litigating the compensability of his vascular disorder.

Here, claimant was diagnosed with and filed a claim for bilateral pes planus. On April 12, 1996, the insurer issued a denial that explicitly denied the bilateral pes planus condition as not related to claimant's work activities. (Ex. 4). Claimant requested a hearing on that denial. Subsequently, but before the July 22, 1996 hearing date, claimant was diagnosed with peripheral vascular disease. Following closure of the hearing record regarding compensability of the pes planus condition, claimant withdrew his hearing request. On August 19, 1996, a prior ALJ issued an order dismissing claimant's hearing request. Subsequently, claimant filed the current claim for his vascular disorder. On April 4, 1997, the insurer denied the vascular disorder claim, contending that the claim was barred by the prior hearing and it did not arise out of and in the course of claimant's employment. (Ex. 17).

A plaintiff who has prosecuted one action against a defendant through to a final judgment is precluded by "claim preclusion" from prosecuting another action against the same defendant where the claim in the second action is based on the same factual transaction that was at issue in the first, and where the plaintiff seeks a remedy additional or alternative to the one sought in the first, and is of such a nature as could have been joined in the first action. Drews v. EBI Companies, 310 Or 134, 140 (1990). Claim preclusion does not require actual litigation. Where, as here, the April 1996 denial became final because claimant withdrew his request for hearing, he may not litigate the same claim or claims which arise from the same transaction or series of transactions.

On the facts of this case, I find that the vascular disorder condition is not barred by claim preclusion. Contrary to the ALJ's finding, the vascular disorder does not simply represent a different diagnosis for the same condition. Instead, it is an entirely separate condition from the pes planus condition the insurer explicitly denied in April 1996. Thus, here, there are two separate "claims" because there are two separate "conditions."

At first glance these claims may appear to arise from the same "series of transactions," but closer examination shows they do not. The following example illustrates my point. If a claimant brought a claim for pes planus, based on years of work activity, and finality attached a decision determining that that claim was not compensable, that decision would not preclude the claimant from later bringing a claim for lumbar disc disease arising out of the same years of employment, even assuming the second condition had been diagnosed at the time of the prior decision.

This is not a case of a claimant asserting a second claim relating to the same condition by another legal theory. Million v. SAIF, 45 Or App 1097 rev den 289 Or 337 (1980) (claimant precluded from bring a second action regarding compensability of a shoulder surgery on an occupational disease theory where prior litigation on an injury theory determined that the same shoulder surgery was not compensable). Here, the second claim is an entirely separate condition. Furthermore, this separate claim for a vascular disorder was not included in the insurer's first denial.

Accordingly, I would find that claimant was not barred from litigating compensability of the vascular disorder condition. However, the record is insufficient to proceed to the merits on review.

The parties agreed to have the ALJ decide the procedural issue (claim preclusion) before proceeding to the merits, and the ALJ decided the case on the procedural issue. However, the record contains no transcript. Therefore, it is unclear whether the parties intended to submit any testimony or additional evidence. Under these circumstances, I would find the record insufficiently developed and remand the case to the ALJ for proceedings on the merits of compensability of the vascular disorder condition. ORS 656.295(5).

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March 25, 1998 Cite as 50 Van Natta 511 (1998)

In the Matter of the Compensation of
**RICHARD N. HAAG, Claimant**
WCB Case No. 97-01422
CORRECTED ORDER ON REVIEW
Richard A. Sly, Claimant Attorney
Robert E. Nelson, Attorney
Alice M. Bartelt (Saif), Defense Attorney

It has come to our attention that, due to a clerical error, our February 23, 1998 Order on Review does not correctly identify the ALJ's order. Our order indicates that the ALJ's order "dated January 26, 1995" is affirmed. The correct date of the ALJ's order is July 31, 1997. Because our February 23, 1998 order does not correctly identify the ALJ's order, we find it appropriate to issue this order to clarify our decision.

Accordingly, we withdraw our February 23, 1998 order. On reconsideration, as corrected herein, we republish our February 23, 1998 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**GEORGE W. WALLER, Claimant**
Own Motion No. 97-0090M
ORDER POSTPONING ACTION
ON REVIEW OF CARRIER CLOSURE
Parker, Bush & Lane, Claimant Attorneys

Claimant has requested Board review of the self-insured employer's January 21, 1998 Notice of Closure, which closed his claim with an award of temporary disability compensation from February 17, 1997 through January 8, 1998. The employer declared claimant medically stationary as of January 8, 1998. Claimant contends he is entitled to additional benefits beyond January 8, 1998.

In response to our request for evidentiary documentation from the employer, the employer submits a new recommendation form and a copy of a denial denying claimant's current degenerative lumbar disc disease. Claimant has requested a hearing with the Hearings Division. (WCB Case No. 98-02059). The Board is unaware of the specific issues submitted for the hearing, however, "denial" and "compensability" are apparently being litigated. Should the Administrative Law Judge (ALJ) find that claimant's current degenerative lumbar disc disease is a compensable portion of his 1979 injury claim, the finding could have an effect on the Board's review of the carrier's closure of the claim. Thus, we conclude that it would be in the best interest of the parties to postpone action on this own motion matter until the pending litigation has been resolved.

Therefore, we defer action on this request for own motion relief and request that Administrative Law Judge (ALJ) Otto, who is scheduled to conduct the hearing in WCB Case No. 98-02059 on June 3, 1998, submit a copy of the hearing order to the Board. In addition, if the matter is resolved by stipulation or disputed claim settlement, the ALJ is requested to submit a copy of the settlement document to the Board. After issuance of the order or settlement document, the parties should advise the Board of their respective positions regarding own motion relief.

IT IS SO ORDERED.

In the Matter of the Compensation of
**NICOLAS GARCIA-GUERROERO, Claimant**
WCB Case No. 97-05228
ORDER ON REVIEW
Darris K. Rowell, Claimant Attorney
Garrett, Hemann, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Baker's order that affirmed an Order on Reconsideration that awarded no unscheduled permanent disability for a cervical and thoracic strain injury. On review, the issue is extent of unscheduled permanent disability.

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

As the ALJ found, the applicable standards require repeat measurements of spinal ranges of motion for consistency. In this regard, the standards provide that "[v]alidity shall be established for findings of impairment according to the criterion noted in the **AMA Guides to the Evaluation of Permanent Impairment, 3rd Ed., Rev., 1990.**"[1] OAR 436-035-0007(27), Admin. Order 96-072 (eff. 2/15/97). Furthermore, Bulletin 242 establishes the same method for determining validity of spinal ranges of motion as provided in the AMA Guides. See Jeana Larson, 48 Van Natta 1278 (1996) (Board upheld the validity of Bulletin 242, reasoning that the Director's bulletin established the same method for determining validity of lumbar flexion as provided in the AMA Guides, with the additional requirement that the examiner note in his or her report any measurements that do not meet the validity criterion). That method requires at least three consecutive measurements of mobility which must fall within plus or minus ten percent or five degrees (whichever is greater) of each other to be considered consistent.

OAR 436-035-0007(27) also 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. When findings are determined invalid, the findings shall receive a value of zero."

As the ALJ found, there is no evidence that Dr. Jura, claimant's attending physician, performed the repeat measurements of spinal ranges of motion for consistency as required by the standards. (Ex. 11). On the other hand, Dr. Becker, the medical arbiter, performed repeat measurements, enumerated wide fluctuations among repeat measurements, and explained why the findings were invalid. (Ex. 19). Thus, we agree with the ALJ that Dr. Becker's opinion persuasively establishes that claimant has no ratable impairment.

ORDER

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

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[1] Although OAR 436-035-0007(27) provides some exceptions to determining validity, none of those exceptions apply to this claim.

In the Matter of the Compensation of
**DAVID E. HORTON, Claimant**
WCB Case No. 97-01863
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Zimmerman, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that upheld the insurer's denial of claimant's current right knee condition. On review, the issues are the procedural propriety of the denial and, if the denial is proper, compensability. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's findings of fact. We summarize the relevant findings of fact as follows.

Claimant is a 36-year-old former security guard, who has a long-standing history of right knee problems. He first injured his knee in 1977, while playing high school football. As a result of the 1977 injury, claimant had surgery which resulted in the total removal of his medial and lateral menisci. Over the next two years, he recovered well, and played football during his senior year of high school.

In June 1991, claimant compensably reinjured his right knee while employed at a gas station. Claimant underwent arthroscopic debridement in September 1991, performed by Dr. Karmy, an orthopedic surgeon. He apparently returned to modified work within two to three weeks of the surgery. He continued to undergo physical rehabilitation, however, and was fitted with a knee brace. In December 1991, he continued to experience knee pain, but was medically stationary and capable of continued modified work.

In June 1992, claimant was walking with a prominent limp. Over two months later, he experienced severe right knee pain and had to stay in bed most of the time. Dr. Karmy treated claimant with medications and continued to restrict him to light work.

In March 1993, claimant walked up some stairs at work and experienced pain and swelling in his right knee. After his shift, he obtained treatment at a hospital emergency room. He was limping and had obvious swelling. He was treated conservatively.

In October 1995, claimant was examined by Dr. Jollo, an osteopath, for burning pain on the inside of his right knee.

Claimant began working for the employer in October 1996. Shortly thereafter, he experienced increased right knee pain and returned to Dr. Karmy for an examination. His security guard duties required him to regularly walk around the premises. On November 25, 1996, he slipped and heard his right knee pop. After finishing his shift, he was examined by Dr. Knower, a physician, who diagnosed a sprain. Later that day, claimant filed a worker's compensation claim, which was accepted as a "right knee strain."

Thereafter, claimant began to treat with Dr. Holmboe, a physician. Holmboe diagnosed a torn medial meniscus and recommended arthroscopic surgery. On February 21, 1997, claimant was examined, on behalf of the insurer, by Dr. James.

On February 25, 1997, the insurer denied the compensability of claimant's current right knee condition on the ground that the injury had combined with claimant's preexisting degenerative condition and that the major contributing cause of claimant's current condition and need for treatment was the preexisting condition. On that same day, the insurer issued a Notice of Closure which awarded a period of temporary, but no permanent, disability.

## CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that claimant has requested that we take administrative notice of the June 6, 1997 Order on Reconsideration. Because it is an agency order and meets the standard for administrative notice, we grant claimant's request and take notice of the order. See Groshong v. Montgomery Ward Co., 73 Or App 403 (1985).

The ALJ found that ORS 656.262(7)(b) and 656.262(6)(c) did not apply since there was no acceptance of a combined condition and no evidence of a change in the condition. However, the ALJ found that the denied condition was separable from the accepted strain condition. On this basis, the ALJ concluded that the insurer's denial was not an impermissible preclosure denial.

Because we find, for the reasons set forth below, that the insurer's "preclosure" current condition denial was procedurally invalid, we do not address the substantive merits of the denial.

Pursuant to ORS 656.262(7)(b), a "preclosure" denial is appropriate 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 the ALJ found, ORS 656.262(7)(b) is not applicable in this case, however, because the employer did not accept a combined condition.[1] See Robin W. Spivey, 48 Van Natta 2363 (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" and not a combined condition involving claimant's preexisting right knee condition.

Because ORS 656.262(7)(b) is inapplicable, the validity of the employer's "preclosure" denial is dependent upon whether the denial constitutes an attempt to limit future responsibility on an accepted claim before the extent of disability arising out of the accepted condition has been determined. If so, it is impermissible. See Roller v. Weyerhaeuser Co., 67 Or App 583, 586 (1984). Although there is no prohibition against issuing a preclosure denial of a condition separate from the accepted condition,[2] the employer may not issue a preclosure denial of a condition to which the accepted condition has contributed. Id.; see also Elizabeth B. Berntsen, 48 Van Natta at 1223 (a carrier may not deny further responsibility for any condition arising from the accepted claim while the claim is in open status and before the extent of permanent disability has been determined).

Here, the employer formally denied claimant's current disability and need for treatment asserting that the compensable injury had now combined with claimant's preexisting degenerative condition and that the preexisting condition was the major cause of the current condition and need for treatment. Therefore, although the employer did not accept a combined condition, it has denied claimant's current condition on the grounds the preexisting condition has combined with the injury and was the major contributing cause of claimant's current condition.

While a preclosure 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 (and a preponderance of the medical evidence establishes[3]), 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,

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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).

[2] See, e.g., Johnson v. Spectra Physics, 303 Or 49 (1987); Tattoo v. Barrett Business Services, 118 Or App 348 (1993) (carrier may issue a partial denial of an unrelated condition while an accepted claim is in open status); see also ORS 656.262(7)(a) (carrier may issue a denial of a new medical condition).

[3] Dr. James persuasively opined that the November 1996 injury is a material contributing cause of claimant's current condition. We find Dr. James' opinion to be more persuasive than that of Dr. Holmboe. See Somers v. SAIF, 77 Or App 259, 263 (1986) (when there is a dispute between medical experts, we rely on those medical opinions which are both well-reasoned and based on complete information). We are not persuaded by Dr. Holmboe, who has diagnosed a medial meniscus tear and surgery for that condition, but has not adequately explained why this surgery is necessary when the record establishes that claimant's medial meniscus has been previously surgically removed. In light of such circumstances, we find that claimant's accepted strain contributed to his need for treatment and disability of his current condition.

we find the employer's preclosure denial procedurally invalid and set it aside.[4] See Elaine M. Borgelt, 50 Van Natta 143 (1998) (a pre-closure denial of a "combined condition" was procedurally invalid where the carrier had accepted only a strain, and the carrier's denial suggested that the accepted injury had combined with a preexisting condition such that the accepted condition and the current condition were not separable).

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 $3,200, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated June 25, 1997 is reversed. The insurer's denial is set aside as procedurally invalid. The claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant's counsel is awarded an assessed fee of $3,200, payable by the insurer.

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[4] In making this determination, we express no opinion on the compensability of claimant's current condition, i.e., whether or not his accepted strain remains the major contributing cause of his disability and need for treatment.

**Board Member Moller specially concurring.**

I concur with the lead opinion's conclusion that the carrier's "pre-closure" denial is procedurally invalid. I write separately in order to express my agreement with the specially concurring opinion of Member Haynes in Elaine M. Borgelt, 50 Van Natta 143 (1998), a case cited herein by the lead opinion.

Further, I find support for the continued viability of the "pre-closure" denial doctrine in the subsequent processing of this matter. In this regard, I note that on reconsideration of the insurer's claim closure, the Appellate Review Unit of the Workers' Compensation Division declined to award permanent partial disability in reliance on the insurer's pre-closure current condition denial. Although the insurer correctly asserts on review that claimant is entitled to request a hearing to challenge the reconsideration order, the existence of that challenge coinciding with this compensability dispute highlights, rather than detracts from, the continued viability of the prohibition on pre-closure current condition denials.

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In the Matter of the Compensation of
**GRACIELA KASPRZYK, Claimant**
WCB Case No. 97-03018
ORDER OF ABATEMENT
Michael B. Dye, Claimant Attorney
Mannix, Nielsen, et al, Defense Attorneys

Claimant requests reconsideration of 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. On reconsideration, claimant argues that we should not have rejected the opinions of claimant's treating doctors, Drs. McNabb and Welch.

In order to consider claimant's motion, we withdraw our February 26, 1998 order. The employer is granted an opportunity to respond. To be considered, the employer's response must be filed within 14 days from the date of this order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**VICKI L. JONES, Claimant**
WCB Case No. 97-06492
ORDER ON REVIEW
Mitchell & Associates, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Brazeau's order that affirmed an Order on Reconsideration that increased claimant's scheduled permanent disability award from 5 percent (2.4 degrees) for loss of use or function of the left thumb, as awarded by a Notice of Closure, to 17 percent (25.5 degrees) for loss of use or function of the left hand. On review, the issue is extent of scheduled permanent disability.

We adopt and affirm the ALJ's order with the following correction and supplementation. The last sentence of the fifth paragraph of the ALJ's findings of fact is corrected to read as follows: "Dr. Mayhall, the medical arbiter, concluded that claimant was significantly limited in the ability to repetitively use the left hand due to a chronic and permanent medical condition arising out of the accepted injury." (Ex. 9-4).

In the last sentence of the fourth paragraph of the ALJ's findings of fact, the ALJ found that Dr. Wilson, treating surgeon, did not "specifically measure" two-point discrimination on the ulnar side of claimant's left thumb during his closing exam. The employer disagrees with that finding, contending that Dr. Wilson measured claimant's two-point discrimination on the ulnar side of the thumb as 4 mm. Admittedly, Dr. Wilson's closing exam is confusing regarding this measurement and can be read as the employer contends. (Ex. 7-1). However, even assuming Dr. Wilson reports claimant's two-point discrimination as the employer contends, for the reasons explained by the ALJ, we find the opinion of Dr. Mayhall, the medical arbiter, more persuasive.

The employer argues that Dr. Mayhall's opinion is unpersuasive because he mistakenly diagnosed claimant as sustaining an ulnar nerve laceration in her left thumb due to the work injury. We disagree.

The Department informed Dr. Mayhall that the accepted condition was a "[d]isabling left thumb laceration" and instructed him to determine "impairment due to the accepted conditions, including any direct medical sequelae." (Ex. 12-19). After reviewing the record provided by the Department and examining claimant, Dr. Mayhall gave his "impression" of claimant's condition. (Exs. 9-3, 12-17). This "impression" was listed in two parts, with each part beginning with a statement to the effect that claimant had sustained a laceration of the thumb and concluding with the effect of this laceration on the radial digital nerve and the ulnar digital nerve. (Ex. 9-3). Regarding effect on the ulnar nerve, Dr. Mayhall stated "neuropraxia noted." (Id.). Thus, contrary to the employer's argument, Dr. Mayhall did not mistakenly diagnose a laceration of the digital ulnar nerve.

The employer also contends that the ALJ erred in finding that claimant established a chronic condition impairment, contending that OAR 436-035-0010(5) provides for a chronic condition impairment value for certain body parts and the thumb is not one of those body parts. However, contrary to the employer's argument, Dr. Mayhall did not limit the loss of repetitive use to claimant's left thumb. Instead, Dr. Mayhall opined that claimant was significantly limited in the repetitive use of her left hand due to the accepted injury. (Ex. 9-4). Furthermore, Dr. Mayhall explained how the loss of sensation in the left thumb limited claimant's ability to use her left hand. Finally, Dr. Mayhall found that the impairment was "100% related to the subject injury." (Ex. 9-4). Thus, we find that claimant has established a chronic condition impairment in her left hand, which is one of the body parts capable of sustaining a chronic condition impairment under the standards. See OAR 436-035-0010(5)(c); German C. Ronquillo, 49 Van Natta 129 (1997) (where the claimant was unable to repetitively use his left hand due to an accepted left thumb injury, the Board awarded a chronic condition impairment for his left hand under former OAR 436-35-075(5)); compare James E. Smith, 44 Van Natta 2556 (1992), recon den 45 Van Natta 300 (1993) (the claimant was not entitled to a hand "chronic condition" award when impairment to a single finger could not be converted to a hand value and there was no medical evidence of chronic condition impairment to the hand).

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

ORDER

The ALJ's order dated November 26, 1997 is affirmed. For services on review, claimant's attorney is awarded a fee of $800, payable by the self-insured employer.

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March 27, 1998 Cite as 50 Van Natta 518 (1998)

In the Matter of the Compensation of
**CHRISTINE M. MULDER, Claimant**
WCB Case No. 97-07276
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Neal's order that: (1) determined that claimant was not entitled to temporary total disability (TTD) from August 18, 1997 to September 2, 1997; and (2) determined that the SAIF Corporation's claim processing was reasonable and proper. On review, the issues are temporary disability, penalties and attorney fees.

We adopt and affirm the ALJ's order with the following supplementation regarding claimant's issue preclusion argument.

The ALJ determined that the requirements of ORS 656.325(5)(b) were satisfied when, on August 18, 1997, SAIF ceased payments of TTD and began paying temporary partial disability (TPD) at the rate of zero.[1] On review, claimant contends that SAIF was barred from relitigating the temporary disability issue by issue preclusion. Claimant cites a prior ALJ's order that determined that SAIF did not properly comply with ORS 656.325(5)(b) when it previously ceased payment of TTD on December 20, 1996. (Ex. 10).

We are not inclined to address claimant's contention, given that her issue preclusion argument was not raised until closing argument. See Kenneth L. Devi, 48 Van Natta 2349 (1996), on recon 49 Van Natta 108 (1997) (declining to consider claim preclusion issue not raised at hearing or until closing argument, at the earliest). Even if we were to address the issue, we would reject claimant's contention.

A different period of temporary disability is at issue in this case (August 18, 1997 to September 2, 1997) than was at issue in the prior proceeding (entitlement to temporary disability after December 20, 1996). In addition, we have reversed the prior ALJ's order. See Christine M. Mulder, 50 Van Natta 521 (1998) (WCB 97-01430); see also Veronica L. Strackbein, 49 Van Natta 2019 (1997) (taking administrative notice of Board order in another case involving same claimant). Under such circumstances, we conclude that issue preclusion is not applicable.

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[1] ORS 656.325(5)(b) provides:

"If the worker has been terminated for violation of work rules or other disciplinary reasons, the insurer or self-insured employer shall cease payments pursuant to ORS 656.210 [temporary total disability] and commence payments pursuant to ORS 656.212 [temporary partial disability] when the attending physician approves employment in a modified job that would have been offered to the worker if the worker had remained employed, provided that the employer has a written policy of offering modified work to injured workers."

ORDER

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

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March 27, 1998 Cite as 50 Van Natta 519 (1998)

In the Matter of the Compensation of
**MARY K. PHILLIPS, Claimant**
WCB Case No. 97-00771
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that: (1) upheld the self-insured employer's denial of claimant's left knee injury claim; and (2) declined to assess a penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant worked for Express Services, a temporary worker agency. Express Services assigned claimant to work at a medical clinic. Claimant parked her car in a lot behind the clinic used by the staff. On December 3, 1996, because the clinic prohibited smoking cigarettes in the clinic, claimant went to her car to smoke. While returning to the clinic, claimant slipped and fell in the parking lot, resulting in a dislocation of her left knee cap.

The ALJ decided that, because Express Services, claimant's employer, did not control the parking lot where claimant fell, claimant's injury did not arise out, or occur in the course, of her employment. Consequently, the ALJ concluded that claimant did not prove a "compensable injury."

The ALJ did not address the parties' argument over whether the employer's denial was limited to "course and scope," as claimant contended, or included medical causation, as the employer asserted. On review, both claimant and the employer continue to contest the scope of the denial. Claimant also challenges the ALJ's reasoning and conclusion that claimant did not sustain a "compensable injury."

We first address the scope of denial issue. The denial states:

> "You have filed a claim for your left knee, which allegedly occurred on or about December 3, 1996, while you were employed with Express Services.
>
> "After a review of all information in your file, we find that your condition did not arise out of or in the course and scope of your employment, either by accident or occupational disease within the meaning of the Oregon Workers' Compensation law. Therefore, without waiving further questions of compensability, we must deny your claim."

According to claimant, the denial provides only that claimant's injury was not in the "course and scope" of employment and the employer is "bound by the express language of its denial" pursuant to Tattoo v. Barrett Business Services, 118 Or App 348 (1993). The employer responds that, by denying that claimant's injury "did not arise out of" employment, its denial also included the defense of medical causation. We agree with the insurer.

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(7)(a). Similarly, an "occupational disease" is "any disease or infection arising out of and in the course of employment[.]" ORS 656.802(1)(a).

The denial mimics the language in these statutes by stating that claimant's condition "did not arise out of or in the course and scope of" employment, either as an accident or occupational disease. Because of the similarity in language, we first construe the denial as asserting that claimant did not sustain a "compensable injury" or an "occupational disease." In analyzing ORS 656.005(7)(a), the court has stated that the "arising out of" language encompasses the concept of medical causation. Tektronix, Inc. v. Nazari, 117 Or App 409, 411, mod 120 Or App 590 (1993). Consequently, because the denial asserts that claimant did not sustain a compensable injury or occupational disease, in part because her condition did not "arise out of" employment, we agree with insurer that its denial included medical causation.[1]

The only evidence in the record addressing medical causation shows that claimant had a preexisting left knee condition and such condition was the major contributing cause of her need for treatment and disability. (Exs. 13, 14). Consequently, claimant failed to prove compensability. See ORS 656.005(7)(a)(B).

Having decided that claimant did not carry her burden of proving medical causation, we need not address whether she was injured "in the course of" her employment. Finally, because there are no "amounts then due," claimant is not entitled to a penalty. See ORS 656.262(11)(a).

ORDER

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

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[1] We acknowledge, as the dissent discusses, the application of OAR 438-005-0055 to this case. Nonetheless, claimant did not challenge the denial as lacking "specificity." Rather, she asserted that the denial did not extend to a contention that claimant's condition was not causally related (on a medical basis) to the work incident. More importantly, claimant did not seek a continuance of the hearing in the event that the ALJ determined that the denial extended to "medical causation." Inasmuch as the remedy for a "non-specific/clarified" denial would have been to request a continuance of the hearing, claimant's failure to make such a request and to accede to the closure of the record moots the effect, if any, OAR 438-005-0055 would have had on this case.

**Board Member Biehl dissenting.**

I concur with the majority's reasoning and conclusion that the scope of the employer's denial generally includes the defense of medical causation. The majority fails to discuss, however, the effect of OAR 438-005-0055. The rule provides, in part, that, "[i]n addition to the requirements of ORS 656.262, the notice of denial shall specify the factual and legal reasons for denial[.]" (Emphasis added.)

This rule requires more specificity of the reasons underlying a denial than contained in the employer's denial. The denial provides only that claimant's "condition did not arise out of or in the course and scope of your employment, either by accident or occupational disease within the meaning of Workers' Compensation Law." On its face, such language does not specify that the employer is denying the claim because of insufficient medical evidence that claimant's condition was caused by an accidental injury or occupational disease. The ambiguity of such language is shown by the fact that the majority must resort to case law in deciding that the term "arising out of" employment includes medical causation.

In short, "arising out of" employment is simply too general to meet the requirement of our rule that the denial "specify" the legal reasons for the denial. For this reason, I would find the denial limited to "course and scope."

In the Matter of the Compensation of
**CHRISTINE M. MULDER, Claimant**
WCB Case No. 97-01430
CORRECTED ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Poland's order that: (1) determined that it improperly terminated temporary total disability on December 20, 1996 pursuant to ORS 656.325(5)(b); and (2) awarded claimant a 25 percent penalty based on SAIF's allegedly unreasonable claim processing. On review, the issues are temporary disability, penalties and attorney fees. We reverse.

## FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" with the following supplementation. Dr. Dordevich approved the job description for the position of "Light Duty Researcher" on December 20, 1996. (Ex. 20).

## CONCLUSIONS OF LAW AND OPINION

Applying ORS 656.325(5)(b), the ALJ determined that SAIF improperly terminated claimant's temporary total disability (TTD) and began paying temporary partial disability (TPD) at the rate of zero on December 20, 1996. The ALJ specifically found that the record did not establish that the employer had a written policy of offering modified work to injured workers when it ceased paying TTD on December 20, 1996, after claimant's employment was terminated for disciplinary reasons. Thus, the ALJ concluded that SAIF was not entitled to "cease payments" of TTD pursuant to ORS 656.325(5)(b). In addition, the ALJ assessed a 25 percent penalty, finding that SAIF did not reasonably believe that the employer had a written policy of offering modified work when it terminated payment of TTD.

On review, SAIF contends that all the requirements of ORS 656.325(5)(b) were satisfied when it ceased payment of TTD on December 20, 1996 and, thus, that its claim processing was legally proper and reasonable. For the following reasons, we agree.

ORS 656.325(5)(b) provides:

> "If the worker has been terminated for violation of work rules or other disciplinary reasons, the insurer or self-insured employer shall cease payments pursuant to ORS 656.210 [temporary total disability] and commence payments pursuant to ORS 656.212 [temporary partial disability] when the attending physician approves employment in a modified job that would have been offered to the worker if the worker had remained employed, provided that the employer has a written policy of offering modified work to injured workers."

Pursuant to the above statute, when an injured worker who is otherwise entitled to temporary total disability is fired for violating a work rule or other disciplinary reasons, the carrier may cease paying TTD and begin paying TPD. However, this may not occur until the attending physician approves the modified job that would have been offered to the worker had he or she remained employed. In addition, the employer must have had a written policy of offering modified work to injured workers. Although the ALJ found that the employer did not have a written policy of offering modified work, we conclude otherwise.

On May 5, 1997, SAIF submitted a written modified work policy for inclusion in the record. (Ex. A). The document is undated except for an April 23, 1997 date stamp showing when SAIF received the written policy. At the hearing, SAIF's counsel showed claimant's supervisor, Mr. Chimienti, the written policy and inquired whether the policy was in effect on December 19, 1996, when claimant's employment was terminated. Mr. Chimienti replied that it was. (Tr. 79). The ALJ discounted Mr. Chimienti's testimony because he testified that he could not say how long the policy had been in effect. However, we are persuaded that Chimienti's unrebutted testimony establishes that the employer had a written modified work policy in place when claimant's employment was terminated.

Claimant argues that Chimienti's testimony is deficient because he did not say that a written policy was in existence at the time of claimant's firing, only that a policy was in place. We reject claimant's argument because SAIF's counsel showed Chimienti the written policy. (Tr. 78). Under such circumstances, we find that Chimienti was referring to the written policy when he confirmed that the modified work policy was in existence.[1]

Claimant also cites her testimony and that of a co-worker (Kusma) in support of her argument that a written policy was not in effect when she was fired. Claimant testified that the modified work policy was not in her personnel file and Kusma testified that he saw the policy in discussions with SAIF's counsel. (Trs. 31, 59). We do not find that this testimony proves that the employer did not have a written policy in place on December 20, 1996, when SAIF ceased payment of TTD.

Kusma also testified that he was shown many documents when he was hired and that the policy "would have been one of them." (Tr. 59). Although he could not say that he definitely saw the written policy prior to discussions with SAIF's counsel, Kusma's testimony does not significantly contradict Chimienti's testimony. Moreover, we do not find that the employer's alleged failure to include the written policy in claimant's personnel file proves that the policy did not exist on December 20, 1996, in light of Chimienti's credible testimony directly addressing the existence of the written modified-work policy.

In Deanna L. Rood, 49 Van Natta 285, 286 (1997), we held that, in order for a carrier to cease paying TTD pursuant to ORS 656.325(5)(b), the attending physician must approve the same modified job that would have been offered to the worker had the worker not been terminated. We found that it is not sufficient for the attending physician to merely release the worker to modified employment; the physician must review and consent to the specific modified job.

Although claimant contends that the attending physician, Dr. Dordevich, had not approved the modified job when she was called back to work on December 19, 1996, we find the portion of the statute requiring specific approval of the modified job was satisfied. Dr. Dordevich approved the modified job on December 20, 1996. (Ex. 10-2). The actual cessation of temporary total disability under ORS 656.325(5)(b) does not correspond to the date of employment termination, but rather does not occur until "the attending physician approves employment in a modified job that would have been offered to the worker if the worker had remained employed...." See Ricardo Chavez, 50 Van Natta 90 (1998). Although Dr. Dordevich had not approved the modified job on the date claimant was terminated (December 19, 1996), he had approved the modified job on December 20, 1996, the date that SAIF "ceased payments" of TTD. Accordingly, we conclude that SAIF complied with this portion of the statute as well.

Finally, claimant contends that the modified job was not a legitimate position, citing Douglas B. Organ, 49 Van Natta 198 (1997). In Organ, we found that the claimant's light duty position at a skills-center training site was not sufficiently related to the claimant's employment as a construction carpenter to constitute modified "employment."

In contrast to Organ, where the record did not establish that the modified work significantly benefited the employer, we accept Chimienti's testimony that the light duty research position was of assistance to the employer's marketing of the bronze sculptures it produced. (Tr. 96). Thus, we conclude that the modified job in this case was legitimate.

In conclusion, we find that the requirements of ORS 656.325(5)(b) were satisfied when SAIF ceased payment of TTD. Thus, we find that SAIF's claim processing was proper. Because the ALJ concluded otherwise, we reverse.[2]

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[1] Claimant argues that Chimienti was not a credible witness, citing alleged inconsistencies in his testimony on other matters. We do not find that the alleged inconsistencies materially affect Chimienti's credibility with respect to his testimony regarding the existence of a written modified work policy.

[2] In light of our conclusion that SAIF's termination of TTD was proper, it follows that SAIF's claim processing was reasonable. Accordingly, we also reverse the ALJ's penalty assessment.

ORDER

The ALJ's order dated July 9, 1997 is reversed. The ALJ's temporary disability and penalty awards are reversed.

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March 27, 1998 Cite as 50 Van Natta 523 (1998)

In the Matter of the Compensation of
**SUSANNE TRACY, Claimant**
WCB Case Nos. 97-05449 & 97-05372
ORDER ON REVIEW
Bischoff, Strooband, et al, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that affirmed an Order on Reconsideration that awarded 21 percent (28.35 degrees) scheduled permanent disability for loss of use or function of the left foot (ankle). On review, the issue is extent of scheduled permanent disability.

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

The employer argues that the ALJ should have relied on the opinion of claimant's attending physician in rating claimant's permanent impairment. We disagree. On this record, we find the evaluation of Dr. Bitter, the medical arbiter to be the most thorough, complete and well-reasoned evaluation of claimant's injury-related impairment. Accordingly, we agree with the ALJ's use of Dr. Bitter's findings to rate claimant's impairment. See Kenneth W. Matlack, 46 Van Natta 1631 (1994).

Further, we are persuaded that claimant's compensable injury extended to her left ankle. We note in this regard that Dr. Worland initially described claimant's injury as a "burn to her left leg" (Ex. 7), and Dr. Naugle reported the injury as involving the "entire anterior foot and ankle" (Ex. 6-3).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review 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 September 10, 1997 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the employer.

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In the Matter of the Compensation of
**DENNIS RAUSCHERT, Claimant**
WCB Case No. 97-02000
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Schultz's order that: (1) set aside its denial of claimant's aggravation claim for left carpal tunnel syndrome; and (2) set aside its denial of claimant's "new medical condition" claim for right carpal tunnel syndrome. On review, the issues are aggravation and compensability. We reverse in part, modify in part, and affirm in part.

## FINDINGS OF FACT

We adopt the ALJ's findings with the following correction: the March 7, 1994 Determination Order awarded 3 percent scheduled permanent disability for the left wrist/hand.

## CONCLUSIONS OF LAW AND OPINION

### Aggravation

On review, the insurer challenges the ALJ's conclusion that claimant has established a compensable aggravation of his accepted left carpal tunnel syndrome. The ALJ's conclusion was based on the following: increased symptoms; the opinion of the treating physician, Dr. Weintraub, including his surgery recommendation; a positive Tinel's sign; a positive Phalen's maneuver; and positive nerve conduction studies. We agree with the insurer and reverse the ALJ's aggravation ruling.

After the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. ORS 656.273(1); SAIF v. Walker, 145 Or App 294, 305 (1996). A worsened condition is established by direct medical evidence of an actual worsening of the compensable condition supported by objective findings. Id. In order for a symptomatic worsening to constitute an "actual worsening," a medical expert must conclude that the symptoms have increased to the point that it can be said that the condition has worsened. Id.

Here, the ALJ concluded that claimant's increased symptoms established an actual worsening based on "persuasive medical opinion evidence that supports a conclusion that in a carpal tunnel cases [sic] 'the symptoms are the disease[.]'" However, claimant may not establish that his symptoms are the disease by relying on medical records and conclusions reached in other cases. Matthew R. Ross, 47 Van Natta 698 (1995). The medical record in this case must persuasively establish that there is no distinction between claimant's left CTS and his left wrist symptoms. Id. Here, no medical expert has opined, either directly or indirectly, that claimant's symptoms are the disease.

Nor has any medical expert concluded that claimant's symptoms have increased to the point that it can be said that his condition has worsened. The insurer's medical expert, Dr. Radecki, opined that there is no clinical evidence that claimant's left carpal tunnel syndrome has changed. Furthermore, nothing in Dr. Weintraub's opinion suggests that surgery is required to treat a worsening of claimant's underlying condition, as distinct from his increased symptoms. To the contrary, Dr. Weintraub opined that "[claimant's] symptoms have worsened and that is why he has sought treatment again[.] I do not think actual worsening of the condition can be substantiated easily[.]"

Moreover, the record does not otherwise contain persuasive direct medical evidence of a worsened condition. Claimant's positive Tinel's sign is not evidence of such a worsening as he demonstrated that finding when his claim was closed in 1994. Furthermore, claimant's positive nerve conduction studies in January 1997 are not evidence of a worsened condition because no baseline studies were performed prior to claim closure in 1994. The only objective finding that arguably supports a worsening is Dr. Weintraub's mention of a positive Phalen's maneuver on March 21, 1997. However, as discussed above, Dr. Weintraub does not relate this finding to a worsening of claimant's underlying condition. Moreover, claimant demonstrated a normal Phalen's maneuver when he was examined by Dr. Radecki in January 1997.

On this record, claimant has not experienced an actual worsening of his left carpal tunnel syndrome within the meaning of ORS 656.273(1). Accordingly, we conclude that claimant has not established a compensable aggravation of that condition.

Compensability of New Medical Condition

We adopt and affirm the ALJ's conclusions and opinion regarding compensability of claimant's "new medical condition" claim for right carpal tunnel syndrome.

Assessed Attorney Fees

The ALJ awarded claimant's attorney a $3,600 assessed fee for prevailing over the insurer's aggravation and new medical condition denials. In light of our reversal of the ALJ's aggravation ruling, claimant is not entitled to an attorney fee for services at hearing on the aggravation issue. However, claimant is entitled to a reasonable assessed fee for services at hearing and on review regarding the insurer's denial of claimant's "new medical condition" claim. ORS 656.386(1) and 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 these services is $3,200, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as presented by the hearings record, claimant's counsel's statement of services, and claimant's brief on review), the complexity of the issue, the risk that claimant's counsel might go uncompensated, and the value of the interest involved.

ORDER

The ALJ's August 25, 1997 order is affirmed in part, modified in part, and reversed in part. That portion of the ALJ's order that set aside the insurer's aggravation denial is reversed, and the aggravation denial is reinstated and upheld. In lieu of the ALJ's award of a $3,600 assessed attorney fee, claimant is awarded a $3,200 assessed fee for services at hearing and on review regarding the insurer's denial of claimant's "new medical condition" claim, to be paid by the insurer. The remainder of the ALJ's order is affirmed.

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March 31, 1998 Cite as 50 Van Natta 525 (1998)

In the Matter of the Compensation of
**DAVID C. THOMPSON, Claimant**
Own Motion No. 95-0646M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Michael A. Bliven, Claimant Attorney
Hoffman, Hart, et al., Defense Attorneys

Claimant requests review of the insurer's November 7, 1997 Notice of Closure which closed his claim with an award of temporary disability compensation from September 12, 1996 through October 29, 1997. The insurer declared claimant medically stationary as of October 29, 1997. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed. Additionally, claimant contends that his current acromioclavicular synovitis and chronic subacromial bursitis had not been processed and therefore, had been "defacto" denied. Claimant requested a hearing. (WCB Case No. 98-00217).

In a January 7, 1998 letter, we requested the parties to submit copies of materials considered in closing the claim. Upon submission of these materials, claimant was allowed 15 days to submit additional materials. The insurer submitted its response on January 19, 1998. On January 30, 1998, we issued an order postponing action until the pending litigation regarding the compensability of claimant's current acromioclavicular synovitis and chronic subacromial bursitis had been resolved.

Claimant submitted a copy of his March 2, 1998 "Response to Motion to Postpone/Motion for Summary Judgment/Written Argument (Opening)." In his motion(s), claimant contends the insurer, by a January 22, 1998 modified notice of acceptance, accepted claimant's current "acromioclavicular synovitis (early arthritis), and chronic subacromial bursitis with impingement of the shoulders,

bilaterally," as part of his 1986 claim. Claimant further contends that the only issue before the Hearings Division is claimant's attorney's entitlement to an assessed attorney fee and penalty.[1] On March 9, 1998, the insurer submitted its response to claimant's March 2, 1998 motion(s) and to our order postponing action. It also contends that with its acceptance of claimant's current acromioclavicular synovitis and chronic subacromial bursitis with impingement, there are no issues pending litigation which would affect our review of the insurer's Notice of Closure. We concur and, therefore, proceed with our review.

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/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 November 7, 1997 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12, (1980).

Claimant's claim was initially reopened on attending physician, Dr. Rusch's, recommendation to perform a partial excision of his left clavicle. This recommendation was based on a diagnosis of acromioclavicular arthritis in claimant's left shoulder. In a June 11, 1996 chart note, Dr. Rusch opined that claimant's left shoulder was medically stationary. A review of the record subsequent to the June 11, 1996 chart note, establishes that claimant's left shoulder continues to remain medically stationary and all further treatment involves only his right shoulder.

On June 19, 1996, claimant sought further treatment from Dr. Rusch with right shoulder complaints. Dr. Rusch diagnosed right shoulder pain due to acromiclavicular synovitis and chronic subacromial bursitis with impingement. After unsuccessfully treating claimant's right shoulder complaints with epidural injections and physical therapy, on September 3, 1996, Dr. Rusch performed a resection of the right distal clavicle and acromioplasty.[2] In an October 29, 1997 chart note, Dr. Rusch opined that "there are no further recommendations for curative treatment for his [claimant's] right shoulder." Dr. Rusch further opined that claimant's "subjective complaints, objective findings and limitations are likely to be permanent." Dr. Rusch's opinions are unrebutted.

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

Accordingly, we affirm the insurer's November 7, 1997 Notice of Closure in its entirety.

IT IS SO ORDERED.

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[1] In his motion(s), claimant erroneously interprets our order postponing action as a determination that the conditions he sought to be accepted were not medically stationary.

[2] Dr. Rusch's treatment of and surgery to claimant's shoulders, was based on the diagnosis of acromioclavicular arthritis and chronic subacromial bursitis with impingement. The fact that those conditions were not formally accepted until January 22, 1998, does not establish that they were not taken into consideration when Dr. Rusch opined that claimant was medically stationary.

# WORKERS' COMPENSATION CASES

Decided in the Oregon Supreme Court:



Decided in the Oregon Court of Appeals:

Cite as 326 Or 413 (1998) February 12, 1998

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Donna M. Wilson, Claimant.

**Donna M. WILSON**, *Petitioner on Review,*
v.
**STATE FARM INSURANCE** and James A. Dederer, CPA, *Respondents on Review.*
(WCB 94-10507; CA A90709; SC S43841)

On review from the Court of Appeals.*

Argued and submitted April 29, 1997.

G. Duff Bloom, of Coons, Cole, Cary & Wing, P.C., Eugene, argued the cause and filed the petition for petitioner on review.

Kenneth L. Kleinsmith, of Meyers, Radler, Replogle & Bohy, Tigard, argued the cause and filed the brief for respondents on review.

Before Carson, Chief Justice, and Gillette, Van Hoomissen, Graber, Durham and Kulongoski, Justices.**

VAN HOOMISSEN, J.

The decision of the Court of Appeals and the order of the Workers' Compensation Board are reversed. The case is remanded to the Workers' Compensation Board for further proceedings.

* Judicial review from the Workers' Compensation Board. 142 Or App 205, 920 P2d 181 (1996).

** Fadeley, J., retired January 31, 1998, and did not participate in this decision.

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326 Or 415> In this case, we review the compensability under the Workers' Compensation Law of an injury incurred by claimant when she "skip-stepped" around a corner within her workplace. The Workers' Compensation Board (Board) denied compensation on the ground that claimant's injury did not "arise out of" claimant's employment. ORS 656.005(7)(a).[1] The Court of Appeals affirmed without opinion. *Wilson v. State Farm Ins.*, 142 Or App 205, 920 P2d 181 (1996). The sole issue presented is whether claimant's injury arose out of her employment. We review for errors of law. ORS 183.482(8)(a). For the reasons that follow, we reverse and remand to the Board for further proceedings.

At the time of her injury, claimant was employed as a secretary for a certified public accountant (employer). Shortly before the end of her workday on a Friday afternoon, she asked her employer if she could leave work early. Her employer told her that she could leave early, after she transferred the office telephone to the answering service. As claimant walked from her employer's office to her work area, she "skip-stepped" around a corner.[2] In doing so, she tore her Achilles tendon, an injury requiring medical attention.

Claimant sought workers' compensation coverage for her injury. Employer's insurer denied the claim. An administrative law judge (ALJ) found that skipping was not an integral part of claimant's job and that skipping was not a risk connected with her employment. The ALJ further found that claimant's injury occurred independently of any physical conditions at work. The ALJ, therefore, concluded that claimant's injury did not "arise out of" her employment.

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

"A 'compensable injury' is an accidental injury * * * arising out of and in the course of employment[.]"

[2] The term "skip-step" originates from claimant's description of the injury before the administrative law judge. She described the "skip-step" as similar to a "little stutter step" that one might take when realizing that there is not enough room to take two steps.

The Board, with one member dissenting, affirmed, concluding that claimant's injury did not result from an act **<326 Or 415/416>** that was an ordinary risk of, or incidental to, her employment and, therefore, did not "arise out of" her employment. Accordingly, the Board held that claimant had failed to establish that her injury was compensable.[3]

On review, claimant argues that her injury arose out of her employment, because moving about in the workplace involves certain inherent work-related risks and "skip-stepping" around a corner was not so unusual as to take her injury outside the realm of work-related injuries.

For an injury to be compensable under the Workers' Compensation Law, it must "arise out of" and occur "in the course of" employment. ORS 656.005(7)(a); *Fred Meyer, Inc. v. Hayes*, 325 Or 592, 596, 943 P2d 197 (1997). Employer does not dispute that claimant was "in the course of" her employment at the time of her injury. Thus, the sole issue presented is whether claimant's injury "arose out of" her employment. "That inquiry tests the causal connection between the claimant's injury and a risk connected with her employment." *Fred Meyer*, 325 Or at 601 (citations omitted). In *Redman Industries, Inc. v. Lang*, 326 Or 32, 35-36, 943 P2d 208 (1997), this court stated:

> "In prior cases interpreting ORS 656.005(7)(a), this court has held that the inquiry into whether an injury 'arises out of employment' tests the causal connection between the injury and the employment. A causal connection requires more than a mere showing that the injury occurred at the workplace and during working hours. A causal connection must be linked to a risk connected with the nature of the work or a risk to which the work environment exposed claimant.
>
> "In some jurisdictions, courts have required not only that an injury be linked to a risk connected with employment, but also that the risk be 'peculiar to the employment' or that the employment 'increase [ ] the risk of injury.' However, this court has 'rejected "the largely obsolete 'peculiar-risk' and 'increased-risk' considerations" in assessing **<326 Or 416/417>** whether a worker's injury was linked to a risk connected with employment.'" (Citations omitted.)

Claimant's possible negligence in maneuvering around the comer is irrelevant. Workers' 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. One objective of the Workers' Compensation Law is to provide, *regardless of fault*, sure, prompt, and complete medical treatment for injured workers. *See* ORS 656.012(2)(a) (so stating); *see also Andrews v. Tektronix, Inc.*, 323 Or 154, 159-60, 915 P2d 972 (same); *Clark v. U.S. Plywood*, 288 Or 255, 259, 605 P2d 265 (1980) ("Contributory fault or contributory negligence is no defense to a claim for compensation benefits, unless due to 'the deliberate intention of the worker.' ORS 656.156(1).").

The Board reasoned:

> "Here, claimant was injured when she skipped around a corner at work. Other than the injury occurring on the employer's premises, we find no risk connected with claimant's employment. The employer did not contemplate or expect claimant to skip around the corner nor had he seen claimant skip in the office. Skipping was not the usual means for claimant to go to her office. The decision to skip was claimant's, not the employer's. Other than the fact that claimant was 'happy' because she could leave work early, there was no condition associated with her work to cause the injury." (Footnotes omitted.)

In a footnote, the Board stated:

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[3] The Board stated in its order that "the record does not persuasively establish that claimant was returning to her office to transfer the phones to the answering service." However, the Board affirmatively found that claimant was "on the way to her office" at the time of her injury. There is no evidence in the record that claimant's return to her office was anything other than work connected.

> "Claimant argues that 'locomoting' herself within the office to perform a specific job duty is within the ambit of conditions of employment. Perhaps, if claimant had used her usual means of ambulation, we may have agreed."

We find nothing in the Workers' Compensation Law, or in any of this court's cases interpreting it, to support the Board's underlying premise, *viz.*, that injuries are not compensable if the worker's method of carrying out a work-related activity--here, moving about the office during working hours while completing a work shift--is not a "usual" means of doing so. In *Clark*, 288 Or at 261, this court stated:

> **326 Or 418>** "Injuries sustained by a worker in doing the appointed task are normally compensate, absent self-inflicted injury. Contributory fault of the employee is no defense."

The fact that the employer did not contemplate or expect claimant to "skip-step" around the corner as she was walking to her work area does not undermine compensability. Certainly, employers cannot contemplate or expect every unusual means that a worker may use to accomplish various work-related tasks. For example, in *Andrews*, 323 Or at 163, the employer argued that, by disobeying the employer's instruction to avoid lifting heavy objects, the worker lost his entitlement to compensation. This court rejected that reasoning, stating:

> "[F]or purposes of determining whether a claimant's injury is *compensable*, his or her status as a worker does not depend on demonstrable submission to the employer's right of direction and control at the precise moment in time that the injury was sustained. This court's opinions on the issue of at-work 'horseplay' are a case in point: Employees who engage in on-the-job horseplay can hardly be said to be subject to the direction and control of their employers for the period of time that they are so engaged, yet injuries sustained in the course of horseplay may nevertheless be deemed to 'arise out of and in the course of employment.'" *Ibid.* (emphasis in original; citation omitted).

If an injury resulting from a *prohibited* method of accomplishing a task is compensable, *a fortiori*, an injury resulting only from an *unusual* method of doing so generally is compensable. In short, the fact that employer did not contemplate or expect claimant's precise method of rounding the corner as she returned to her office does not render her resulting injury noncompensable.

We conclude that claimant has satisfied the "arising out of" prong of the work-connection test by showing a causal link between her injury and her work. The "in the course of" prong was uncontested. Thus, claimant demonstrated her entitlement to compensation.

The decision of the Court of Appeals and the order of the Workers' Compensation Board are reversed. The case is remanded to the Workers' Compensation Board for further proceedings.

Cite as 151 Or App 510 (1997) December 17, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of James I. Weathers, Claimant.

**SAIF CORPORATION**, *Petitioner*, and DEPARTMENT OF CORRECTIONS, *Employer*,
v.
**James I. WEATHERS**, *Respondent*.
(93-09767; CA A93738)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 25, 1997.
Julene M. Quinn, Special Assistant Attorney General, argued the cause for petitioner. With her on the brief were Hardy Myers, Attorney General, and Virginia L. Linder, Solicitor General.
Victor Calzaretta argued the cause and filed the brief for respondent.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
WARREN, P. J.
Reversed and remanded for reconsideration.

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**151 Or App 512>** SAIF Corporation (SAIF) appeals an order of the Workers' Compensation Board affirming claimant's occupational disease claim for stress-related depression. The first question is whether the Board applied the correct legal standard; the second question is whether the Board correctly applied that legal standard to the facts. We review for errors of law and remand for further consideration.

Claimant began working for the Department of Corrections in September 1982. He suffered a compensable back injury in 1988, for which he received an award of permanent disability and vocational training for a new job. On May 20, 1990, claimant began a trial service period as a corrections counselor at the Santiam Correctional Institution (SCI). For the first two years he worked in an "underfilled" position, which means that he did not have the requisite training or experience at the time but would obtain the training and experience on the job. In July 1992, he was reclassified as a corrections counselor.

Also in July 1992, it was learned that several correction counselors would need to be transferred to another state institution in Portland. SCI was required to decide which employees to transfer because no counselors volunteered. It was understood all along that the transfers would be based on inverse seniority. However, the question arose whether claimant's time spent as an underfill employee would be counted in determining his seniority.

Claimant and the other corrections counselors are members of AFSCME, a public employee union. During this time, they were subject to a 1992-94 agreement between the State of Oregon, the Department of Corrections and the union. In July 1992, a personnel officer from the State Employee Services Division sent a memorandum to one of the corrections counselors, who might be affected by the transfer. In it, she wrote that workers would receive credit for their time spent in trial service pursuant to Article 44 of the employment contract. Claimant learned of the memorandum and its contents. Under Article 44, section 3, an employee was considered to be part of the classification for which he or **<151 Or App 512/513>** she was training when a layoff occurred and received credit for seniority for time spent in an underfill position. Additionally, seniority was defined as the employee's total length of continuous service with the agency. Based upon these initial communications, claimant assumed in 1992 that he would not be transferred.

In April 1993, with the deadline for transfer approaching, the manager of the employee relations unit for the Department of Corrections sent a letter to the AFSCME representative outlining the department's position on the seniority question. The department concluded that persons who were in an underfilled position would be considered to be in the classification for which they were training for purposes of the transfer.

The AFSCME representative took the opposite view. In June, she wrote back indicating that there was no reason to conclude that employees working in an underfilled position should be given credit for service in the classification for which they were training.

Despite the fact that the union's position was inconsistent with the position SCI had taken all along, SCI acquiesced in the union's position. Claimant was notified that he would be transferred to the Columbia River Correctional Institution in Portland effective July 20, 1993.

At this point, claimant became depressed. He began seeing a psychiatrist, who diagnosed a major episode of depression. Claimant filed this claim on July 27, 1993.

The claim was denied by SAIF on August 16, 1993. On review, the administrative law judge (ALJ) set aside SAIF's denial and remanded the claim to the insurer for processing. Specifically, the ALJ made the following findings:

> "Claimant was notified that he was being transferred by letter dated June 14, 1993 * * *. He was then sent a memo on July 19 indicating that the transfer would be effective July 20, 1994.[1] * * *
>
> **151 Or App 514>** "At this point, claimant became very depressed and stressed out as a result of the manner in which the transfer had occurred. He had been led to believe all along that he was at no risk for a transfer and then at the last minute the State changed its mind and transferred him in violation of the terms of his union contract. Accordingly, claimant returned to his psychiatrist, Dr. Mead, who[m] he had previously seen for treatment. Dr. Mead diagnosed a major episode of depression. Ultimately, claimant was taken off work and has not yet returned to work.
>
> "* * * * *
>
> "The major contributing stressor that Dr. Mead identifies as the cause of claimant's depression was the unreasonable transfer of claimant from SCI to CRCI."

The ALJ then issued the following conclusions and opinion:

> "Claimant must establish that the employment conditions that produced his stress existed in a real and objective sense, that there is a generally recognized diagnosis, that there is clear and convincing evidence that the disorder arose out of and in the course of employment, and that the condition which produced the disorder are conditions other than conditions generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluations actions by the employer, or cessation of employment or employment decisions attendant upon ordinary business or financial cycles.'
>
> "* * * * *
>
> "The employer acted unreasonably in leading claimant on to believe that he would not be subject to the transfer and then within a matter of days switched its position completely without any explanation and without any good reason to do so. The employer certainly had the opportunity to present evidence to explain its action. None of the witnesses were able to do so. As far as I can tell from this record, claimant is the only employee who has ever been treated in this manner in terms of not getting any credit for his underfill time. Claimant was not transferred by his union, although his union certainly did not do him any good in this instance. Claimant was transferred by his employer.
>
> "* * * * *

---

[1] The ALJ mistakenly identified the effective date as July 20, 1994. The record establishes the correct effective date as July 20, 1993.

**151 Or App 515>** "Here, claimant's stress was caused by the circumstances and manner of the lay-off and is, therefore, related to the employment relationship and can be considered a condition of employment."

The Board adopted and affirmed the ALJ's order, with supplementation. That supplementation centered on the unreasonableness of the transfer based on its conclusion that the transfer violated the terms of the union contract. The Board found:

> "In May 1992, the employer determined that, in order to meet anticipated changes in the State's post-prison release program, it would have to transfer two corrections counselor positions from its facility in Salem to its facility in Portland. The employer * * * notified its employees, via their public employees union, that, pursuant to its contract with the union, transfer of personnel to staff the relocated positions would be based on inverse seniority. In the interim (based on inverse seniority), two corrections counselors were temporarily transferred to Portland. Claimant was not one of the two.
>
> "On several occasions over the next year, claimant was advised that the total time performing the counselor job (including the two years underfilling that position) would be credited in calculating seniority. A representative for the union replied that underfill time should not be considered. The employer thereafter revised its seniority list and, on July 19, 1993, notified claimant that he was slated for permanent transfer to the Portland facility effective July 20, 1993.
>
> "Claimant became depressed by what he perceived as an unreasonable last minute decision to transfer him to Portland, and he sought treatment * * *."

The Board ultimately concluded:

> "Consequently, we conclude that, in light of the plain language of Article 44, the employer's actions in not crediting claimant with the total time he performed the counselor job (including the two years underfilling that position), were in violation of its legal contract and, thus, unreasonable."

**151 Or App 516>** The compensability of a mental disorder under Oregon's Workers' Compensation laws is governed by ORS 656.802, which provides, in part:

> "(3) Notwithstanding any other provision of this chapter, a mental disorder is not compensable under this chapter unless the worker establishes all of the following:
>
> "(a) The employment conditions producing the mental disorder exist in a real and objective sense.
>
> "(b) The employment conditions producing the mental disorder are conditions other than conditions generally inherent in every working situation 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.
>
> "(c) There is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community.
>
> "(d) There is clear and convincing evidence that the mental disorder arose out of and in the course of employment."

Here, the Board found, and SAIF does not now dispute, that claimant has a recognized mental disorder. SAIF makes four assignments of error on review. First, SAIF asserts that any mental disorder arising out of an employer's decision to transfer an employee is not compensable because it is not a condition of employment, but, in the alternative, if it is a condition of employment, it is one generally inherent in every working situation and, thus, not compensable. Second, SAIF argues that the Board erred in

addressing the question of whether employer's actions violated the terms of the contract, because the Board lacks jurisdiction to determine employment rights between a worker and an employer. Third, SAIF claims that the Board erred by determining the reasonableness of employer's actions based almost solely on whether employer's interpretation of the employment agreement was correct. And fourth, SAIF says that the Board erred in concluding that employer violated the contract. We address only the first assignment of error, as it is dispositive.

**151 Or App 517>** The first issue is whether the Board applied the correct test in concluding that claimant's depression was caused by an employment condition not generally inherent in every working situation. We hold that the Board articulated the correct test but erred in its application. In *Bogle v. Department of General Services,* 136 Or App 351, 901 P2d 968 (1995), we pointed out that "the circumstances or manner of possible layoff or job transfer are events intrinsic to the employment relationship[.]" Unusual stress related to those events, however, may produce a compensable illness. In *Elwood v. State Acc. Ins. Fund Corp.*, 298 Or 429, 433, 693 P2d 641 (1985), the Supreme Court stated that the line runs between illness resulting from the stress of actual or anticipated unemployment, which is not compensable, and illness resulting from the circumstances and manner of discharge, which can be regarded as events still intrinsic to the employment relationship before termination and can lead to compensation.

Thus, a transfer, in and of itself, is a condition generally inherent in every working situation. However, the manner and circumstances surrounding the decision to transfer, and how it is carried out, may result in a compensable mental disorder. Further, it is not a question of whether the employer, the union, or both caused claimant's illness; as long as the illness was caused by a condition of employment, and that condition is not generally inherent in every working situation, it is compensable. Thus, the Board was substantially correct in its articulation of the law.

However, the Board erred in its application of the law by relying almost wholly on its conclusion that employer violated the union contract. In fact, whether employer violated the contract is not determinative. For example, assuming that employer *did not* violate the union contract, claimant could still prevail on his claim. The Board could find that the employer led claimant to believe that he would not be transferred, and then at the last moment changed its position, and that those actions resulted in claimant's depression. Additionally, claimant was the only employee ever to be treated this way. The medical testimony could support a finding that those actions resulted in claimant's depression. The **<151 Or App 517/518>** employer's actions exist regardless of whether employer acted consistently with the terms of the contract.

The Board also relied on its finding that employer acted unreasonably. The test is whether the manner and circumstances of the transfer caused the mental illness and whether those circumstances are generally inherent in every transfer. The reasonableness of employer's conduct may be a factor when considering whether the circumstances of the transfer are generally inherent in every transfer and whether they affected claimant's perception of employer's actions, but reasonableness is not the test.

Although the Board, at times, alludes to the facts and circumstances surrounding the transfer as the cause of claimant's depression, we cannot assume that it would come to the same conclusion had it not relied on its belief that employer's actions were in violation of the contract. Accordingly, we remand for further consideration.

Reversed and remanded for reconsideration.

Cite as 151 Or App 531 (1997) December 17, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Fernandita Nichols, Claimant.

**OREGON LOX COMPANY** and EBI Companies, *Petitioners,*
v.
**Fernandita NICHOLS**, *Respondent.*
(WCB 96-01546; CA A96746)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 30, 1997.
Kenneth L. Kleinsmith argued the cause for petitioners. With him on the brief was Meyers, Radler, Replogle, Roberts & Miller.
G. Duff Bloom argued the cause for respondent. With him on the brief was Cole, Gary and Wing, P.C.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
RIGGS, P. J.
Affirmed.

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**151 Or App 533>** Employer seeks review of an order of the Workers' Compensation Board, contending that the Board erred in affirming an order of an administrative law judge (ALJ), which had affirmed the Appellate Review Unit's order on reconsideration increasing claimant's scheduled disability award for the left and right wrists. Employer asserts that the issue of the extent of claimant's scheduled disability was not properly before the Appellate Review Unit because, although claimant filed a request for reconsideration of employer's notice of closure, she did not specifically seek reconsideration of the scheduled disability award and therefore failed to preserve it. Employer asserts, therefore, that the Board should have reduced claimant's award to that made by the notice of closure. We conclude that, because employer did not make its argument at the hearing or before the Board, the challenge is waived and unpreserved. Accordingly, we affirm the Board.[1]

Claimant compensably injured her wrists while working in employer's salmon processing factory. Employer accepted a claim for bilateral carpel tunnel syndrome and overuse syndrome involving both hands, arms, shoulders and the neck. Employer issued a notice of closure of the claim with an award of five percent scheduled permanent partial disability for each wrist and no unscheduled disability. Claimant sought reconsideration of the notice of closure with the Appellate Review Unit of the Workers' Compensation Division of the Department of Consumer and Business Services. On the request form, claimant listed as issues her entitlement to temporary disability and to unscheduled permanent disability for the neck and shoulders. The matter was assigned to a medical arbiter pursuant to ORS 656.268(7) and, based on the findings of the medical arbiter, the Appellate Review Unit awarded claimant five percent unscheduled permanent disability and also increased claimant's scheduled permanent disability awards to 24 percent for the left arm and 16 percent for the right forearm. Claimant and **<151 Or App 533/534>** employer each requested a hearing, claimant seeking additional benefits for scheduled and unscheduled disability and employer asserting that the scheduled disability awards should be reduced. The ALJ reduced the left arm award to 22 percent and increased the right arm award to 18 percent, for a net increase in the scheduled awards of 6.72 degrees, and increased the unscheduled award to 19 percent.

Employer sought review of the ALJ's order, again contending that the awards for scheduled and unscheduled permanent partial disability should be reduced, and asserting for the first time that, "because claimant did not challenge scheduled permanent partial disability at the reconsideration proceeding, she cannot at the time of the hearing challenge scheduled permanent disability." Employer argued that, pursuant to ORS 656.268(8) and ORS 656.283(7), claimant was barred from asserting *at the*

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[1] There is no contention made by employer that the extent of disability is not supported by substantial evidence.

*hearing* that she was entitled to an increase in scheduled disability *over and above that awarded by the order on reconsideration,* and that the ALJ lacked jurisdiction over that issue and could only consider employer's assertion that scheduled disability should be reduced.[2] Employer conceded that it had not raised the issue at the hearing, but argued that because the issue was jurisdictional the Board should consider it.

The Board held that, assuming that claimant had not raised the issue of scheduled disability in her request for reconsideration, the question of claimant's entitlement to additional scheduled disability "arose out of the order on reconsideration" by virtue of the *sua sponte* award of additional scheduled disability and, hence, was subject to review by the ALJ pursuant to ORS 656.268(8). On the merits, the **<151 Or App 534/535>** Board affirmed claimant's awards and assessed an attorney fee.

We need not determine whether the Board was correct in its reasoning that the question of claimant's entitlement to additional scheduled disability over that awarded by the order on reconsideration arose out of the determination order. On judicial review, employer no longer challenges the awards directly or even contends that there is ajurisdictional defect. Further, it no longer challenges the ALJ's authority to order an increase in scheduled disability benefits over that made in the order on reconsideration. Rather, employer's only argument is that claimant failed to preserve her entitlement to additional scheduled disability *over and above the awards made by the notice of closure,* that the *Appellate Review Unit* therefore lacked authority to increase the awards and that the awards should therefore be reduced to the awards made *in the notice of closure.* The resolution of that issue must await another day, because it was not raised at the hearing or before the Board. *See Fister v. South Hills Health Care,* 149 Or App 214, 942 P2d 833 (1997).

Affirmed.

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[2] 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."

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"

Cite as 151 Or App 602 (1997) December 17, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Donna Goodman-Herron, Claimant.

**Donna GOODMAN-HERRON**, *Petitioner,*
v.
**SAIF CORPORATION** and Advanced Navigation & Positioning Corporation, *Respondents.*
(94-09926; CA A95833)

Judicial Review from Workers' Compensation Board.
Argued and submitted September 24, 1997.
Judy Danelle Snyder argued the cause for petitioner. With her on the brief were Daniel Snyder and Hoevet & Snyder, P.C.
David L. Runner argued the cause and filed the brief for respondents.
Nancy F. A. Chapman filed the brief *amicus curiae* for the Oregon Trial Lawyers Association.
Before De Muniz, Presiding Judge, and Deits, Chief Judge,* and Haselton, Judge.
DE MUNIZ, P. J.
Reversed and remanded for reconsideration.

* Deits, C. J., *vice* Richardson, S. J.

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**151 Or App 604>** Claimant seeks review of an order of the Workers' Compensation Board (Board) denying her claim for psychological injuries resulting from a sexual assault and subsequent sexual harassment by a coemployee. The Board held that claimant's injuries did not "arise out of' her employment. We review for errors of law and substantial evidence, ORS 656.298(6); ORS 183.482(7) and (8), and reverse and remand.[1]

In January 1994, claimant began working for employer, with Hirsch acting as her supervisor. In March 1994, Hirsch, claimant and other coworkers traveled to Quantico, Virginia to meet with customers. Claimant's hotel room contained a computer, printer, paper and other materials used during meetings with customers. In the evenings, Hirsch and claimant would return to claimant's room and prepare presentations for the following day.

On March 8, 1994, following a business dinner, Hirsch and claimant returned to claimant's hotel room to prepare for meetings the next day. After finishing her work, claimant took some pain medication for her neck, later falling asleep while watching television. During this time, Hirsch continued to work in claimant's room. Later, claimant awoke to find Hirsch sexually assaulting her. Afterward, Hirsch convinced claimant that she would lose herjob if she reported the incident. Claimant did not immediately contact the police or inform employer.

Claimant continued to work for employer, hoping to put the incident behind her. However, after returning from Virginia, Hirsch continually subjected claimant to sexual harassment, including unwanted physical touching. Claimant became increasingly despondent over the situation and, **<151 Or App 604/605>** in April 1994, she reported the Quantico incident to two coworkers.

Shortly thereafter, employer's upper management learned of the incident. In response, employer assigned claimant a new supervisor and changed the location of her desk, moving it away from Hirsch. However, Hirsch continued to walk by claimant's desk on a daily basis. Claimant felt that this arrangement was unsatisfactory and voiced her concerns to employer. Employer's executive vice president suggested that she quit if the changes were not acceptable.

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[1] SAIF argues that remand is not appropriate because claimant did not request one. However, we note that, in fact, claimant did identify remand as an appropriate remedy. Moreover, our statutory authority to review administrative orders includes the power to "affirm, reverse or remand the order." ORS 183.484(8)(a). Because claimant sought review and prevailed, we can remand with or without a specific request to do so.

On June 16, 1994, claimant felt unable to go to work and met with a psychiatrist the same day. The psychiatrist found that claimant was having recurrent and distressing recollections of the sexual assault and harassment, including vivid nightmares of the events. The psychiatrist diagnosed claimant as suffering from Major Unipolar Depression, Single Episode, with some symptoms of Post-Traumatic Stress Syndrome (PTSS).

Claimant sought compensation benefits for her psychological injuries. SAIF (employer's insurer) denied her claim and she requested a hearing. The administrative law judge (ALJ) found that the sexual assault and subsequent sexual harassment had occurred and that claimant had suffered compensable psychological injuries as a result. Nonetheless, relying on *Carr v. US West*, 98 Or App 30, 779 P2d 154, *rev den* 308 Or 608 (1989), the ALJ held that the claim was not compensable because claimant's injuries did not "arise out of claimant's employment." The Board affirmed that denial, supplementing the ALJ's order with two specific additional holdings, both based on *Carr*. The Board held that *Carr* "is binding precedent in our forum[;]" and, that, without deciding "whether claimant's [traveling employee] argument was timely raised," claimant would not prevail under the traveling employee rule because claimant did not distinguish her case from *Carr* and, thus, did not prove that her injury "arose out of" the employment.

Claimant argues that the Board erred "when it concluded * * * that claimant's injuries were not incurred in the course of her employment or did not arise out of her employment[.]" Claimant further contends that the traveling **<151 Or App 605/606>** employee rule supports a finding that her injuries arose out of her employment and that the Board erred by relying on *Carr*. We address only claimant's last argument because, for the reasons that follow, it is dispositive.

Claimant argues that *Carr* does not apply because it "was an evidentiary case[,]" and, as such, can be factually distinguished from the present one. We disagree with claimant's reasoning because the court in *Carr* analyzed similar facts and addressed the same legal issue regarding causation as is presented here. However, we conclude that the recent opinion of the Oregon Supreme Court in *Redman Industries, Inc. v. Lang*, 326 Or 32, 943 P2d 208 (1997), rejected the approach that we had followed in *Carr*.

In *Carr*, an employee was sexually harassed, assaulted and eventually raped by her supervisor while he accompanied the employee on outside sales calls. *Carr*, 98 Or App at 32. Later, the supervisor continued to harass her sexually in the office. *Id.* This court held that the employee's injuries were not covered by Oregon's workers' compensation law because there was no evidence that the assaults were provoked by anything related to the work and because there was no evidence that the nature of the job or the job environment created or enhanced the risk of assault. *Id.* at 35.

In our opinion in *Redman Industries, Inc. v. Lang*, 142 Or App 404, 406, 921 P2d 992 (1996), we explained:

> "Claimant, a Caucasian male, worked at employer's plant with [assailant], an African-American, male coworker. Claimant installed windows on manufactured homes, and [assailant] installed doors. On August 3 or 4, 1994, claimant jokingly called [assailant] a 'watermelon,' which angered [assailant]. On August 4, referring to that or a similar remark, [assailant] told claimant 'don't be playing with me like that.' The next morning, claimant referred to [assailant] as 'watermelon' and, less than an hour later, as 'buckwheat,' 'Kentucky Fried Chicken,' and 'watermelon eatin' fool.' Although [assailant] knew claimant was trying to joke with him, [assailant] became angry and called claimant 'cracker' and another name, possibly 'honkey.'
>
> "[Assailant] remained very upset by claimant's remarks. Within a few minutes, another worker called **<151 Or App 606/607>** [assailant] a Spanish name that [assailant] believed was a racial slur. [Assailant] struck that worker. Moments later [assailant] saw claimant talking with an inspector. Assuming he would lose his job for striking the other employee, [assailant] struck claimant at least twice. [Assailant] asked claimant, 'Who's a Toby now?'"

In our *Redman* decision, we relied in significant part on *Carr,* using the same "created or enhanced" analysis that we had applied there. We held that the claimant's injuries were not compensable because his injuries did not "arise out of" his employment. 142 Or App at 408-10. We noted specifically that, "as in *Carr,* * * * there was nothing about the nature of claimant's job as a window-installer that 'created or enhanced' the risk of assault by a coworker. Furthermore, * * * the dispute * * * was not work-related." *Id.* at 408.

On review, the Supreme Court reversed our decision, expressly rejecting the "created or enhanced" test. *Redman,* 326 Or at 36. The court concluded that the test's focus was too narrow, explaining that, "at least in part, [that test] simply reformulate[d] the 'peculiar-risk'/'increased risk' inquiry rejected by this court in [*Phil A. Livesly Co. v. Russ,* 296 Or 25, 672 P2d 337 (1983)] and [*Fred Meyer, Inc. v. Hayes,* 325 Or 592, 943 P2d 197 (1997).]" *Redman,* 326 Or at 36.

The court held that "[a]n injury arises out of employment if the risk of injury results from the nature of the claimant's work *or from the work environment.*" *Id.* at 39 (emphasis supplied). By adding the factor "work environment," the court constructed a test that "does not [necessarily] require that the motivation for a coemployee's assault be an argument over job performance or some other work related factor." *Id.*

The court explained that the "rationale for the 'proximity' test is that a workplace assault by a coemployee is caused by circumstances *associated with the work environment*[,]" 326 Or at 40 (emphasis in original), and, as such, causes injuries that are work related. The court cautioned, however, that the rationale does not apply

> "[w]hen the motivation for an assault by a coemployee is an event or circumstance pertaining to the assailant and the **<151 Or App 607/608>** claimant that originated entirely separate from the workplace, and the only contribution made by the workplace is to provide a venue for the assault[.]" *Id.*

Thus, in the absence of evidence showing that the motivation for the assault was personal to the claimant, and accordingly, imported *into* the work environment, "the risk of an assault by a coemployee in the workplace is a risk to which the work environment exposes an employee." *Id.*

In *Redman,* the court ultimately held that the claimant's injuries "arose out of" his employment for two reasons. First, the court held that "there [wa]s no evidence that [the] claimant and his assailant had any relationship outside of work or that the motivation for the assault was fueled by an occurrence involving them outside of work." 326 Or at 41. Second, the court held that the events giving rise to the motivation for the assault (*i.e.,* the assailant's anger over being called a racially derogatory name and his fear of being fired for assaulting another employee moments earlier), although not related directly to work, all "*occurred at the workplace.*" *Id.* (emphasis supplied).

We reverse the Board's order and remand to the Board for reconsideration in the light of *Redman.*

Reversed and remanded for reconsideration.

Cite as 151 Or App 616 (1997) December 17, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Dennis G. Hansen, Claimant.

**LINNTON PLYWOOD ASSOCIATION**, *Petitioner,*

v.

**Dennis G. HANSEN**, *Respondent.*

(94-08198; CA A93415)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 16, 1997.

Montgomery W. Cobb argued the cause for petitioner. With him on the brief was Cobb and Woodworth.

Robert Wollheim argued the cause for respondent. With him on the brief was Welch, Bruun, Green & Wollheim.

Before Riggs, Presiding Judge, and Landau and Leeson, Judges.

LANDAU, J.

Affirmed.

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**151 Or App 618>** At issue in this case is whether claimant, who voluntarily left his job to participate in a federally sponsored job retraining program for workers in distressed industries, remained "in the work force" for the purposes of determining eligibility to receive workers' compensation benefits. The Workers' Compensation Board (Board) concluded that claimant remained in the work force. We agree and affirm.

The facts are not in dispute. Claimant suffered a compensable lumbar disk herniation while working at employer's plywood mill in 1986. After surgery, claimant returned to work, and employer closed his claim. When the mill experienced financial difficulties, its employees became eligible to participate in a retraining program funded by the federal government under the Federal Trade Readjustment Act. 19 USC § 2331. Participants in the program are paid a wage in addition to the direct costs of retraining. The program is administered through the state unemployment benefits system.

In September 1992, claimant voluntarily left his job to participate in the program. He entered a medical lab technician training program at Portland Community College. He received a wage and expenses during his participation in the program. Claimant intended to look for work in his new field immediately after completing training and earning the necessary certification.

In November 1992, claimant experienced back pain and was diagnosed with a recurrent disk herniation. Claimant underwent surgery for the recurrent herniation on December 3, 1992. Employer reopened the claim, but it did not pay temporary disability benefits, contending that claimant was not entitled to those benefits, because he was no longer in the work force. Meanwhile, claimant attempted to return to classes at Portland Community College, but, because of post-surgery limitations on his ability to sit or stand for more than a short period of time, he was unable to continue. When he withdrew from the program, his wage replacement benefits stopped.

**151 Or App 619>** On June 23, 1994, the claim was closed by determination order awarding no temporary disability benefits and finding claimant medically stationary as of January 28, 1994. Claimant requested a hearing on his entitlement to temporary disability benefits for the period from December 3, 1992, through January 28, 1994. The administrative law judge (ALJ) concluded that, because claimant attended retraining classes and received wage replacement at the time of the aggravation of his herniated disk, he had exhibited a willingness to work and made reasonable efforts to obtain employment. Accordingly, the ALJ ordered employer to pay claimant temporary disability benefits. The Board affirmed.

On review, employer argues that the Board erred as a matter of law, because, at the time of the aggravation, claimant voluntarily had left work and had taken no steps to obtain other employment during his retraining. According to employer, temporary disability benefits are available only to workers, and "claimant was a full-time paid student, not a worker." Claimant contends that the Board's decision was correct as a matter of fact, because his participation in the retraining program establishes substantial evidence that he was willing to work and making reasonable efforts to find work.

In *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 778 P2d 497 (1989), the Supreme Court described the test that determines whether a claimant is "in the work force" for the purposes of determining eligibility for temporary disability benefits:

> "A claimant is deemed to be in the work force if:
>
> "a. The claimant is engaged in regular gainful employment; or
>
> "b. The claimant, although not employed at the time, is willing to work and is making reasonable efforts to obtain employment; or
>
> "c. The claimant is willing to work, although not employed at the time and not making reasonable efforts to obtain employment because of a work-related injury, where such efforts would be futile."

**151 Or App 620>** *Id.* at 258 (citations omitted). We have addressed the ultimate conclusion of whether a claimant remains in the work force as a question of law. *See, e.g., Roseburg Forest Products v. Gibson*, 115 Or App 127, 130, 836 P2d 1365 (1992); *Roseburg Forest Products v. Phillips*, 113 Or App 721, 725-26, 833 P2d 1359, *rev den* 314 Or 727 (1992).

In this case, although claimant was not employed at the time of his aggravation, he expressed a willingness to work, and his participation in the retraining program further evinces that willingness. Claimant was not merely enrolled in general academic studies; he was attending classes to acquire training and skills to enable him to obtain employment in a specific occupation under the auspices of a federal program that paid him wage replacement only as long as he continued the course of retraining. We conclude that claimant remained "in the work force" at the time of his aggravation.

Affirmed.

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Cite as 151 Or App 693 (1997) December 17, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Sandy L. Rector, Claimant.

**LIBERTY NORTHWEST INSURANCE CORPORATION** and Sacred Heart Hospital, *Petitioners,*

v.

**Sandy L. RECTOR**, *Respondent.*

(WCB 95-09339; CA A94334)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 26, 1997.

E. Jay Perry argued the cause for petitioners. With him on the brief was Employers Defense Counsel.

Dale C. Johnson argued the cause for respondent. With him on the brief was Malagon, Moore, Johnson & Jensen.

Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.

ARMSTRONG, J.

Affirmed.

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**151 Or App 695>** Employer seeks review of an order of the Workers' Compensation Board that set aside employer's denial of claimant's claim for a low back condition and awarded a penalty against employer for unreasonable claim processing. We affirm.

Claimant has been employed as a nurse at employer's hospital since 1980. In 1993, claimant began experiencing ongoing pain in her groin that was worse with activity. "On March 8, 1994, claimant was working with patients, including lifting, when her [groin] pain suddenly worsened." Her doctor diagnosed "inguinal ligament discomfort" and prescribed medication. Claimant did not miss any work due to her condition. She filed a workers' compensation claim for a right "groin strain." On June 10, 1994, employer denied the claim on the ground that "the injury had not resulted in either treatment or disability." Claimant did not appeal the denial.

Through April 1995, claimant had intermittent groin pain that varied with her activities, but she did not experience any back pain. Then in April, "claimant developed right low back pain and buttock pain in addition to her groin pain in association with lifting at work." She sought treatment, but her symptoms worsened and "spread to include her right leg." "On May 13, 1995, claimant felt a snap in her back while lifting a patient." Her back pain became severe and she stopped working. Although her doctor later released claimant to light-duty work, employer did not want her to resume work while on medication. Claimant filed a workers' compensation claim for her low back condition. On August 10, 1995, employer denied the claim on the ground that its investigation had failed to establish that her condition was related to her employment.

Claimant sought a hearing. An administrative law judge set aside the denial and the Board affirmed that decision, stating:

> "The symptoms in claimant's low back and right leg that have caused disability and required treatment since April **<151 Or App 695/696>** 1995 have probably been due to internal disc disruption and an annular fissure at L5-S1. * * *
>
> "Claimant's L5-S1 disc has probably degenerated, in part, due to aging. However, her ongoing work activities for employer over a matter of at least years through May 1995 is the major cause of her internal disc disruption and annular fissure at L5-S1 and the pathological worsening associated with those conditions. * * *
>
> "As of August 10, 1995, the only medical opinion concerning the cause of claimant's low back condition indicated that her work for employer was the major cause of her condition."

Analyzing her low back and right leg condition as an occupational disease, *see* ORS 656.802, the Board concluded that claimant had satisfied her burden of proving a compensable condition. *See* ORS 656.266. The Board rejected employer's argument that claimant's decision not to request a hearing after its denial of her claim for a groin strain precluded her current claim, and it assessed a penalty against employer for unreasonably delaying payment of compensation to claimant.

Employer seeks review of that order. First, it assigns error to the Board's conclusion that the denial of claimant's 1994 claim for a groin strain did not preclude her 1995 claim for her low back condition. Second, it assigns error to the Board's finding that claimant's condition had changed between its denial of her claim for a right groin injury in June 1994 and its denial of her low back claim in August 1995. Because resolution of the second assignment of error simplifies analysis of the first assignment of error, we address it first.

As an initial matter, employer asserts that the Board did not actually find that claimant's condition had changed between June 1994 and August 1995. That position is without support. In a section labeled "Findings of Fact," the Board made the following findings: In March 1994, claimant injured her groin. Her doctor diagnosed "inguinal ligament discomfort," for which claimant filed a workers' compensation claim that employer denied. Claimant had no back pain until early April 1995. In May 1995, her back pain **<151 Or App 696/697>** became severe and she stopped working. Claimant's back condition was diagnosed as an "internal disc disruption and an annular fissure at L5-Sl." The major cause of that condition was "her ongoing work activities for employer over a matter of *at least years through May 1995.*" (Emphasis supplied.) In a section labeled "Ultimate Findings of Fact and Conclusions of Law" the Board found that, between June 10, 1994, and August 10, 1995, claimant's "condition had changed to include significant new low back and right leg symptoms, with a subsequent new diagnosis of internal disc disruption and an annular fissure at L5-S1." Thus, the Board did find that claimant's condition had changed between June 1994 and August 1995.

The Board's findings are supported by substantial evidence in the record. "Substantial evidence exists to support a finding of fact when the record, viewed as a whole, would permit a reasonable person to make that finding." ORS 183.482(8)(c). The evidence in the record supports a finding that claimant's back pain was caused by the internal disc disruption and annular fissure at L5-Sl. Employer does not dispute that finding but argues that the evidence also supports a finding that that condition caused claimant's groin pain. Even if that were true, it is irrelevant. The relevant issue is whether, considering the record as a whole, a reasonable person could find that claimant's condition had changed after the rejection of the groin claim. We conclude that a reasonable person could make that finding.

According to the record, when claimant went to the doctor in 1994, she was diagnosed with "inguinal ligament discomfort," a groin strain. There was nothing to indicate either to claimant or to her doctor that she had a low back injury. The reports of the doctors who examined claimant a year later in connection with her back and right leg pain noted her continuing groin pain, but they did not connect it to her low back condition. The record contains the depositions of two of those doctors, Miller and Karasek. Miller testified that he did not focus on the groin pain in making his assessment of claimant's back condition, but that, "taking the whole picture into account," the groin pain was probably connected to the back condition. He also stated, however, that it was not **<151 Or App 697/698>** "clear-cut" because, generally, when considering a back condition, referred groin pain originates from an upper disc disorder, which was not present here. Karasek testified that "the low back pain that [claimant] reported has a very high probability of coming from the L5-S1 disc" but that "[t]he groin and leg pain is more probably than not from this disk but is not nearly as certain as the low back pain." Like Miller, he noted that referred groin pain was much more common with an upper disc problem. Moreover, because claimant's back pain was not present when claimant initially injured her groin in 1994, he questioned whether the back condition explained the groin pain and stated that the groin pain and the back pain might be unrelated. Finally, he testified that he could not say when her back condition began to develop in the past years, but he believed that the injury culminated in May 1995. Based on that record, although claimant continued to have groin pain, there is substantial evidence to support the finding that claimant's condition had changed between June 1994 and August 1995.

Given that finding, employer's claim preclusion argument fails. "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." *Messmer v. Deluxe Cabinet Works*, 130 Or App 254, 257, 881 P2d 180 (1994), *rev den* 320 Or 507 (1995). In this case, claimant's claim for her right groin injury became final when she chose not to file a request for a hearing after employer denied her 1994 claim. *See Drews v. EBI Companies*, 310 Or 134, 149, 795 P2d 531 (1990). Thus, claimant is precluded from relitigating the compensability of her groin injury. However,

> "[a]lthough a claimant may be barred from presenting new evidence relating to the same condition, [she] may renew a request for medical services if [her] condition has changed and the request is supported by new facts that could not have been presented earlier."

*Liberty Northwest Ins. Corp. v. Bird*, 99 Or App 560, 564, 783 P2d 33 (1989), *rev den* 309 Or 645 (1990) (emphasis in original). In this case, the Board determined that claimant's condition had changed since her earlier request. Employer does **<151 Or App 698/699>** not contend that, at the time it denied claimant's groin injury, claimant or her doctor knew or should have known that claimant had a low back condition. Consequently, the facts on which claimant's current claim is based are facts that the Board could find that claimant could not have presented earlier. Therefore, the Board properly concluded that claim preclusion does not bar claimant's current claim.

Employer also assigns error to the Board's decision to impose a penalty against employer under ORS 656.262(11)(a). We have considered employer's argument and affirm the Board's decision without discussion.

Affirmed.

Cite as 151 Or App 710 (1997) December 24, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Milan F. Shubert, Claimant.

**Milan F. SHUBERT**, *Petitioner,*
v.
**BLUE CHIPS** and SAIF CORPORATION, *Respondents.*
(94-08858; CA A89283)

In Banc
Judicial Review from Workers' Compensation Board.
Argued and submitted May 13,1996; resubmitted in banc October 1, 1997.
Kimberley Chaput argued the cause and filed the brief for petitioner.
Michael O. Whitty argued the cause and filed the brief for respondents.
DEITS, C. J.
Affirmed.
De Muniz, J., dissenting.

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**151 Or App 712>** Claimant seeks review of an order of the Workers' Compensation Board (Board) denying him an award of permanent partial disability (PPD). He challenges the validity of a temporary rule adopted by the Director of the Department of Consumer and Business Services (Director) pursuant to ORS 656.726(3)(f)(C) that amended the disability standards to address his impairment but awarded him no compensation. We affirm.

We recite the facts as found by the administrative law judge (ALJ). The Board adopted them, and they are supported by substantial evidence. ORS 183.482(8)(c). Claimant injured his left shoulder on April 30, 1987, and was eventually awarded unscheduled PPD of five percent. That award was later increased to 17 percent. On July 30, 1990, claimant underwent surgery to remove a screw that had been inserted in his shoulder to treat the original injury. Claimant filed an aggravation claim for his condition resulting from the surgery. That claim was closed by a July 30, 1991, determination order that did not award claimant any additional permanent disability benefits.

Following the issuance of that determination order, claimant obtained a report from Dr. Brenneke concluding that claimant suffered from a chronic condition that limited repetitive use of his left arm and shoulder and that claimant's surgery entitled claimant to an impairment value of 10 percent. Claimant's treating physician, Dr. Tesar, concurred in Brenneke's report. These reports were submitted by claimant in support of his request for reconsideration of the determination order awarding no additional PPD. The request for reconsideration also included a request to stay the reconsideration proceedings while, pursuant to ORS 656.726(3)(f), the Director adopted a temporary rule addressing the impairment value of the effects of the surgery. The ALJ concluded that a temporary rule was not required and affirmed the determination order. The Board, however, held that the effects of the screw-removal surgery was not addressed by the standards for rating disability and that, consequently, the Director was required to adopt a temporary rule.

**151 Or App 713>** Pursuant to ORS 656.726(3)(f)(C), the Board remanded the claim to the Director for adoption of a temporary rule addressing the appropriate standards for rating claimant's disability. On remand, the Director adopted OAR E38-6617, which provides, in part:

> "This worker underwent Bristow repair and malleolar screw removal in the left shoulder. * * * Bristow repair of a dislocating shoulder improves the function of the shoulder and reduces the chance of dislocation. Removal of the screw fixation device does not result in recognized loss of shoulder function. In this case, the impairment value for these procedures shall be a value of zero. * * * Notwithstanding OAR 436-35-003, this rule applies only to WCD file no. E38-6617."

Claimant filed a request for hearing on the Director's decision. The ALJ upheld the Director's action. Claimant then appealed to the Board. The Board concluded that the Director, not the Board or the Hearings Division, has the statutory authority to adopt disability standards for particular conditions pursuant to ORS 656.726(3)(f)(C). The Board held that, under the specific statutory scheme, neither it nor the Hearings Division had the authority to substitute its judgment for that of the Director on disability standards.[1] The Board noted, as it had in previous decisions, that it did have the authority to review a temporary rule for consistency with the applicable statutes. *See Weston C. Foucher*, 47 Van Natta 1518 (1995); *Timothy H. Krushwitz*, 45 Van Natta 158 (1993). Based on its understanding of its review authority, the Board concluded that the rule at issue in this case was not inconsistent with the statute and that it lacked authority to invalidate the rule on any other basis.

Claimant first argues that the Board erred in concluding that it lacked authority to invalidate the Director's temporary rule. Claimant's argument in this assignment of error is based on the general assertion that the Workers' Compensation Board and the Director of the Department of Consumer and Business Services are one agency and that, therefore, it necessarily follows that the Board has complete **<151 Or App 713/714>** authority to review the Director's rules. However, it is unnecessary to resolve the question of whether these entities technically constitute one agency, because the respective roles of the Director and the Board relating to the adoption of disability standards is specifically addressed by the applicable statutes. The Director is the entity specifically authorized by statute to adopt such standards. ORS 656.726(3)(f)(C) provides, in part:

> "When, upon reconsideration of a determination order or notice of closure * * * it is found that the worker's disability is not addressed by the standards adopted pursuant to this paragraph, * * * *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." (Emphasis supplied.)

Although throughout ORS chapter 656 the roles of the Director, Hearings Division and the Board, with respect to specific types of actions and how each is reviewed, are clearly detailed, there is no indication anywhere in chapter 656 that the Board has the authority to substitute its judgment for that of the Director regarding disability standards. The plain language of the statutes makes it clear that the legislature delegated that authority to the Director.

As we held in our decision in *Gallino v. Courtesy Pontiac-Buick-GMC*, 124 Or App 538, 863 P2d 530 (1993), however, if the Board determines that there is no existing standard to rate a disability, it does have the authority to remand the matter to the Director to adopt a standard. In concluding that the Board had that authority, we relied on the statutory provision that "upon a finding that a disability is not addressed by existing standards the Director shall stay further proceedings and shall adopt temporary rules." We concluded that if, in the course of a contested case proceeding on a claim, the Board decided that there was no disability standard that covered the claimant's condition, it was necessary for the Board to remand the matter to the Director to adopt such a standard.[2] That, of course, is what happened here.

**151 Or App 715>** Further, there are no other general statutes that give the Board the authority to substitute its judgment for that of the Director regarding disability standards. ORS 183.400 generally governs the review of rules adopted by an agency. There is nothing in that statute, however, that provides authority for the Board to substitute its judgment for that of the Director regarding disability standards. Under ORS 183.400, the Director's rules are subject to direct review by this court. The only instance where direct review to this court is not available is when

> "the petitioner is a party to an order or a contested case in which the validity of the rule may be determined *by a court*." ORS 183.400(1). (Emphasis supplied.)

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[1] However, the Board did hold alternatively that, even if it had the authority to substitute its judgment for that of the Director, it would not find the rule invalid.

[2] The question of whether the Board could substitute its judgment for that of the Director on a disability standard was not before this court in *Gallino*, and we did not address that question.

Petitioner is a party to a contested case. Consequently, the rule may be and in fact is being reviewed pursuant to ORS 183.400 by *this court* in this judicial review.[3] We conclude that the Board's conclusions regarding its authority to review the Director's rule were correct.

Claimant's second assignment of error is that the Board erred in holding that the Director acted properly in promulgating a temporary rule awarding claimant zero disability. Claimant argues that the Board expressly found that claimant had sustained permanent impairment from the surgical procedure and that, by adopting a rule awarding zero disability, the Director "violated the law of the case."

The Board's order, however, directly disputes claimant's assertion that it found that claimant had a rateable disability. As the Board explained:

> "Here, pursuant to our remand order, the Director found that claimant's left shoulder Bristow repair and malleolar screw removal surgery was not addressed by the **<151 Or App 715/716>** 'standards.' Our order did not determine whether or not claimant had ratable [*sic*] impairment as a result of the surgery, but merely determined that the surgical procedure was not addressed by the Director's 'standards.' In this regard, our review of a worker's permanent disability is limited to the application of the Director's 'standards.' ORS 656.295(5).
>
> "* * * * *
>
> "The promulgation of a temporary rule does not automatically result in a worker receiving an impairment value. Not all impairment necessarily results in a worker receiving an impairment value under the 'standards.' For example, a worker is not entitled to an impairment value for all range of motion losses. Rather, the lost range of motion must meet the requisite level established by the Director's 'standards.' *See* OAR 436-35-330(1) (a worker not entitled to an impairment rating for the shoulder joint where he retains 150 degrees of forward elevation)."

Therefore, even assuming a law of the case principle would be applicable here, the Director's action was not inconsistent with the Board's determination and did not violate the law of the case.

Claimant's final argument is that, even if the Board was correct that the Director could adopt a rule that awarded claimant no rateable disability, the rule is nevertheless invalid, because, under ORS 656.726(3)(f) and the general provisions of the Administrative Procedures Act (APA), a rule must concern matters of general applicability, and this rule does not. Claimant contends that this temporary rule is case specific and, because of that, comes within the definition of an "order" rather than a "rule" under the APA. Accordingly, claimant argues that the required procedures for the adoption of an order must have been followed here.

Claimant may be correct that the Director's action here comes closer to the APA definition of an order rather than a rule. That argument would be persuasive were it not for the fact that here, a specific statute dictates the applicable procedures for the Director's action and, accordingly, that statute controls over the general APA definitions. ORS 174.020. As noted above, ORS 656.726(f) specifically directs the Director to adopt disability standards for specific cases as **<151 Or App 716/717>** temporary rules. It is within the legislature's authority to designate specific procedures for particular actions, even if the procedures are somewhat unusual, and it has done so here. The Board did not err in refusing to invalidate the Director's rule on the ground that it was improperly adopted as a rule.[4]

Affirmed.

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[3] Claimant did seek direct review by this court of the temporary rule in question here. We dismissed that request for review, however, based on our conclusion that we did not have jurisdiction, because

> "petitioner is a party to a contested case pending before the Workers' Compensation Board in which the validity of the rule may be determined *by this court* on judicial review of the Board's order in that case." (Emphasis supplied.) *Shubert v. Department of Consumer and Business Services*, CA No. A86479, dismissed May 17, 1995, citing ORS 183.400(1).

We adhere to that holding.

[4] The dissent would hold that the Director's rule is inconsistent with ORS 656.726(3)(f)(C) because it does not "accommodate" claimant's impairment. However, claimant does not make that argument on review.

**DE MUNIZ, J., dissenting.**

The majority holds that the Board lacked authority to invalidate the director's temporary rule and that the director acted properly in promulgating a temporary rule awarding claimant zero disability. I disagree with both holdings and respectfully dissent.

I begin with the Board's authority to review the validity of temporary rules adopted pursuant to ORS 656.726(3)(f)(C). In *Gallino v. Courtesy Pontiac-Buick-GMC*, 124 Or App 538, 863 P2d 530 (1993),[1] we held that, under ORS 656.295(5), "the Board has the authority to review the correctness of the director's application of standards," and, under ORS 656.726(3)(f)(C), to remand to the director to amend those standards when they do not address a worker's disability. 124 Or App at 541-42. We cited the mandatory language of ORS 656.726(3)(f)(C) in rejecting SAIF's contention that the director has sole discretion to determine whether a temporary rule is required. *Id.* at 541 ("the director shall stay further proceedings * * * and shall adopt temporary rules").

The Board's power to remand for adoption of temporary rules must necessarily include the authority to review the rules actually adopted. Otherwise, those rules are unreviewable,[2] and the director is effectively granted sole discretion to determine whether a temporary rule is required. That **<151 Or App 717/718>** is contrary to the mandatory language of ORS 656.726(3)(f)(C) and our reasoning in *Gallino*. If the legislature had intended to insulate the director's temporary rules from Board review, it would have employed discretionary language (for example, "the director may stay further proceedings * * * and may adopt temporary rules"). By using mandatory language, however, the legislature intended to carve out a specific exception to the director's general authority to adopt disability standards. *See* ORS 174.020; *Smith v. Multnomah County Board of Commissioners*, 318 Or 302, 309, 865 P2d 356 (1994) (specific statute is deemed exception to inconsistent general statute).

Although it was not a part of our reasoning in *Gallino*, other language in ORS 656.295(5) and similar language in ORS 656.283(7) also reveal the legislature's intention that the Board review the

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[1] In *Gallino v. Courtesy Pontiac-Buick-GMC*, 124 Or App 538, 863 P2d 530 (1993), we referred to the director of the Department of Insurance and Finance (DIF), which has since been renamed the Department of Consumer and Business Services.

[2] For example, while his case was pending before the Board, claimant moved that this court determine whether we had jurisdiction outside of the contested case process to pass on the validity of the rule at issue. In an unpublished order, we ruled that we did not have jurisdiction because

> "petitioner is a party to a contested case pending before the Workers' Compensation Board in which the validity of the rule is at issue, and the validity of the rule may be determined by this court on judicial review of the Board's order in that case." *Shubert v. Department of Consumer and Business Services*, CA No. A86479, citing ORS 183.400(1).

In other words, we can determine the validity of the rule only as part of this contested case proceeding--*i.e.*, on review of the Board's order. However, if the Board lacks authority to address that issue, then so do we, because the validity of the rule is not part of the Board's order.

The majority asserts that "[p]etitioner is a party to a contested case and the rule may be and is, in fact, being reviewed, pursuant to ORS 183.400, by *this court* in this judicial review." 151 Or App at 715 (emphasis in original). That is so, however, only because we have determined that the Board had authority to review the validity of the rule. "We are unable to review an agency's action without the agency first making a decision." *Liberty Northwest Ins. Corp. v. Griggs*, 112 Or App 44, 49, 827 P2d 921 (1992). If the Board lacks authority to review the rule, as the majority would hold, then the Board has made no substantive decision as to that rule, and there is no agency action for this court to review.

Furthermore, although ORS 656.726(3)(f)(C) requires the director to submit temporary rules to the Workers' Compensation Management-Labor Advisory Committee for review at its next meeting, the committee is only authorized to make recommendations "to the director for such action *as the director deems appropriate.*" ORS 656.790(2) (emphasis supplied). The committee cannot bind the director. Accordingly, in the absence of review by the Board, the director has unfettered discretion in adopting temporary rules. *But see Gallino*, 124 Or App at 541.

temporary rules of the director. ORS 656.283(7)[3] and ORS 656.295(5)[4] provide, in part, that the <151 **Or App 718/719>** ALJ at the hearing of a claim and the Board on review of a claim *shall apply* the standards for evaluation of disability as may be adopted by the director pursuant to ORS 656.726. Application of disability standards by the ALJ and the Board must necessarily include the authority to determine the validity of those standards. The majority is wrong to conclude that the Board does not have the authority to review the validity of a temporary rule adopted by the director pursuant to ORS 656.726(3)(f)(C).

As to the validity of the rule, claimant contends that the director cannot adopt a rule that does not award PPD pursuant to ORS 656.726(3)(f)(C). The Board disagreed, holding that promulgation of a temporary rule does not always result in compensation. Rather, the impairment must satisfy the director's disability standards before a claimant is entitled to a PPD award. The Board concluded that claimant's impairment did not meet those standards here, because the screw-removal surgery was designed to improve the function of claimant's shoulder, and Dr. Brenneke failed to explain why he believed that the surgery resulted in a 10 percent impairment.

ORS 656.726(3)(f)(C) delegates to the director "certain rule-making authority." *See Hadley v. Cody Hindman Logging*, 144 Or App 157, 160, 925 P2d 158 (1996) (reaching same conclusion regarding ORS 656.210(2)(c)). There are three classes of statutory terms that delegate rule-making authority to an agency, "each of which conveys a different responsibility for the agency in its initial application of the statute and for the court on review of that application." *Springfield Education Assn. v. School Dist.*, 290 Or 217, 223, 621 P2d 547 (1980). Those classes are:

> "1.) Terms of precise meaning, whether of common or technical parlance, requiring only factfinding by the agency and judicial review for substantial evidence;
>
> **151 Or App 720>** "2.) Inexact terms which require agency interpretation and judicial review for consistency with legislative policy; and
>
> "3.) Terms of delegation which require legislative policy determination by the agency and judicial review of whether that policy is within the delegation." *Id.*

The application of ORS 656.726(3)(f)(C) in this case involves "inexact terms"--*i.e.*, the legislature has completely expressed its meaning, but that meaning must be spelled out in the agency's rule or order.[5] *England v. Thunderbird*, 315 Or 633, 638, 848 P2d 100 (1993).

> "An inexact term gives the agency interpretive but not legislative responsibility. With respect to an inexact term, the role of the court is to determine whether the agency 'erroneously interpreted a provision of law,' ORS 183.482(8)(a), and the ultimate interpretive responsibility lies with the court in its role as the arbiter of questions of law." *Id.* (citations omitted).

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[3] ORS 656.283(7) provides, in part:

"The Administrative Law Judge shall apply to the hearing of the claim such standards for evaluation of disability as may be adopted by the director pursuant to ORS 656.726."

[4] ORS 656.295(5) provides, in part:

"The board shall apply to the review of the claim such standards for the evaluation of disability as may be adopted by the director pursuant to ORS 656.726. Nothing in this section shall be construed to prevent or limit the right of a worker, insurer or self-insured employer to present evidence to establish by a preponderance of the evidence that the standards adopted pursuant to ORS 656.726 for evaluation of the worker's permanent disability were incorrectly applied in the reconsideration order[.]"

[5] The application of ORS 656.726(3)(f)(C) does not involve "exact terms," which "impart relatively precise meaning, *e.g.*, 21 years of age, male, 30 days, Class II, farmland, rodent, Marion County." *Springfield Education Assn. v. School Dist.*, 290 Or 217, 223, 621 P2d 547 (1980). Nor does it involve general "delegative terms," such as "good cause," "fair," "unfair," "undue" and "unreasonable," which the legislature uses when it cannot foresee all possible applications of a statute. *Id.* at 228.

In assessing whether the director "erroneously interpreted a provision of law," it is necessary to determine whether a temporary rule that awards no compensation "accommodate[s] the worker's impairment," as required under ORS 656.726(3)(f)(C). In construing a statute, our task is to discern the legislature's intent. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610, 859 P2d 1143 (1993). That analysis first requires an examination of the statute's text and context, proceeding to legislative history if, and only if, intent remains unclear. *Id.* at 610-12.

Although ORS 656.726(3)(f) grants the director authority to promulgate disability standards, subsection (C) *requires* the director to "adopt temporary rules amending the [disability] standards to accommodate the worker's impairment" when "it is found that the worker's disability is not **<151 Or App 720/721>** addressed by the standards adopted pursuant to this paragraph." It is first necessary to determine whether there was a finding that claimant's disability was not addressed by the disability standards. In its initial order, the Board found *as fact* that claimant suffered a permanent impairment as a result of the screw-removal surgery. That finding was based on a report by Brenneke, who concluded that claimant suffered a loss of motion in his left arm and shoulder. Under ORS 656.214(1),[6] "permanent partial disability" includes the permanent and partial loss of use of an arm. The Board also found that neither the surgical procedure nor the resulting impairment was addressed by existing disability standards. Accordingly, the director was required, pursuant to the mandatory language of ORS 656.726(3)(f)(C), to adopt "temporary rules amending the standards to accommodate the worker's impairment."

The text of ORS 656.726(3)(f)(C) does not define "accommodate." In examining the text of a statute, we must apply rules of construction bearing directly on how to read that text, including the principle that words of common usage should be given their plain, natural and ordinary meaning. *PGE*, 317 Or at 611. The dictionary defines "accommodate" as "ADAPT: * * * make fit, suitable or congruous[.]" *Webster's Third New International Dictionary* 12 (unabridged ed 1993). The rule adopted here does not "adapt" the disability standards to "fit" claimant's impairment. Instead, it essentially ignores the Board's impairment finding, summarily concludes that this *type* of surgery "does not result in recognized loss of shoulder function" and assigns an impairment value of zero. The rule "accommodates" the *surgical procedure*, not the resulting impairment. That is not what the text of ORS 656.726(3)(f)(C) authorizes.

**151 Or App 722>** I acknowledge that the director generally is granted authority to promulgate disability standards, ORS 656.726(3)(f), and an impairment typically is not rateable unless it is covered by those standards. However, the entire thrust of subsection (C) is to *require* the director to make an impairment rateable when existing standards do not apply. As we held in *Gallino*, the director does not have discretion to determine whether a temporary rule is required under ORS 656.726(3)(f)(C). 124 Or App at 541. Allowing the director discretion to determine whether an impairment not covered by the standards is rateable, as the Board did here, involves an impermissible construction of the statute under *Gallino*. In my view, claimant is correct that a compensation award is a necessary consequence of remanding a case for adoption of a temporary rule pursuant to ORS 656.726(3)(f)(C). I would hold that the Board erred in concluding otherwise.

Leeson, Haselton, and Armstrong, JJ., join in this dissent.

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[6] ORS 656.214(1), provides, in part:

"(a) 'Loss' includes permanent and complete or partial loss of use.

"(b) 'Permanent partial disability' means the loss of either one arm, one hand, one leg, one foot, loss of hearing in one or both cars, loss of one eye, one or more fingers, or any other injury known in surgery to be permanent partial disability."

Reading those two sub-sections together, "permanent partial disability" means the permanent and complete or partial loss of use of one arm, one hand, one leg, one foot, etc.

Cite as 151 Or App 727 (1997) December 24, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Gregory D. Schultz, Claimant.

**Gregory D. SCHULTZ**, *Petitioner*
v.
**SPRINGFIELD FOREST PRODUCTS** and SAIF Corporation, *Respondents.*
(WCB 94-07903; CA A91008)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 9, 1997.
Dale C. Johnson argued the cause for petitioner. With him on the brief was Malagon, Moore, Johnson & Jensen.
Steven R. Cotton argued the cause and filed the brief for respondents.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
WARREN, P. J.
Affirmed.

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**151 Or App 729>** Claimant seeks review of an order of the Workers' Compensation Board modifying an order of the administrative law judge (ALJ) increasing claimant's unscheduled permanent partial disability (PPD) award. The issues are whether the Board or the ALJ may invalidate a rule of the director of the Department of Consumer and Business Services, and, if so, whether OAR 436-35-320(5) is a valid exercise of the director's rule-making authority. We affirm.

The facts are undisputed. Claimant was injured when he fell from a ladder while working for employer as a veneer dryer feeder. As a result of the fall, claimant sustained a compression fracture of his L-1 vertebra and an injury to his left elbow.

Claimant filed a claim and sought permanent partial disability. ORS 656.214(5) provides, in part:

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

ORS 656.726(3)(f)(A) provides:

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

OAR 436-35-320(5)(a) provides:

> "Unscheduled chronic condition impairment is considered after all other unscheduled impairment within a body area, if any, has been rated and combined under these rules. Where the total unscheduled impairment within a body area is equal to or in excess of 5%, the worker is not entitled to any unscheduled chronic condition impairment."

On December 17, 1993, SAIF issued a notice of closure, awarding claimant 29 percent scheduled PPD for his left elbow and 20 percent unscheduled PPD for his low back **<151 Or App 729/730>** injury. The Appellate Review Unit of the Department of Consumer and Business Services affirmed the notice of closure by an order on reconsideration dated July 10, 1994. Claimant sought a hearing.

After the hearing, the ALJ increased claimant's unscheduled PPD award for his low back injury to 32 percent, which included a five percent award for a chronic condition. The ALJ acknowledged that OAR 436-35-320(5)(a) prevented an award of impairment for a chronic condition because claimant's total unscheduled impairment award for his low back was greater than five percent, but she concluded that the rule was invalid and declined to apply it. She explained:

> "The total disregard of acknowledged impairment in some circumstances pertaining to unscheduled PPD, unlike full recognition of scheduled impairment, is arbitrary and inconsistent with the statutory directives regarding the standards. Consequently, the Director exceeded his authority in the promulgation of such a discriminatory rule."

SAIF sought review by the Board, which modified the ALJ's order and reduced claimant's unscheduled PPD award to 22 percent. It followed OAR 436-35-320(5)(a) and excluded the unscheduled chronic condition award from the total award. It did so for two reasons. First, it held that neither the ALJ nor the Board had authority to invalidate the director's rule; second, and in the alternative, it reasoned that OAR 436-35-320(5)(a) did not exceed the director's statutory authority to promulgate disability standards. We conclude that the Board does have the authority to review the validity of a director's rule to determine if it is consistent with applicable statutes and we hold that the Board was correct in determining that the director's rule is consistent with the statute.

The Supreme Court held in *Nutbrown v. Munn*, 311 Or 328, 346, 811 P2d 131 (1991), *cert den* 502 US 1030 (1992), that "[a]lthough it is an authority to be exercised infrequently, and always with care, Oregon administrative agencies have the power to declare statutes and rules unconstitutional." While the issue here is not a constitutional question, the reason for the court's holding in *Nutbrown* applies equally in this context. Administrative agencies, including those with quasi-judicial power, are required to follow the **<151 Or App 730/731>** law. If the agency concludes that an administrative rule that it must apply is not in accordance with a statute or is unconstitutional it must follow the superior rather than the subordinate law. It would be an unnecessary limitation of the agency's role for it blindly to apply a rule that is inconsistent with a statute or constitutional provision. *See Hadley v. Cody Hindman Logging*, 144 Or App 157, 160, 925 P2d 158 (1996) (so long as the director prescribed a method that is within the delegation by the legislature, neither we nor the Board may substitute our own judgment regarding the method of computation); *cf. Shubert v. Blue Chips*, 151 Or App 710, ___ P2d ___ (1997) (the Board may not substitute its judgment for that of the director of the Department of Consumer and Busness Services regarding temporary disability standards) (emphasis supplied). Additionally, "[i]t would be pointless to reverse an agency for correctly deciding a legal question on the ground that the agency should have waited for the reviewing court to decide the question." *Cooper v. Eugene School Dist. No. 4J*, 301 Or 358, 364, 723 P2d 298 (1986), *appeal dismissed* 480 US 942 (1987).

The question then is whether OAR 436-35-320(5)(a) is consistent with the applicable statutes. The legislature provided that for unscheduled PPD "the criteria for rating * * * shall be the permanent loss of *earning capacity* due to the compensable injury." ORS 656.214(5) (emphasis supplied). Earning capacity is an inexact term because the legislature has expressed its meaning completely, but that meaning remains to be spelled out in the agency's rule or order. *England v. Thunderbird*, 315 Or 633, 638, 848 P2d 100 (1993). The role of the court, with respect to inexact terms, is to determine whether the agency interpreted a provision of law in a way that is consistent with legislative policy. ORS 183.482(8)(a); *England*, 315 Or at 637. Accordingly, we review the validity of OAR 436-35-320(5)(a) for consistency with the relevant provisions of the workers' compensation statutes. *See SAIF v. Cline*, 135 Or App 155, 158, 897 P2d 1172, *rev den* 321 Or 560 (1995).

Claimant contends that it is inconsistent with the statutes for the director to treat unscheduled chronic conditions differently from scheduled chronic conditions.[1] This **<151 Or App 731/732>** echoes the reasoning of the ALJ, who found that it "is arbitrary and inconsistent with the statutory directives regarding the standards." That is not correct.

Scheduled impairment "means a compensable permanent *loss of use or function* which results from injuries to those body parts listed in ORS 656.214(2) through (4)." OAR 436-35-005(12). Only the "loss of physical function is to be considered in determining the amount of compensation" in scheduled injuries. *Powell v. Wilson*, 10 Or App 613, 616, 501 P2d 338 (1972). The amount awarded is set without consideration of any other factors. Thus, there is no chance that other factors that have already been considered will be taken into account in evaluating "loss of physical function".

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[1] Scheduled chronic condition awards are not restricted to instances when total impairment is less than five percent. OAR 436-35-010(6)(a).

In contrast, unscheduled impairments "means the permanent loss of earning capacity due to a compensable condition." OAR 436-35-005(16). Earning capacity is measured by taking the permanent loss of use or function of a body part and modifying it by the factors of age, education and adaptability. OAR 436-035-320(2); ORS 656.726(3)(f)(A). It is the inclusion of those additional factors that distinguishes the treatment of unscheduled impairments from scheduled impairments.

Specifically, when evaluating adaptability, restrictions are taken into account. Restrictions are permanent physical limitations that restrict repetitive motions. *See* 436-35-310(3)(l). A chronic condition, by definition, is the inability to use a body part repetitively. OAR 436-35-320(5). If claimant were awarded recovery for "restrictions" under adaptability and independently for impairment caused by chronic condition impairment, the claimant would receive a double award for the same component of the condition.

However, if a claimant's total impairment between one and four percent, adaptability is not considered.[2] OAR 436-35-310(8). Thus, when adaptability is not factored into the equation, a claimant may be awarded a chronic condition award of five percent. OAR 436-35-320(5). The **<151 Or App 732/733>** result is that a chronic condition ultimately is compensated. It is recoverable as a "restriction" when adaptability is considered, or as a chronic condition award when adaptability is not considered. That prevents a double recovery.

Claimant also asserts that, according to ORS 656.726(3)(f)(A), all injury-related impairments, including chronic conditions, must be rated before the rating may be "modified." We agree with the Board that the phrase "permanent impairment due to the industrial injury as modified by the factors of age, education and adaptability" must be viewed as a whole in determining loss of earning capacity. Viewing it otherwise would mean that the legislature intended double recovery in some instances. That would not be consistent with legislative policy. Thus, we hold that the Board was correct in concluding that OAR 436-35-320(5) did not violate the statute.

Affirmed.

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[2] Presumably, the director concluded that if total impairment is less than four percent, a worker would be adaptable to any job. Thus, adaptability would not be an appropriate consideration.

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Cite as 151 Or App 800 (1997) December 24, 1997

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Dana Quackenbush, Claimant.

**Dana QUACKENBUSH**, *Petitioner,*
v.
**ROGUE VALLEY MEDICAL CENTER**, *Respondent.*
(95-05061; CA A93055)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 11, 1997.
Roger Ousey argued the cause for petitioner. With him on the brief was Bischoff, Strooband & Ousey.
Adam T. Stamper argued the cause and filed the brief for respondent.
David L. Runner filed a brief *amicus curiae* for SAIF Corporation, South Hills Health Care Center and Highland Laboratories, Inc.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
PER CURIAM
Affirmed.

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**151 Or App 801>** Claimant seeks review of a decision of the Workers' Compensation Board in which the Board reduced claimant's unscheduled permanent partial disability award from 36 percent to 28 percent. Claimant's petition raises two issues. He argues that the Board erred by applying amended

ORS 656.283(7)[1] retroactively to his claim, which was in existence at the time of the 1995 changes to the Workers' Compensation Law. Claimant further argues that the Board's refusal to consider his hearing testimony was a denial of due process under the Oregon and United States Constitutions. Claimant raises those issues for the first time on review and we decline, therefore, to address them. *Wall v. Raising Preschool, Inc.*, 126 Or App 170, 171, 866 P2d 525 (1994).

Affirmed.

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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."

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Cite as 152 Or App 15 (1998) January 7, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of James W. Jordan, Claimant.

**James W. JORDAN**, *Petitioner*,

v.

**BRAZIER FOREST PRODUCTS**, SAIF Corporation, and Department of Consumer and Business Services, *Respondents*.

(95-02636; CA A96162)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 18, 1997.

Donald M. Hooton argued the cause and filed the brief for petitioner.

Steve Cotton argued the cause and filed the brief for respondents Brazier Forest Products and SAIF Corporation.

Mary H. Williams, Assistant Attorney General, argued the cause for respondent Department of Business and Consumer Services.

Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.

WARREN, P. J.

Reversed and remanded.

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**152 Or App 17>** Claimant seeks review of a decision in which the Workers' Compensation Board held that it did not have jurisdiction over an Order Denying Reconsideration of a Notice of Closure of claimant's claim. He argues, in effect, that an order denying reconsideration, to the extent that it has any significance, is in essence identical to an order on reconsideration, over which the Board does have jurisdiction. We hold that the Board has jurisdiction over any order that resolves a request for reconsideration of a Notice of Closure, however the order may be denominated. We therefore reverse and remand.

Claimant suffered a compensable injury in 1986. In 1992, he ffled an aggravation claim; later that year, SAIF accepted that claim as part of a settlement. On November 23, 1992, a SAIF claims adjuster prepared a Notice of Closure of the aggravation claim. However, neither claimant nor his attorney received that notice until June 24, 1994. On June 28, immediately after his attorney received the notice, claimant requested reconsideration by the Department of Consumer and Business Services (the Department).[1] On July 20, the Department issued an Order Denying Reconsideration in which it refused to proceed with the reconsideration process on the ground that the request was untimely. That order contained a notice of a right to appeal by requesting a hearing before the Director of the Department (the Director). Because claimant believed, despite the notice, that the correct appeal route was to the Board, he requested that it review the order.

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[1] The Department's brief on judicial review is the primary respondent's brief. In its brief SAIF adopts the Department's arguments without submitting any additional ones of its own.

On review of the Department's order, SAIF did not contest the administrative law judge's (ALJ) jurisdiction or otherwise suggest that claimant had chosen the wrong appeal route. The only issue was whether the appeal from the Notice of Closure was timely, which included the issue of whether SAIF had mailed it in November 1992. The ALJ found that the appeal was timely because SAIF had failed to establish that it had mailed or otherwise served the order on **<152 Or App 17/18>** either claimant or his lawyer before June 24, 1994. He therefore remanded the case to the Department to conduct the reconsideration proceeding. Neither SAIF nor claimant appealed that order to the Board.

Despite the ALJ's order, the Department on remand refused to proceed with reconsideration of the closure of the claim on the ground that the ALJ (and, thus, the Board) did not have jurisdiction over an order denying reconsideration. After a hearing on that refusal, a different ALJ reaffirmed that claimant had followed the correct appeal route and again remanded the case to the Department. Claimant sought Board review, objecting to the remand; in response, SAIF argued that the ALJ was without jurisdiction. The Board agreed with SAIF, holding that it had no jurisdiction over an order denying reconsideration, and denied claimant any relief. Claimant seeks judicial review of that decision.

*Former* ORS 656.268[2] establishes the procedure for closing claims. It permits an insurer to close a claim without the necessity for a determination order from the Department, ORS 656.268(4), subject to the worker's right to the Department's reconsideration in accordance with the later subsections of ORS 656.268. Departmental reconsideration, thus, is the first independent consideration of a claim that the insurer closes directly. ORS 656.268(6)(a) establishes a schedule for the reconsideration and refers to an order on reconsideration as the conclusion of the process. The statutes do not refer to an order denying reconsideration.

The Department's rules establish the procedure for seeking reconsideration of a Notice of Closure. OAR 436-30-115(1)[3] provides that the Department "shall" reconsider a **<152 Or App 18/19>** Notice of Closure upon receipt of a written request for reconsideration within 180 days from the mailing date of the notice. OAR 436-30-125(1) describes the information that the request must contain, while OAR 436-30-135(1) states on whom the claimant must serve it. Upon receipt of the request, the Department will notify the parties of the date the request was received and when they can submit additional information. It will also tell them "the last date an Order on Reconsideration can be issued and the status of their request if the Department fails to mail a reconsideration order" on time. OAR 436-30-135(3). The rules contain a number of other provisions concerning the order on reconsideration, all of which assume that a request for reconsideration will lead to an order on reconsideration that is subject to the Board's administrative review under ORS 656.283.

Despite this assumption in the rules, the Department argues that there is an essential distinction between an order on reconsideration, which is the result of a decision on the merits, and an order denying reconsideration, which occurs before any Departmental consideration of the merits. There is presently some support for that position in OAR 436-30-008(3), which provides that certain actions would be subject to the Director's review because they do not involve the payment of compensation, which is necessary for Board review under ORS 656.283. The only specific examples that the rule gives of things in that category are "orders denying reconsideration [and] jurisdictional dismissals[.]" That is the only reference in the workers compensation rules or statutes to an "order denying reconsideration."[4] The difficulty with the Department's approach is that, under the statutes, the correct appeal route depends solely on the nature of the proceeding, not on the nature of the Director's order.

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[2] Claimant argues that the 1995 amendments to ORS 656.268 do not apply to this case, because they apply only to claims in which the injured worker became medically stationary after June 7, 1995, and because they do not apply to changes in time limitations on any act taken before that date. Or Laws 1995, ch 332, § 66(4), (6). The Department does not appear to challenge that argument. All future references to the relevant statutes and administrative rules are to the versions that were in effect at the times involved in this case, without prefacing them with the signal *former*. Unless otherwise stated, references to the administrative rules are to the version that became effective on January 1, 1995. Although both the statutes and the rules have since been amended, the subsequent changes do not appear to affect the issues that we decide.

[3] The rule in effect when claimant filed his request for consideration, OAR 43630-050 (repealed effective January 1, 1995), had similar but less detailed requirements than those in the rules discussed in that paragraph.

[4] In July 1994, when the Department issued the Order Denying Reconsideration in this case, the rules did not contain any reference to such an order.

In its brief, the Department argues that filing a request for reconsideration does not necessarily mean that the Department will reconsider the notice. In this case, it states, "[c]ontrary to claimant's assumption, the department did not initiate the reconsideration process,[5] because the **<152 Or App 19/20>** department determined that the request for reconsideration was not properly submitted." The Department thus appears to distinguish between orders on the merits of the request and orders dismissing the request without reaching the merits and to assume that the second category of orders does not involve a "matter conceming a claim" and thus is not subject to Board review under ORS 656.283.

The statutes do not support the Department's position. ORS 656.704(3) provides that, for the purpose of distinguishing between the Director's and the Board's authority to review decisions, a matter concerning a claim includes "those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue." The statute, that is, focusses on the nature of the *proceeding*, not on the nature of the *decision*. By filing his request for reconsideration, claimant initiated a reconsideration proceeding. The issue that he wants the Department to reconsider is whether the amount of compensation that SAIF awarded in its Notice of Closure is correct. Whether the Department conducted the reconsideration or determined that the request was untimely does not affect the fact that a proceeding in which the issue was additional compensation had begun. The effect of the Department's determination that claimant's request was untimely was to terminate a proceeding whose purpose was to determine the correct amount of compensation for a claimant who has an accepted claim. That question was directly in issue.

That the Department decided that claimant was not entitled to additional compensation on procedural rather than substantive grounds does not affect the basic nature of the proceeding that claimant initiated and, thus, does not affect the route for him to appeal that decision. Because that conclusion flows directly from the statutes, the one passing reference in the rules to an order denying reconsideration does not bring it into question. The Director cannot by rule change an appellate route established by statute.

The Board and the Department rely on *Lankford v. Copeland*, 141 Or App 138, 917 P2d 55 (1996), *overruled as to disposition, Oldham v. Plumlee*, 151 Or App 402, 404, ___ P2d ___ (1997),[6] to support their position. In that case the question in the proceeding was whether the claimant was a subject worker; the Director had concluded that she was not. Whether the claimant **<152 Or App 20/21>** had a right to compensation, and if so the amount of the compensation, would be directly in issue only if she were a subject worker and thus entitled to seek compensation. The proceeding that we reviewed could determine only whether she had crossed that preliminary hurdle. For that reason, we held that the proceeding was not a matter concerning a claim and that the Board did not have jurisdiction over it. In contrast, in this case the proceeding directly involves the amount of claimant's compensation. Because the nature of the proceeding, not the nature of the decision, determines the appropriate appeal route, *Lankford* does not support the Department's position.

Claimant initiated a reconsideration proceeding when he filed a request for reconsideration. That proceeding directly involved the amount of claimant's compensation. The Department terminated that proceeding when it issued the Order Denying Reconsideration. The reason for the termination, or whether the Department engaged in any evaluation of the merits, is irrelevant to the nature of the proceeding that claimant initiated and to the Board's jurisdiction to review the merits of the termination. The Board erred when it ruled otherwise.

Reversed and remanded.

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[5] It may be more accurate to state that the Department did not undertake the review on the merits that a full reconsideration would entail. Under the relevant statutes and rules, claimant, by filing a request for reconsideration, inititated a reconsideration proceeding.

[6] Nothing in *Oldham v. Plumlee*, 151 Or App 402, ___ P2d ___ (1997), affected the merits of our decision in *Lankford*.

Cite as 152 Or App 117 (1998) January 7, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Julio Filippi, Claimant.

**HASKELL CORPORATION** and Employers Insurance of Wausau, a mutual company, *Petitioners*
v.
**Julio FILIPPI**, SAIF Corporation, Oregon Parks and Recreation, and Circle C. Farms, Inc., *Respondents.*
(WCB 96-00397, 96-00383, 95-04502, 95-07470; CA A95201)

Judicial Review from Workers' Compensation Board.

On respondents SAIF Corporation and Oregon Parks and Recreation's Motion to Dismiss Petitions for Judicial Review and Summarily Affirm the Board's Order Denying Reconsideration filed June 10, 1997.

David L. Runner, Special Assistant Attorney General for motion.

David O. Horne, *contra.*

Before Landau, Presiding Judge, and Haselton and Armstrong, Judges.

HASELTON, J.

Motion to dismiss the judicial review granted. Motion to summarily affirm granted. Motion to remand denied.

Armstrong, J., dissenting.

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**152 Or App 119>** Employers Insurance of Wausau (Wausau) seeks judicial review of the Workers' Compensation Board's order on reconsideration, in which the Board modified and republished an order on review affirming the administrative law judge's (ALJ) determination of Wausau's responsibility under ORS 656.308(1) for claimant's condition. Altematively, Wausau seeks judicial review of the Board's subsequent order denying Wausau's request that the Board abate and republish its order on reconsideration. Respondent SAIF Corporation has moved to dismiss the judicial review of the order on review and order on reconsideration and to summarily affirm the Board's subsequent order denying abatement and republication. In response, Wausau has moved to remand the case to the Board. We grant the motions to dismiss and to summarily affirm and deny the motion to remand.

The underlying facts pertaining to claimant's condition are not germane to our consideration of these motions. It suffices to say that Wausau and SAIF dispute responsibility for claimant's back condition. The ALJ concluded that Wausau's employer was responsible for that condition. Wausau sought review of the ALJ's order, and, on October 11, 1996, the Board issued an order on review affirming the ALJ's responsibility determination.

On November 7, 1996, Wausau filed with this court a timely petition for judicial review of the Board's order on review. On November 8, 1996, in response to claimant's motion, the Board withdrew its order on review for reconsideration.[1]

On December 6, 1996, the Board issued an order on reconsideration. The Board modified its order on review to **<152 Or App 119/120>** award claimant $500 in attorney fees but otherwise republished its order on review in its entirety. Wausau did not file an amended petition forjudicial review within 30 days of the Board's December 6, 1996 order.

On January 17, 1997, this court issued a notice of default to Wausau for failure to cause the record to be served and filed in connection with its November 7, 1996 petition for judicial review. At that point, according to Wausau's attorney, he discovered that he had not received a copy of the Board's December 6, 1996 order on reconsideration. On January 23, 1997, Wausau asked the Board to abate and republish its order on reconsideration because Wausau's attorney had not been served with that order. Wausau did not contend that it had not been served, only that its attorney had not been served.

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[1] Although Wausau's petition for judicial review had already been filed when the Board withdrew its order on review, the Board retained plenary authority under ORS 656.295 to decide all matters committed to it by the legislature, limited only by ORS 656.295(8), which provides that orders become final 30 days after mailing. Thus, because the Board acted within 30 days of October 11, 1996, it had authority to withdraw its order on review notwithstanding the intervening petition for judicial review. *See SAIF v. Fisher*, 100 Or App 288, 291-92, 785 P2d 1082 (1990).

On January 28, 1997, the Board denied Wausau's request. The Board noted that, for its order on reconsideration to become final, it was necessary only that the *parties*, and not their attorneys, be served. *See, e.g., Berliner v. Weyerhaeuser Company*, 92 Or App 264, 266 n 1, 758 P2d 384 (1988). Because Wausau admitted that it had received a copy of the order, the Board concluded that its December 6, 1996 order on reconsideration had become final by operation of law and that it was without authority to abate and reconsider that order.[2]

On January 30, 1997, Wausau responded to our notice of default and moved for leave to cause the record to be filed and served. Also on January 30, 1997, Wausau filed an amended petition seeking judicial review of the Board's December 6, 1996, order on reconsideration or, alternatively, of the Board's January 28, 1997, order denying its request for abatement and republication. On February 3, 1997, we granted Wausau relief from default.

SAIF moves to dismiss Wausau's petition for judicial review as to the October 11, 1996, order on review and the **<152 Or App 120/121>** December 6, 1996, order on reconsideration and to summarily affirm the Board's January 28, 1997, order denying Wausau's request for abatement and republication of the order on reconsideration. SAIF contends that we lack jurisdiction with respect to the first two matters. SAIF acknowledges that the original petition for judicial review of the October 11, 1996, order was timely. However, SAIF contends that, because the Board withdrew that order and allowed reconsideration within 30 days of October 11, 1996, that order was rendered a "nullity," and, notwithstanding the intervening petition for judicial review, this court's jurisdiction was "extinguished."[3] SAIF further argues that, under ORS 656.295(8), if Wausau wished to challenge the Board's December 6, 1996, order on reconsideration, it had to file an amended petition for judicial review within 30 days, *i.e.*, no later than January 6, 1997.[4] Because Wausau did not file an amended petition forjudicial review until January 30, 1997, SAIF asserts that we lack jurisdiction to review the December 6, 1996, order and that the only matter properly before us is the January 28, 1997, order.

Wausau makes three responses: (1) SAIF's jurisdictional objection is "untimely."[5] (2) The Board erred in concluding that the order on reconsideration had become final 30 days after December 6, 1996, regardless of whether Wausau's attorney was served with that order--*i.e.*, that service on a party's attorney is not a prerequisite of finality. (3) Notwithstanding the Board's alternative factual finding that Wausau's attorney had actually been served, *see* 152 Or App at **<152 Or App 121/122>** 120 n 2, we should remand to the Board for an evidentiary hearing on that matter.

Wausau's "timeliness" argument is unavailing. A motion challenging this court's subject matter jurisdiction can be raised at any time. ORAP 7.05(1)(c); *State ex rel Juv. Dept. v. Paull*, 129 Or App 227, 229, 878 P2d 1135 (1994) (state moved to dismiss for lack of appellate jurisdiction after it waived the filing of a brief and indicated it would not appear in the case); *Blundell v. Holm*, 73 Or App 346, 698 P2d 981 (1985) (motion to dismiss for lack of appellate jurisdiction made after our decision had been issued). Indeed, even if parties never raise the issue, we are obligated to consider our jurisdiction. *See, e.g., Emmert Industrial Corp. v. Douglass*, 130 Or App 267, 269, 881 P2d 827, *rev den* 320 Or 325 (1994). *Cf. State v. Threet*, 294 Or 1, 4, 653 P2d 960 (1982) (appellate court jurisdiction cannot be conferred by stipulation of the parties). Thus, whether or not SAIF previously asserted that we lack jurisdiction, we are required to examine the issue.

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[2] The Board alternatively found that, in all events, Wausau's attorney had, in fact, been served with a copy of the order on reconsideration.

[3] In paraphrasing SAIF's argument, we do not endorse its characterization that our jurisdiction is "extinguished" when an agency withdraws an order for reconsideration. *See State ex rel Hall v. Riggs*, 319 Or 282, 294, 877 P2d 56 (1994) ("[W]here an order has been withdrawn only for reconsideration, rather than being withdrawn completely, the reviewing court retains jurisdiction over the judicial review proceeding concerning that order."); *see generally* ORAP 4.35.

[4] Thirty days after December 6, 1996, was January 5, 1997, a Sunday. Because the thirtieth day fell on a Sunday, Wausau would have had until the following Monday, January 6, 1997, in which to file an amended petition. *See* ORS 174.120; *SAIF v. Edison*, 117 Or App 455, 458, 844 P2d 261 (1992).

[5] Wausau asserts that, because, after it filed its amended petition for judicial review, it filed a document entitled "response and motion" in which it argued that this court still had jurisdiction, and because SAIF did not respond to that document within 14 days, ORAP 7.05(3), SAIF should be precluded from now raising a jurisdictional objection.

Wausau next argues that the Board's December 6, 1996, order on reconsideration is a "nullity" or "invalid" because its attorney was not served with the order. Although the argument is somewhat amorphous, we understand Wausau to be contending that, if the December 6, 1996, order was not served on its attorney, that order did not become "final" under ORS 656.295(8)--*i.e.*, unreviewable--before Wausau filed its amended petition for judicial review and, thus, it is reviewable within the ambit of the amended petition for review.

We reject that argument. Pursuant to ORS 656.295(8), a petition for judicial review of any Board order must be made within 30 days after the order is mailed "to the parties."[6] If no petition for judicial review is filed within 30 days, the order is unreviewable by this court. *See Southwest Forest Industries v. Anders*, 299 Or 205, 218, 701 P2d 432 (1985) ("No later than midnight on the 30th day the order is **<152 Or App 122/123>** final, both internally and externally."); *see also* ORS 656.295(7) (requiring service of order on "the parties").

ORS 656.005(21) defines "party" as "a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer." ORS 656.005(21). *See also* ORS 656.003 ("Except where the context otherwise requires, the definitions given in this chapter govern its construction."). Nothing in ORS 656.295(7) or (8) expands the definition of "party" or requires service on or mailing to a party's attorney before the 30-day period is triggered. *See generally Berliner v. Weyerhaeuser Company*, 92 Or App 264, 266 n 1, 758 P2d 384 (1988) (in addressing whether mailing of Board order complied with ORS 656.295(8), we observed, "Claimant is the only party claiming that he did not receive the order; his attorney asserts that he did not receive it either.") (emphasis in original); *cf. United Pacific Ins. v. Harris*, 63 Or App 256, 258 n 1, 663 P2d 1307, *rev den* 295 Or 730 (1983) (denying motion to dismiss under ORCP 9A on ground that an insurer's attorney was not served with the petition for judicial review: ORS 656.298(3) "requires that a notice of appeal be sent to all *parties*, [but] does not *require* that it be sent to all *attorneys* representing the parties") (emphasis in original).[7] Thus, Wausau's attorney's receipt, or nonreceipt, of the December 6, 1996 order on reconsideration was immaterial to the determination of whether that order became final for purposes of ORS 656.795(8).[8] Because Wausau did not file an amended petition within 30 days, that order became final and unreviewable.[9]

**152 Or App 124>** That, however, does not end our inquiry. Although Wausau does not so argue, SAIF acknowledges that it is at least arguable that Wausau was not required to file *any* amended petition to obtain review of the December 6 order on reconsideration, that is, that the original November

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[6] ORS 656.295(8) provides, in part:

"An order of the board is final unless within 30 days after the date of mailing of copies of such order to the parties, one of the parties appeals to the Court of Appeals for judicial review pursuant to ORS 656.298."

[7] *See also Adams v. Transamerica Insurance*, 45 Or App 769, 776, 609 P2d 834 (1980) (Gillette, J., specially concurring) ("appeals" from Board "may only be taken by a 'party'" as defined in ORS 656.005(22) and "cannot include plaintiff here," who was claimant's attorney).

[8] Given our conclusion in that regard, we necessarily deny Wausau's motion to remand.

[9] The requirements of ORS 656.295 differ from those of other workers' compensation statutes in which failure to serve a party's attorney may be material. For example, under ORS 656.319(1), a claimant must request a hearing on a denied claim within 60 days after the denial is mailed but, upon a claimant's showing of good cause, that limited period may be extended to 180 days. We have held that an insurer or self-insured employer's failure to serve the denial on a claimant's attorney may be such "good cause." *See, e.g., Freres Lumber Co. v. Jegglie*, 106 Or App 27, 806 P2d 164 (1991); *Cowart v. SAIF*, 94 Or App 288, 765 P2d 226 (1988). *See also* ORS 656.331(1)(b) (setting forth situations in which insurers and self-insured employers may not contact claimants without also contacting their attorneys); OAR 436-060-0015 (same).

The legislature has not created any similar mechanism with respect to ORS 656.295(8). If a petition for judicial review is not filed before the order becomes final, we lack the authority to consider *why* the petition was not timely. *Cf. Pease v. National Council on Comp. Ins.*, 113 Or App 26, 29, 830 P2d 605, *rev den* 314 Or 391 (1992) (holding that agency properly dismissed appeal not filed within statutory time limit where "the legislature has not chosen to provide a way around the limitation for those who were unable to meet it for some reason").

7 petition was sufficient by itself to confer jurisdiction to review not only the original (and now superseded) October 11 order but also the subsequent order on reconsideration. Having raised that argument, SAIF then refutes it. SAIF asserts that, regardless of the original petition, Wausau was required to file a timely amended petition for judicial review following the Board's issuance of the order on reconsideration and that Wausau's failure to do so is fatal. We agree.

Two provisions are pertinent. ORS 183.482(6) provides, in part:

> "If the petitioner is dissatisfied with the agency action after withdrawal for purposes of reconsideration, the petitioner may refile the petition for review and the review shall proceed upon the revised order. An amended petition for review shall not be required if the agency, on reconsideration, affirms the order or modifies the order with only minor changes."

ORAP 4.35(4) provides, in part:

> "(a) After the filing of an order on reconsideration, if the petitioner desires judicial review of the order on reconsideration, the petitioner shall file an amended petition for judicial review within a period equal to that allowed for filing an original petition. * * *
>
> "* * * * *
>
> "(c) If no petition is timely filed, the judicial review proceeding in the Court of Appeals will be dismissed."

**152 Or App 125>** Thus, ORS 183.482(6) requires the filing of an amended petition for judicial review from an order on reconsideration except when that order either completely affirms or makes only "minor changes" to the original, withdrawn order. In contrast, ORAP 4.35(4) requires the filing of an amended petition for judicial review in *all* cases.[10]

We have not decided whether ORS 183.482(6) applies to workers' compensation proceedings. Compare *United Foam Corp. v. Whiddon*, 92 Or App 492, 758 P2d 435 (1988) *with SAIF v. Fisher*, 100 Or App 288, 785 P2d 1082 (1990). *See also Fischer v. SAIF*, 76 Or App 656, 711 P2d 162 (1985), *rev den* 300 Or 605 (1986).[11] We need not resolve that issue here, because even assuming, without deciding, that ORS 183.482(6) does apply, its terms require an amended petition in this case. The Board's order on reconsideration materially differed from the original order in that it conferred additional substantive relief, *viz.* an award of attorney fees. Because the order on reconsideration did not merely "affirm [ ] the order or modif[y] the order with only minor changes," Wausau was required under ORS 183.482(6) to file a timely amended petition for judicial review. Because Wausau failed to do so, the original judicial review proceeding initiated by **<152 Or App 125/126>** the November 7 petition must be dismissed. *See, e.g., Knapp v. Employment Division*, 67 Or App 231, 677 P2d 738 (1984) (dismissal after the petitioner failed to file a timely amended petition for judicial review after issuance of an order on reconsideration).

Conversely, assuming, without deciding, that ORS 183.482(6) does not apply to review of workers' compensation proceedings, the plain terms of ORAP 4.35(4)(c) compel dismissal of the original

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[10] Because of that "slippage" between the statute and the rule, a party can comply with the former but nevertheless violate the latter. That is, in a case subject to ORS 183.482(6), where the agency made only "minor changes" on reconsideration, a petitioner who failed to file an amended petition would comply with the statute, but violate ORAP 4.35(4). That disparity may be a historical anomaly. At the time ORAP 4.35(4) was promulgated in 1990, the then-extant version of ORS 183.482 required the filing of an amended petition in every case. *See Nida v. Bureau of Labor and Industries*, 112 Or App 1, 3-4, 826 P2d 1045 (1992) (observing that ORAP 4.35(4) is consistent with a previous version of ORS 183.482(6)). Thereafter, the statute was amended to add the second sentence of the present text.

[11] Before 1987, it was clear that ORS 183.482(6) applied to workers' compensation proceedings. *Fischer v. SAIF*, 76 Or App at 569-60. However, in 1987, the legislature amended ORS 656.298(6) by adding the sentence, "[Judicial r]eview shall be as provided in ORS 183.482(7) and (8)." In *United Foam*, we relied on that language in holding that ORS 183.482(5) did not apply to workers' compensation proceedings. *United Foam*, 92 Or App at 493. Although *United Foam* did not discuss the applicability of ORS 183.482(6), our broader point--that the legislature "intended only what it expressly said" when it included "specific reference to specific parts" of ORS 183.482 in ORS 656.298(6)--might seem to apply equally to ORS 183.482(6). In *SAIF v. Fisher*, without referring to *United Foam*, we expressly noted, but did not reach, the question of whether the legislature, in amending ORS 656.298(6), intended to render ORS 183.482(6) inapplicable to workers' compensation proceedings. 100 Or App at 291 n 2.

judicial review proceeding because Wausau failed to file an amended petition for judicial review within 30 days of December 6.

Because the December 6 order on reconsideration is final and thus unreviewable by this court and because, without a timely amended petition for judicial review, review proceedings as to the October 11 order on review cannot continue, we grant SAIF's motion to dismiss.

We turn finally to the one remaining matter that is properly before us: Wausau's January 30, 1997, amended petition for judicial review. For the reasons described above, the only matter that is reviewable under that petition is the Board's January 28, 1997, order denying Wausau's motion to abate and republish the December 6 order on reconsideration. SAIF asks us to summarily affirm with respect to that petition. We agree that summary affirmance is appropriate. Wausau identifies no error in the Board's order beyond matters that are necessarily derivative of Wausau's arguments that we have addressed and rejected.

Motion to dismiss the judicial review granted. Motion to summarily affirm granted. Motion to remand denied.

**ARMSTRONG**, J., dissenting.

I dissent from the majority's decision to dismiss the petition for review of the Board's order on reconsideration. In dismissing the petition, the majority asserts that it need not decide whether ORS 183.482(6) applies to workers' compensation cases. 152 Or App at 125. It bases that assertion on its conclusion that the order on reconsideration changed the original order in a nonminor, material manner. Thus, even if ORS 183.482(6) were applicable to this case, petitioner had to **<152 Or App 126/127>** submit an amended petition for judicial review within 30 days of the order on reconsideration. The majority fails, however, to provide any convincing support for its conclusion that the order on reconsideration so changed the original order as to require the filing of an amended petition. Because I believe that the addition of the attorney-fee award to the order on reconsideration was not a change that required the filing of an amended petition if ORS 183.482(6) applies to this case, I believe that we must decide whether ORS 183.482(6) applies to workers' compensation cases.

The majority notes that we have questioned whether ORS 183.482(6) applies to workers' compensation cases. 152 Or App at 125 n 11 and accompanying text. *See, e.g., SAIF v. Fisher*, 100 Or App 288, 291 n 2, 785 P2d 1082 (1990). We have held that subsection (5) of ORS 183.482 does not apply to workers' compensation cases, but that was a narrow holding that was premised on the fact that that subsection includes a procedure that the legislature specifically removed from our review authority under ORS 656.298. *United Foam Corp. v. Whiddon*, 92 Or App 492, 493, 758 P2d 435 (1988) (*per curiam*). We have not held that the statute as a whole does not apply to workers' compensation cases.

Respondents argue that the legislative history of ORS 656.298 indicates that the legislature intended to make ORS 183.482(6) inapplicable to workers' compensation cases. Indeed, in *Fisher*, 100 Or App at 291 n 2, we recognized that there was some concern by the legislature about whether ORS 183.482 as a whole should apply to those cases. The concern, voiced by Senator Hill, was that ORS 183.482 was redundant of procedures already applicable to those cases or, where not redundant, was inappropriate. We further noted, however, that in the context of workers' compensation cases, subsection (6) of ORS 183.482 was neither redundant nor inappropriate. *Id.* Moreover, there is nothing in the legislative history that supports a conclusion that the legislature intended to overrule our earlier decision in *Fischer v. SAIF*, 76 Or App 656, 659-60, 771 P2d 162 (1985), *rev den* 300 Or 605 (1986), in which we applied ORS 183.482(6) to a workers' compensation case. *Fisher*, 100 Or App at 291 n 2.[1]

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[1] In fact, the legislative history of the 1989 amendment to ORS 183.482(6) indicates that it was adopted to respond to what one representative perceived as a "glitch" that had come to light in a *workers' compensation case*. Representative Edmundson proposed the amendment to address what he saw as an unnecessary and expensive step in the judicial-review process. Referring to a workers' compensation case that was then pending before the Supreme Court, Representative Edmundson explained that one of the issues in that case was SAIF's failure to file an amended petition after the Board had withdrawn its order and then republished it without modification. He stated:

> "SAIF has been caught by [this] trip in the rope. It's happened to me in other cases, in our practice in our office. We file the amended petitions and it just seems like extra expense that really shouldn't have to be gone through."

Tape recording, House Subcommittee on Civil Law, May 8, 1989, Tape 94, Side B.

**152 Or App 128>** It is true that certain portions of ORS 183.482 are redundant of ORS 686.298, *see, e.g.*, ORS 183.482(1) and (4), or facially inapplicable to workers' compensation cases, *see, e.g.*, ORS 183.482(2) and (3). Unlike those subsections, however, ORS 183.482(6) is neither redundant of a provision of the Workers' Compensation Law nor on its face inapplicable to workers' compensation cases. In fact, there is *nothing* in our earlier decisions or in the various revisions of the Workers' Compensation Law to indicate that it should not apply to those cases. Hence, I conclude that ORS 183.482(6) applies to this case. Accordingly, the dispositive question is whether the addition of an award of $500 in attorney fees to the order on reconsideration is a sufficient modification of the original order to trigger the requirement that petitioner file an amended petition for judicial review.

The majority concludes that the award of attorney fees materially changed the original order by conferring additional substantive relief, 152 Or App at 125, and therefore required an amended petition. I disagree. I believe that the legislature amended ORS 183.482(6) to require a petitioner to file an amended petition only when the changes to the original order are significant enough to lead the petitioner to reevaluate the wisdom of going forward with the review process. Hence, minor changes are those that, from the petitioner's perspective, do not affect the essential nature and reasoning of the decision. In this case, petitioner seeks review of the Board's conclusion that petitioner is responsible for claimant's compensation. The Board's order on reconsideration did not change that conclusion or the facts and reasoning that supported it. Indeed, should petitioner prevail on review, the issue of attorney fees, insofar as it applies to **<152 Or App 128/129>** petitioner, would itself be moot. In the past 15 years, the legislature has tried to streamline and make more efficient the workers' compensation process and the appeal and review process. *See, e.g.*, Or Laws 1985, ch 734, § 5; note 1 above. To require petitioner to file an amended petition when the underlying facts relevant to its decision to seek review have not changed would fly in the face of that legislative effort.

Finally, the majority concludes that ORAP 4.35(4)(a) also requires dismissal of this case. That rule requires a petitioner who has filed a petition for judicial review to file an amended petition when an agency withdraws the order on which review was sought and enters an order on reconsideration. It provides that the court will dismiss a petition if the required amended petition is not filed within the time limit that applied to the original petition. The rule apparently is based on ORS 183.482(6) as it read *before* the legislature amended it in 1989 to permit review to go forward without an amended petition when the order on reconsideration "affirms the [original] order or modifies the order with only minor changes." We have the authority to waive our rules for good cause on our own motion. ORAP 1.20(4). Because ORAP 4.35(4) is inconsistent with ORS 183.482(6), and because of the circumstances under which petitioner failed to file an amended petition in this case, I would waive ORAP 4.35(4) and permit the review to go forward.

For the foregoing reasons, I respectfully dissent from the decision to dismiss the review of the order on reconsideration.

Cite as 152 Or App 239 (1998) January 21, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Virginia McClearen, Claimant.

**ROGUE VALLEY MEDICAL CENTER**, *Petitioner*,
v.
**Virginia McCLEAREN**, *Respondent*.
(WCB 95-04438; CA A96102)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 14, 1997.
Adam T. Stamper argued the cause for petitioner. With him on the brief was Cowling, Heysell, Plouse & Ingalls.
Bruce D. Smith argued the cause and filed the brief for respondent.
Before De Muniz, Presiding Judge, and Haselton and Linder, Judges.
LINDER, J.
Affirmed.

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**152 Or App 241>** Employer seeks review of a Workers' Compensation Board order reinstating claimant's award of permanent total disability (PTD). The primary issue on review is whether the Board correctly concluded that ORS 656.283(7), as amended in 1995,[1] bars the admission of evidence not submitted at the reconsideration level in a PTD dispute. We review for errors of law, ORS 656.298(7), ORS 183.482(8), and affirm.

Claimant worked for employer for approximately 18 years as a medical transcriptionist. In 1991, she fell at work, compensably injuring her left knee, hip and buttock. Claimant also suffered from congenital back and pulmonary health problems, neither of which affected her ability to do her job, but which limited treatment options for her compensable injury. Increased pain in her left lower back and left hip resulting from the injury caused claimant to reduce her work schedule in late 1992. Due to chronic pain and her inability to work while taking pain relievers, claimant resigned on March 31, 1993.

On September 23, 1994, claimant's claim was closed by a determination order awarding her 18 percent unscheduled permanent partial disability (PPD). Claimant requested reconsideration. In the reconsideration proceeding, claimant requested PTD and presented a written report of a vocational expert, stating that claimant could not be gainfully employed at that time. Claimant also presented reports from her attending physician. The order on reconsideration, dated April 6, 1995, awarded claimant PTD.

Employer requested a hearing. In advance of the hearing, employer, by letter, advised the administrative law judge (ALJ) that the parties had conferred about "the admissibility of medical, vocational and lay evidence at a post-SB 369 hearing where the issue is permanent total disability." The parties asked for "some guidance concerning the admissibility of expert vocational testimony that was not before the Appellate Review Unit on reconsideration." In response, the **<152 Or App 241/242>** ALJ issued an "interim order" in which the ALJ concluded that "the limitations of ORS 656.283(7) do not apply to the issue of permanent total disability."

At the hearing, employer submitted the report of a doctor who had examined claimant on August 8, 1995, and who opined that claimant could perform part-time work at home. Employer also called as a witness a vocational consultant, who testified that he had reviewed the documentary evidence and concurred that claimant could be gainfully employed working in her home on a part-time basis. Relying on that evidence, the ALJ reinstated the 18 percent unscheduled PPD that had been awarded in the determination order.

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[1] Or Laws 1995, ch 332, § 34. We have held that chapter 332 generally applies retroactively to pending cases. *Volk v. America West Airlines*, 135 Or App 565, 899 P2d 746 (1995), *rev den* 322 Or 645 (1996).

Claimant appealed the ALJ's order to the Board. The Board determined that "the record at any subsequent hearing concerning a challenge to the reconsideration is limited as stated in *amended* ORS 656.283(7)." Thus, the Board concluded that the ALJ erroneously considered the post-reconsideration evidence. Examining the record *de novo* and without the post-reconsideration evidence, the Board found that claimant was entitled to PTD and reinstated the April 6, 1995, award on reconsideration.

On judicial review, employer disputes the Board's application of ORS 656.283(7), arguing that the evidentiary limitation in the statute does not apply to PTD determinations. Employer also asserts that claimant's challenge to the post-reconsideration evidence was not preserved.[2]

We begin with the preservation question. Employer relies on *Fister v. South Hills Health Care*, 149 Or App 214, 216, 942 P2d 833 (1997), to argue that the Board erred in considering the admissibility of the post-reconsideration evidence under ORS 656.283(7), because the evidence was submitted at the hearing without objection. This case differs **<152 Or App 242/243>** from *Fister*, however. Here the parties sought and obtained a prehearing ruling from the ALJ on the admissibility of the new evidence. As a general proposition, a party does not have to object to evidence at the time of trial or hearing when a conclusive determination of admissibility has been made beforehand. *See, e.g., State v. Cole*, 323 Or 30, 35, 912 P2d 907 (1996) (pretrial ruling sufficient to preserve error even where objection to evidence could have been renewed at trial). Nevertheless, employer urges that the parties, by requesting the preheating ruling, were agreeing to be bound by it. We find no support, however, for that characterization of what occurred. The record reflects only that the parties agreed to seek a prehearing ruling on the admissibility of the post-reconsideration evidence. The ALJ gave them that ruling. Neither the letter requesting the ruling nor the ALJ's interim order suggests that the parties were waiving their ability later to dispute the ALJ's legal conclusion on the application of the statute. We conclude that the issue was properly preserved for the Board's review.

We turn to the merits. In interpreting the statute, the starting point, of course, is the statute's text and context. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610, 859 P2d 1143 (1993). ORS 656.283(7), as amended, provides, in part:

> "Except as otherwise provided in this section * * * the [ALJ] is not bound by common law or statutory rules of evidence[.] * * * Evaluation of the worker's disability by the [ALJ] shall be as of the date of issuance of the reconsideration order pursuant to ORS 656.268. Any finding of fact regarding the worker's impairment must be established by medical evidence that is supported by objective findings. * * * Evidence on an issue regarding a * * * determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing * * *."

The statute's terms are relatively straightforward. The statute provides that evidence on an issue regarding a determination order is not admissible at the hearing before the ALJ if it was not submitted at the reconsideration level.

There is no ambiguity in that language. As we stated in *Precision Castparts Corp. v. Plummer*, 140 Or App 227, 231, 914 P2d 1140 (1996):

> **152 Or App 244>** "The unmistakable import of the text of ORS 656.283(7) is that *any* evidence, including a claimant's own testimony concerning the notice of closure or reconsideration order, is inadmissable at a subsequent hearing concerning the extent of the injured worker's permanent disability if not submitted at reconsideration and not made part of the reconsideration record." (Emphasis in original.)

We agree with that observation in *Precision Castparts* and find the import of ORS 656.283(7) to be as unmistakable now as it was then. Under the amended terms of the statute, in determining permanent disability, *any* evidence, including vocational evidence, not submitted during the reconsideration process is inadmissible at a subsequent hearing.

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[2] We note that employer also assigns error to the Board's PTD finding. Employer does not separately argue that point, however. *See* ORAP 5.45(6) (separate argument must follow each assignment of error unless the assignments present essentially the same legal question). We therefore understand employer to challenge the PTD finding only on the theory that the Board should have considered employer's post-reconsideration evidence of employability. Because we conclude that the Board properly rejected that evidence, employer's limited challenge to the PTD finding fails.

Employer, however, argues that the statute does not apply to PTD determinations, for two reasons. Looking to context, employer urges that the statute conflicts with ORS 656.287(1), which provides:

> "Where there is an issue regarding loss of earning capacity, reports from vocational consultants * * * regarding job opportunities, the fitness of claimant to perform certain jobs, wage levels, or other information relating to claimant's employability shall be admitted into evidence at compensation hearings, provided such information is submitted to claimant 10 days prior to hearing and that upon demand from the adverse party the person preparing such report shall be made available for testimony and cross-examination."

Employer's argument seems to be that ORS 656.287(1) provides broadly for the admission of vocational evidence in PTD hearings and it therefore will be rendered "without effect" if ORS 656.283(7) excludes post-reconsideration vocational evidence at the hearing before the ALJ. To be sure, ORS 656.287(1) standing alone provides for the admission of vocational report evidence at "compensation hearings" (that is, at the hearing before the ALJ) subject only to the condition that the report be disclosed to the claimant 10 days prior to the hearing. As amended, however, ORS 656.283(7) provides a further qualification on the admissibility of vocational evidence. Now, the vocational evidence must also have been submitted at the reconsideration level. We agree with the Board's order on review, where it stated:

> **152 Or App 245>** "In the face of the 1995 Legislature's clear and unqualified intent to limit evidence at hearing to evidence submitted at reconsideration, we decline to broadly interpret ORS 656.287(1) as a grant of authority to admit 'post-reconsideration' vocational evidence at such a hearing. Such an interpretation would undermine the evidentiary limitation the legislature sought to impose under the 1995 Act. Rather, in order to best harmonize the provisions of ORS 656.287(1) and amended ORS 656.283(7), we interpret ORS 656.287(1) as a grant of authority to admit at hearing vocational reports so long as: (1) the reports were previously submitted at the reconsideration proceeding; and (2) the other requirements of ORS 656.287(1) are fulfilled. These requirements include the condition that the vocational consultant whose report is being offered into evidence at hearing must be made available for testimony and cross-examination at hearing, upon request by the adverse party."

The Board correctly concluded that the two statutes can be harmonized to give effect to both. Because they can be, they must be. ORS 174.010.[3]

Employer's remaining argument is that the evidentiary limitation in ORS 656.283(7) must be understood to apply only to permanent partial disability (PPD) determinations. Employer reasons that permanent total disability (PTD) determinations require the most contemporaneous information available about a claimant's ability to work, rather than "outdated or speculative information." In effect, employer argues that the record in a PTD case must remain open at the hearing before the ALJ, because PTD determinations demand the most current evidence bearing on a claimant's employability.

Employer's argument ignores the statutory change at issue in this case. Previously, ORS 656.283(7) contained no procedural limitation on the evidence that the AJJ could consider in evaluating a claimant's disability. That was true even though ORS 656.283(7), since 1990,[4] has provided that a **<152 Or App 245/246>** worker's disability is to be evaluated as of the date of issuance of the reconsideration order. We therefore held in *Safeway Stores, Inc. v. Smith*, 122 Or App 160, 857 P2d 187 (1993), that although the ALJ must evaluate disability as of the date of issuance of the reconsideration order, the ALJ may consider evidence on that question that could not have been submitted on reconsideration. We described that result as "curious," but "compelled by the statutes." *Id.* at 163.

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[3] Moreover, we note that the Board in this case also interpreted ORS 656.287(1) to permit cross-examination at the ALJ hearing of the person who prepared the report, if the adverse party requests it. Assuming that the Board is correct in that conclusion (a conclusion neither party disputes on review), the statute has continuing force and effect in that regard as well.

[4] Or Laws 1990, ch 2, § 20 (Spec Sess).

The 1995 amendment to ORS 656.283(7) eliminated that curious result, and in doing so, eliminated the premise from which employer argues. The legislature now has limited the disability determination to evidence submitted at the reconsideration proceeding, thus effectively closing the record at that point. It no longer is true that the record remains open through the hearing before the ALJ to new and more current evidence of the extent of a worker's disability.[5] Employer's argument is, at root, an objection to the statutory change, not a basis to construe the statute to mean something other than what it plainly says.

Affirmed.

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[5] That is not to suggest that the extent of a worker's disability is not subject to reexamination based on new evidence and circumstances. *See* ORS 656.206(4),(5) and OAR 436-30-055(5) (reexamination of PTD claims to occur every two years, on the basis of current information about a worker's employability). The point is that the review before the ALJ is no longer the time and place to expand the record to encompass any new information.

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Cite as 152 Or App 322 (1998) February 4, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Benjamin G. Santos, Claimant.

**Benjamin G. SANTOS**, *Petitioner,*
v.
**CARYALL TRANSPORT** and SAIF Corporation, *Respondents.*
(92-05344, 93-11469; CA A94232 (Control), A94233) (Cases Consolidated)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 22, 1997.
Donald M. Hooton argued the cause and filed the brief for petitioner.
Michael O. Whitty argued the cause and filed the brief for respondents.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LANDAU, J.
Affirmed.

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**152 Or App 324>** Claimant seeks review of two orders of the Workers' Compensation Board (Board) denying claimant's request for temporary partial disability benefits after the date that he became medically stationary. We affirm.

The facts are not in dispute. Claimant worked for employer as a full-time transport driver. On January 7, 1991, he injured his low back and right hip. He was taken off work and was referred to Dr. Flemming for physical therapy and chiropractic treatment. Employer began paying temporary total disability benefits. On February 8, 1991, Flemming released claimant to light-duty work, although there apparently was no such work available with employer at the time. On May 13, 1991, claimant began work as a school bus driver for a different employer. He worked only half time, but at the same hourly rate that he was paid at the time of his injury. Employer ceased paying temporary total disability benefits and began paying temporary partial disability benefits. On December 6, 1991, claimant saw Dr. Feldstein for continued low back symptoms. Feldstein stated that she would not authorize time loss. Employer then terminated temporary partial disability benefits.

Claimant requested a hearing on the termination of his temporary partial disability benefits. Meanwhile, the claim was closed by a January 6, 1993, determination order finding that claimant became medically stationary on December 5, 1991. Claimant requested reconsideration of the determination order. Thus, two separate proceedings began concerning claimant's entitlement to temporary partial disability benefits.

In the first proceeding, concerning the employer's unilateral termination of the benefits, the administrative law judge (ALJ) ultimately held for employer, on the ground that, under our opinion in *Lebanon Plywood v. Seiber*, 113 Or App 651, 833 P2d 1367 (1992), employer could not be ordered to pay

temporary partial disability benefits beyond the date that claimant became medically stationary. Claimant requested review, and the Board affirmed on the same ground. Claimant sought judicial review, and we remanded **<152 Or App 324/325>** for reconsideration in the light of recent amendments to the workers' compensation statutes. *Santos v. Caryall Transport*, 137 Or App 527, 905 P2d 865 (1995). On remand, the Board concluded that the recent amendments to the relevant statutes did not affect the viability of the *Lebanon Plywood* decision and reaffirmed its conclusion that it could not order employer to pay temporary partial disability benefits beyond claimant's medically stationary date. The Board's order on remand is the first of the two orders of which claimant now seeks review.

In the second proceeding, the appellate review unit affirmed the January 6, 1993, determination order and awarded temporary disability only through the medically stationary date of December 5, 1991. Claimant requested a hearing, and the ALJ affirmed. Claimant requested Board review, and the Board likewise affirmed, again citing *Lebanon Plywood*. Claimant sought judicial review, and we remanded for reconsideration in the light of the recent statutory amendments. *Santos v. Caryall Transport*, 138 Or App 701, 909 P2d 903 (1996). On remand, the Board affirmed its prior decision, again citing *Lebanon Plywood*. The Board's order on remand is the second of the two orders of which claimant now seeks review.

On consolidated review, claimant contends that the Board erred in denying him temporary partial disability benefits beyond his medically stationary date. According to claimant, no statute authorizes an employer to terminate unilaterally the payment of temporary partial disability benefits on the medically stationary date. Claimant contends that he is entitled to temporary disability benefits as long as his claim "is in open status and the determination of entitlement to benefits has not yet been made through a closure of the claim." Our decision in *Lebanon Plywood*, claimant contends, is incorrect and should be overruled. He contends that the decision has been superseded by amendments to ORS 656.268, which now limit to specific grounds--which do not include a claimant becoming medically stationary--the authority of an employer to terminate unilaterally temporary disability benefits.[1]

**152 Or App 326>** Employer contends that, under *Lebanon Plywood*, it paid claimant all the benefits to which he was entitled. Employer contends that the Board correctly concluded that nothing in the current version of the relevant statutes creates an entitlement to continued payment of temporary partial disability benefits beyond the medically stationary date. To the contrary, employer argues, ORS 656.262(4)(f) (1995)[2] expressly provides that temporary disability compensation is no longer due when the worker's attending physician ceases to authorize temporary disability, and, in this case, no physician authorized temporary disability benefits after December 5, 1991. To that argument, claimant replies that ORS 656.262(4)(f) (1995) was enacted after his case went to hearing and cannot be applied to him retroactively.

In *Lebanon Plywood*, we held that, because a worker is entitled to temporary disability benefits only until he or she becomes medically stationary, the Board lacks authority to order that such benefits be paid beyond the medically stationary date. We recognized that delays in processing information about the worker's medical status may result in the worker being paid temporary disability benefits

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[1] ORS 656.268(3) provides:

"Temporary total disability benefits shall continue until whichever of the following events first occurs:

"(a) The worker returns to regular or modified employment;

"(b) The attending physician advises the worker and documents in writing that the worker is released to return to regular employment;

"(c) The attending physician advises the worker and documents in writing that the worker is released to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment; or

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

[2] In 1997, ORS 656.262(4)(f) (1995) was renumbered to ORS 656.262(4)(g). Or Laws 1997, ch 639, § 7.

beyond the medically stationary date until the determination order is issued. That set of circumstances creates an overpayment of benefits, which the employer is later entitled to recoup by deduction from any permanent disability compensation awarded. We nevertheless held that, because "[s]ubstantively, the worker's entitlement to temporary benefits ends on the medically stationary date," the Board lacks authority <152 Or App 326/327> affirmatively to create such an overpayment. *Lebanon Plywood*, 113 Or App at 653-54.

*Lebanon Plywood* was decided under the version of the workers' compensation statutes in effect in 1989; it did not consider the effects of amendments to the statutes in 1990 or in 1995. We have consistently applied the decision, however, to cases arising under the amended versions of the statutes. *See, e.g., Atchley v. GTE Metal Erectors*, 149 Or App 581, 583-85, 945 P2d 557, *rev den* 326 Or 133 (1997); *Foster Wheeler Constructors, Inc. v. Parker*, 148 Or App 6, 11-12, 939 P2d 52 (1997); *Vega v. Express Services*, 144 Or App 602, 605-08, 927 P2d 1106 (1996), *rev den* 325 Or 446 (1997); *Anodizing, Inc. v. Heath*, 129 Or App 352, 355-57, 879 P2d 218 (1994).

Because we conclude that the Board correctly determined that this claim is controlled by the holding in Lebanon *Plywood*, we need not consider the parties' arguments about the applicability of ORS 656.262(4).[3]

Affirmed.

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[3] Because we decline to reconsider the effects of recent statutory changes on the validity of *Lebanon Plywood*, we also express no opinion on claimant's contentions concerning the effect of amendments to ORS 656.268(3)--which, by its terms, refers only to "temporary total disability"--to this case, which involves the unilateral termination of temporary partial disability benefits.

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Cite as 152 Or App 328 (1998) February 4, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Trevor E. Shaw, Claimant.

**Trevor E. SHAW**, *Petitioner*
v.
**Thom and Dorothy REBHOLZ**, and Mid-Century Insurance Company, *Respondents*.
(94-10424; CA A89711)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 22, 1997.
Donald M. Hooton argued the cause and filed the brief for petitioner.
Vera Langer argued the cause for respondents. With her on the brief was Scheminske, Lyons & Bussman, LLP.
Michael O. Whitty filed a brief *amicus curiae* for SAIF Corporation and Timber Products.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LANDAU, J.
Affirmed.

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**152 Or App 330>** Claimant seeks review of an order of the Workers' Compensation Board (Board) denying claimant temporary disability benefits beyond the date he became medically stationary. Claimant contends that the Board is precluded from determining that he is not entitled to benefits after that date because, in an earlier proceeding, it concluded that employer had improperly terminated his temporary disability benefits. We conclude that the Board correctly determined that it is not precluded from determining claimant's entitlement to temporary disability benefits and affirm.

We take the relevant, undisputed facts from the Board's order. On April 30, 1993, claimant suffered a compensable low back injury. He was treated by Dr. Sedgwick, his attending physician. Employer accepted the claim and began paying temporary total disability benefits. On May 20, 1993,

Sedgwick noted that claimant should follow up with him in two weeks and anticipated that claimant would be able to return to regular work at that time. Claimant did not follow up with Sedgwick, as requested. On June 3, 1993, claimant instead saw Dr. Barnhouse, who gave claimant a release for regular work on June 7, 1993, and scheduled a follow-up appointment for June 18, 1993. Claimant did not follow up with Barnhouse either. On the basis of Barnhouse's release to regular work, employer unilaterally terminated temporary total disability payments.

Claimant sought a hearing on the termination of those benefits, contending that employer lacked authority to terminate unilaterally his temporary total disability benefits. Employer argued that it was authorized to terminate benefits under the version of ORS 656.268(3)(b) in effect at the time, which provided for unilateral termination by the employer when "[t]he attending physician gives the worker a written release to return to regular employment."[1] The Board ultimately concluded that claimant was correct. The Board found that, because Barnhouse was not claimant's attending physician at the time of his June 7, 1993, release, that release did not suffice to authorize employer to terminate temporary <152 Or App 330/331> total disability benefits under ORS 656.268(3)(b) (1991). The Board further found that, because Sedgwick's chart note was not actually given to claimant, it cannot qualify as a "written release" within the meaning of ORS 656.268(3)(b) (1991). The Board ordered employer to continue paying benefits "until properly terminated according to law."

Meanwhile, employer closed the claim by notice of closure dated January 17, 1994, awarding temporary disability through June 6, 1993. Claimant sought reconsideration and, later, a hearing. The Board ultimately held that claimant was not entitled to temporary total disability benefits beyond June 6, 1993, because he failed to demonstrate that he was disabled beyond that date. The Board's order affirmed the award of temporary disability benefits through June 6, 1993. It is that order that claimant challenges on review.

Claimant argues that principles of issue preclusion prevent the Board from examining the extent to which claimant was disabled beyond June 6, 1993. According to claimant, when he originally challenged employer's unilateral termination of his temporary total disability benefits as of June 7, 1993, whether he remained disabled was put in issue. And, he argues, when the Board concluded that he was entitled to temporary disability benefits "until properly terminated according to law," his disability necessarily was established because he could not have been entitled to such benefits unless he were disabled in the first place.

Employer argues that, because the only issue properly before the Board in the initial proceeding was whether employer had satisfied the statutory requirements for unilaterally terminating benefits, the separate issue of whether claimant, in fact, was disabled was not actually litigated by the parties nor even necessary to a disposition of the matter before the Board. Accordingly, employer concludes, principles of issue preclusion do not prevent it from challenging in the later proceeding--in which claimant's disability was directly at issue--the extent to which claimant was disabled after June 6, 1993.

In *Washington Cty. Police Officers v. Washington Cty.*, 321 Or 430, 435, 900 P2d 483 (1995), the Supreme Court explained that a decision in a prior proceeding may preclude <152 Or App 331/332> relitigation of the issue in another proceeding if five requirements are met: (1) The issue in the two proceedings is identical; (2) the issue was actually litigated and was essential to a final decision on the merits in the prior proceeding; (3) the party sought to be precluded has had a full and fair opportunity to be heard on that issue; (4) the party sought to be precluded was a party or was in privity with a party to the prior proceeding; and (5) the prior proceeding was the type of proceeding to which this court will give preclusive effect.

In this case, employer accepted claimant's claim and began paying temporary total disability payments in response to the authorization of claimant's attending physician. When employer attempted to terminate those benefits unilaterally, claimant requested a hearing, and the sole issue before the Board was whether employer had satisfied the statutory conditions for doing so. Whether claimant remained disabled was not contested by any party and was not actually litigated in that first proceeding. The sole issue on which the Board made any findings and expressed any conclusion was whether employer had satisfied the requirements of the law for unilaterally terminating temporary total disability benefits, specifically, whether claimant had been released for regular work by his attending physician. ORS 656.268(3)(b) (1991).

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[1] Amendments to the statute in 1995 do not affect the arguments before us.

The second proceeding, the one now before us on review, concerns the determination of the amount of claimant's temporary disability benefits at the time of closure. *See* ORS 656.268(4)(b) (insurer or employer shall issue notice of closure advising parties of the "amount of any further compensation, including permanent disability compensation to be awarded [and] of the amount and duration of temporary total or temporary partial disability compensation"). That determination is based on the extent to which claimant demonstrates continuing disability during the pendency of the open claim, which demonstration occurs only after the claim is closed. *SAIF v. Taylor*, 126 Or App 658, 660-61, 870 P2d 245 (1994). Employer was not required to litigate, while a claim was still open, an issue that did not arise until the claim was closed. *Hewlett-Packard Co. v. Leonard*, 151 Or App 307, 311, 948 P2d 1256 (1997).

**152 Or App 333>** Claimant insists that the distinction between his entitlement to temporary disability benefits during the pendency of the open claim and his entitlement to the benefits at closure relies on a distinction between "substantive" and "procedural" entitlements that has been legislatively overruled. We have rejected that argument. *See, e.g., Santos v. Carjall Transport*, 152 Or App 326-27, ___ P2d ___.

We conclude that the issues in the first proceeding and the one before us on review were not identical and that the extent to which claimant was disabled beyond June 6, 1993, was neither actually nor necessarily litigated in that proceeding. The Board therefore correctly concluded that it was not precluded from examining the extent to which claimant remained disabled after June 6, 1993, in this proceeding.

Affirmed.

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Cite as 152 Or App 367 (1998) February 4, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Richard S. Gaffke, Claimant.

**SAIF CORPORATION** and Graphic Arts Center, Inc., *Petitioners,*
v.
**Richard S. GAFFKE**, *Respondent.*
(96-02998; CA A96002)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 3, 1997.
David L. Runner argued the cause and filed the brief for petitioners.
Donald M. Hooton argued the cause for respondent. With him on the brief was Schneider, Hooton.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LEESON, J.
Reversed.

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**152 Or App 369>** SAIF seeks review of an order of the Workers' Compensation Board (the Board), contending that the Board erred in affirming an award of unscheduled permanent partial disability (PPD). We review for errors of law, ORS 656.298(6); ORS 183.482(7), and reverse.

Claimant worked in employer's mail department, a job that required him continuously to lift and move heavy mail bags during 12-hour shifts. On September 7, 1995, claimant sought medical treatment for pain in his right shoulder that began some time earlier and gradually became worse. Dr. McDonald diagnosed "rotator cuff strain right shoulder," prescribed a course of treatment and released claimant to modified work. SAIF accepted claimant's claim as "strain right shoulder."

On November 6, 1995, McDonald determined that claimant was medically stationary, without impairment, and released him to regular work. SAIF closed the claim on November 22, 1995, with no award of PPD. Claimant requested reconsideration of the Notice of Closure from the Department of Consumer and Business Services (DCBS) and requested a medical arbiter's examination. The medical arbiter, Dr. Dinneen, concluded that

> "[t]here is some decreased range of motion of the right shoulder, but this is not medically probably due to the reported incident, although there was apparently no one specific incident. On his last two visits to [McDonald] his range of motion of the right shoulder was described as full, indicating objective recovery from the reported incident."

At claimant's request, DCBS asked Dinneen for more information about the cause of claimant's limited range of motion in his shoulder. Dinneen responded: "The cause is not known." The Workers' Compensation Division issued an Order on Reconsideration on February 26, 1996, affirming SAIF's denial of PPD.

Claimant requested a hearing. The administrative law judge (ALJ), relying on *Kim E. Danboise*, 47 Van Natta 2163 (1995), *affd SAIF v. Danboise*, 147 Or App 550, 937 P2d 127, *rev den* 325 Or 438 (1997), concluded that because **<152 Or App 369/370>** Dinneen did not attribute the cause of claimant's loss of range of motion to something other than the compensable injury, "claimant is entitled to have his right shoulder rated using Dr. Dinneen's physical examination findings." The ALJ awarded claimant five percent unscheduled PPD. The Board's Order on Review adopted and affirmed the ALJ's order, adding that Dinneen's opinion that claimant's shoulder impairment was not related to the compensable injury was unpersuasive because it was "utterly unexplained." *See Somers v. SAIF*, 77 Or App 259, 263, 712 P2d 179 (1986) (Board may give more weight to medical opinions that are well reasoned and based on complete information.).

In its first assignment of error, SAIF argues that the Board erroneously relieved claimant of his burden of proving that his right shoulder impairment was due to the compensable injury, because "there is no medical evidence in this case stating that claimant's impairment is 'consistent with' the compensable injury." Claimant responds that the Board found that "the preponderance of medical opinion" established that claimant suffered impairment due to his compensable injury and that that finding is supported by substantial evidence.

Entitlement to PPD requires a claimant to establish the impairment by a preponderance of medical evidence based upon objective findings. ORS 656.726(3)(f)(B). Claimant also must establish that the impairment is due to a compensable injury. ORS 656.214(2). In *SAIF v. Danboise*, 147 Or App 550, 553, 937 P2d 127, *rev den* 325 Or 438 (1997), we held 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."

In that case, the issue was whether the claimant had established that his neck impairment was due to the compensable injury. Although the medical evidence described the claimant's impairment as "consistent with" the compensable injury rather than "due to" that injury, we affirmed the Board's award of unscheduled PPD.

**152 Or App 371>** *Danboise* does not assist claimant here. The Board rejected Dinneen's report as "utterly unexplained." Claimant agrees: "Unfortunately that is exactly what it is." Because claimant's symptoms appeared gradually rather than as a result of a single precipitating event, the question of causation is a complex one, requiring expert medical opinion. *Uris v. Compensation Department*, 247 Or 420, 426, 427 P2d 573 (1967); *Barnett v. SAIF*, 122 Or App 279, 282, 857 P2d 228 (1993). McDonald determined that claimant suffered no impairment. Without Dinneen's report, there is no evidence of impairment in this case, let alone a causal link to claimant's compensable injury. Because claimant failed to meet his burden of proof, the Board erred in awarding PPD.

In the light of this disposition, we need not address employer's other assignments of error.

Reversed.

Cite as 152 Or App 449 (1998) February 11, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Debra I. Jensen, Claimant.

**Debra I. JENSEN**, *Petitioner,*
v.
**CONAGRA, INC.**, *Respondent.*
(WCB 95-05637; CA A93736)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 14, 1997.
Karen Stolzberg argued the cause for petitioner. With her on the brief was Goldberg, Mechanic & Stuart,
Kenneth Kleinsmith argued the cause for respondent. With him on the brief was Meyers, Radler, Replogle & Bohy.
Before Warren, Presiding Judge, and Haselton and Armstrong, Judges.
ARMSTRONG, J.
Affirmed.

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**152 Or App 451>** Claimant seeks review of an order of the Workers' Compensation Board that held that a 1995 amendment to ORS 656.262(4) applied retroactively to her claim, thereby denying her temporary disability benefits for a portion of the time for which her attending physician had authorized those benefits. We affirm.

In May 1993, claimant first sought compensation for symptoms of what later was diagnosed and treated as carpal tunnel syndrome. Her injury was declared compensable by an order of the Board on February 2, 1994. On November 9, 1994, claimant's attending physician authorized temporary disability payments retroactive to May 6, 1993. On May 8, 1995, in response to employer's failure to pay benefits due, claimant filed a request for a hearing before the Board.

On June 7, 1995, Senate Bill 369 (Oregon Laws 1995, chapter 332) was signed into law and became effective. That enactment made extensive changes to the Workers' Compensation Law. Included among those changes was the addition of subsection (f) to ORS 656.262(4). That subsection provides:

> "Temporary disability compensation is not due and payable pursuant to ORS 656.268 after the worker's attending physician ceases to authorize temporary disability or for any period of time not authorized by the attending physician. No authorization of temporary disability compensation by the attending physician under ORS 656.268 shall be effective to retroactively authorize the payment of temporary disability more than 14 days prior to its issuance."

Section 66(1) of Senate Bill 369 provides:

> "Notwithstanding any other provision of law, this Act applies to all claims or causes of action existing or arising on or after the effective date of this Act, regardless of the date of injury or the date a claim is presented, and this Act is intended to be fully retroactive unless a specific exception is stated in this Act."

Pursuant to that provision, the Board held that the 1995 amendment to ORS 656.262(4) on the payment of temporary disability benefits applied to claimant's claim. *See Volk v.* **<152 Or App 451/452>** *America West Airlines*, 135 Or App 565, 573, 899 P2d 746 (1995), *rev den* 322 Or 645 (1996). Finding that temporary disability payments were first authorized by claimant's attending physician on November 9, 1994, the Board held that claimant was entitled to temporary disability payments only from October 26, 1994.

Claimant contends that subsection (6) of section 66 of Senate Bill 369 prohibits the retroactive application of amended ORS 656.262(4)(f) to her claim. We disagree. Section 66(6) of Senate Bill 369 provides:

> "The amendments to statutes by this Act and new sections added to ORS chapter 656 by this Act do not extend or shorten the procedural time limitations with regard to any action on a claim taken prior to the effective date of this Act."

Claimant argues that, because ORS 656.262(4)(f) now sets a limit on the receipt of temporary disability benefits that is linked to the timing of her attending physician's authorization, the enactment of that provision "shorten[ed] the procedural time limitations with regard to [an] action on a claim." Employer contends that the amendment simply established a substantive limit on the amount of temporary disability benefits that an injured employee can obtain. We agree with employer.

We have defined procedural law as "that which prescribes methods of enforcing rights or obtaining redress for their invasion." *Long v. Storms*, 52 Or App 685, 687, 629 P2d 827, *rev den* 290 Or 727 (1981). In *Norstadt v. Murphy Plywood*, 148 Or App 484, 492-93, *adhered to as modified* 150 Or App 245, 945 P2d 654 (1997), we discussed the legislature's intent in creating the exception to retroactivity in section 66(6). We concluded that it intended the exception to cover those claimants who were operating within a time frame that had run or was running, or who had relied on certain statutory time limits in taking action on a claim. In that case, we determined that the elimination of a disclaimer provision touched on multiple time frames and, therefore, could not apply retroactively. Claimant argues that the physician's authorization is the method by which she enforces her right to receive retroactive temporary disability benefits and that **<152 Or App 452/453>** the amended statute creates a time limitation on the issuance of that authorization. Nothing in the amended statute, however, prescribes or changes the time period in which the authorization can or must be written. Rather, the amendment merely creates a limit on the amount of retroactive benefits to which claimant is entitled, *i.e.*, two weeks. That limit, defining as it does a claimant's rights, is substantive. *Long*, 52 Or App at 687-88. Accordingly, we conclude that the exception set forth in section 66(6) does not apply to this claim.[1] None of claimant's other arguments requires discussion.

Affirmed.

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[1] Claimant further argues that we must read the amendment as procedural because to do otherwise would be absurd and unjust. She hinges her argument on the fact that, before the amendment, she would have been entitled to benefits retroactive to the date of her injury, whereas now she is entitled to retroactive benefits of two weeks only. It is not our role to decide whether the legislature's change is fair or unfair. Claimant conceded at oral argument that the legislature was free to set an absolute limit on benefit amounts. We do not see how the time limit set in amended ORS 656.262(4) is any different.

Cite as 152 Or App 476 (1998) February 11, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Morris B. Grover, Claimant.

**SAIF CORPORATION** and G & S Masonry, *Petitioners,*
v.
**Morris B. GROVER**, *Respondent.*
(Agency No. 96-0403M; CA A95722)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 9, 1997.
Michael O. Whitty argued the cause and filed the brief for petitioners.
Dale C. Johnson argued the cause for respondent. With him on the brief was Malagon, Moore, Johnson & Jensen.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
ARMSTRONG, J.
Reversed.

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**152 Or App 478>** SAIF seeks review of an own-motion order of the Workers' Compensation Board. *See* ORS 656.278(1)(a). In that order, the Board concluded that claimant was entitled to temporary total disability (TTD) benefits from SAIF for the time in which he was hospitalized for back surgery, even though at that time he was receiving permanent total disability (PTD) benefits from another carrier. We conclude that a worker who is permanently totally disabled and receiving payments for that disability cannot at the same time be temporarily totally disabled. Accordingly, we reverse the Board's order.

Before he became disabled, claimant was self-employed as a mason.[1] In 1988, he began receiving PTD benefits when the Board determined that a combination of knee and back injuries so incapacitated him that he could not regularly perform work at a gainful and suitable occupation. ORS 656.206(1)(a). Claimant's knee injuries first had been accepted as compensable by EBI Companies in 1979, and claimant received an award of 10 percent permanent partial disability for those injuries. In 1980, claimant injured his back and, in 1982, submitted a claim to SAIF, the current insurer. SAIF accepted the claim and claimant was awarded an additional 25 percent permanent partial disability. Claimant appealed that award, contending that he was entitled to permanent total disability. Between 1982 and 1984, while his appeal on the back injury claim was pending, claimant had knee surgery. The claim with EBI for claimant's knee injuries was reopened, and the permanent partial disability award for his knees was raised to 40 percent for the right knee and 45 percent for the left. Claimant appealed that ruling as well, again contending that he was entitled to permanent total disability. The appeals were consolidated and, after a review by this court, claimant was awarded PTD. In that opinion, we stated:

> **152 Or App 479>** "Claimant's injuries occurred over a number of years, *and each materially contributed to his overall disability.* The most recent injury that bears a causal relation to claimant's total disability is the aggravation of the knee conditions. EBI was responsible for the first knee injury, and it was the aggravation of that injury that last contributed to the disability. * * * EBI is the responsible carrier."

*EBI Companies v. Grover*, 90 Or App 524, 526, 752 P2d 1274, *rev den* 306 Or 155 (1988) (citation omitted; emphasis supplied).

In 1996, claimant was hospitalized for back surgery at three spinal vertebrae levels; he submitted a claim to SAIF for that surgery. SAIF issued a partial denial in which it agreed to pay the medical

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[1] The facts and timing of claimant's injuries leading to his PTD status are found in *EBI Companies v. Grover*, 90 Or App 524, 526, 752 P2d 1274, *rev den* 306 Or 155 (1988).

expenses only for the treatment at one level.[2] Claimant also submitted a claim for TTD, to be paid by SAIF, for the time spent in surgery and recovery. SAIF submitted a "Carrier's Own Motion Recommendation" to the Board, in which it recommended that TTD be denied because claimant was already receiving PTD. The Board concluded that claimant was "in the work force" at the time of his hospitalization and, therefore, was entitled to TTD. The Board did not address the seeming inconsistency of declaring an individual both permanently and temporarily disabled at the same moment in time, but it did recognize that to do so would allow a claimant to receive a double recovery. For that reason, the Board recommended that SAIF petition the Workers' Compensation Division for a *pro rata* distribution of payments. When SAIF petitioned the Division for relief, however, the Division ruled that, although there was a rule allowing for such a distribution between two TTD awards, there was no comparable rule authorizing a distribution between a PTD award and a TTD award. SAIF then sought review of the Board's own-motion order.

In *Gwynn v. SAIF*, 304 Or 345, 745 P2d 775 (1987), the Supreme Court attempted to provide a clear description of the meaning of temporary, permanent, partial and total disability:

> **152 Or App 480>** "[T]he adjectives 'permanent' and 'temporary' describe duration, not the extent, of disability. 'Partial' and 'total' describe extent. It follows that if a worker meets the test of being totally disabled but that it cannot be said that the disability is permanent, that worker is temporarily totally disabled.
>
> "If a worker is permanently disabled but not to the extent of being totally disabled, as the statute defines total disability, that worker must be permanently partially disabled. The fact that the worker is not totally disabled excludes the worker from the class of those permanently totally disabled, and either the fact that the disability is permanent or that it is not total excludes the worker from the class of those temporarily totally disabled.
>
> "To be a bit redundant but to emphasize a point, one who is only temporarily disabled cannot fall into either class of permanent disability."

*Gwynn*, 304 Or at 351. What was left unsaid by the court in *Gwynn*, but which must follow, is that one who has been determined to suffer from permanent total disability cannot, by force of logic, be *temporarily* totally disabled as well.

Claimant argues that he is entitled to benefits under both categories, because two different insurers are involved. He contends that, although EBI is responsible for the permanent disability benefits, SAIF has an independent responsibility to pay temporary disability benefits for the time that he spent in the hospital for treatment of the back injury previously accepted by SAIF. That argument is not well taken. Once the Board determined that claimant was permanently and totally disabled, claimant was entitled to full wage-replacement benefits under ORS 656.206(2). Temporary total disability benefits are also wage-replacement benefits. Nothing in the relevant statutes suggests that a person who is receiving permanent and total wage replacement is entitled to receive additional wage-replacement benefits.

We find further support for our conclusion that PTD and TTD are mutually exclusive benefit categories in the fact that the legislature has recognized situations in which overlap of disability benefits may occur and has provided offset mechanisms to ensure against double recovery. *See, e.g., ORS* **<152 Or App 480/481>** 656.209 (allows for reduction of PTD benefits by amount of federal social security disability benefits); *see also* OAR 436-060-0020(8) (allows for *pro rata* distribution of compensation due for two or more concurrent TTD claims). There is no offset provision for a PTD/TTD overlap, either statutory or regulatory, presumably because such an overlap is not logically possible.

Reversed.

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[2] Claimant did not appeal the partial denial, and we do not address it.

Cite as 152 Or App 549 (1998) February 18, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Janice B. Bowen, Claimant.

**LIBERTY NORTHWEST INSURANCE** and Nite Hawk Cafe, *Petitioners,*
v.
**Janice B. BOWEN**, *Respondent.*
(WCB 96-00358; CA A95579)

Judicial Review from Workers' Compensation Board.
Argued and submitted September 30, 1997.
Conway C. McAllister argued the cause for petitioners. On the brief was Alexander D. Libmann.
Linda C. Love argued the cause and filed the brief for respondent.
Before De Muniz, Presiding Judge, Haselton, Judge, and Rossman, Senior Judge.
HASELTON, J.
Affirmed.

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**152 Or App 551>** Employer seeks review of a Workers' Compensation Board Order on Review that, in pertinent part, set aside employer's denial of claimant's current occupational disease claim for cervical degenerative disc disease. The Board determined that a September 1993 stipulation between the parties, which awarded claimant an eight percent unscheduled disability on a thoracic compression fracture arising out of a November 1991 workplace injury, and which dismissed "all issues raised or raisable," did not preclude claimant's current claim. We agree with the Board and affirm.

Claimant worked as a waitress for 36 years and worked at the Nite Hawk Cafe in Portland from 1990 through July 1995. On November 4, 1991, claimant suffered a compensable injury while lifting a heavy container of milk at work. Claimant's physician, Dr. Brett, diagnosed two separate conditions--(1) a T-8 compression fracture and (2) bilateral C6 nerve root impingement from spondylitic disease at C5-6- and recommended surgery to address the latter condition. Brett stated that the November 1991 work incident was the major cause of the thoracic compression fracture but that claimant's cervical disc disease was not related to work activities. On November 27, 1991, Brett performed the recommended cervical surgery, and he billed claimant's private medical insurance for the expenses. On January 23, 1992, employer accepted the T-8 compression fracture.

Thereafter, on April 13, 1992, claimant requested a hearing, contending that employer's acceptance should be expanded to include the cervical disc condition. Claimant's request for hearing identifies the date of injury as November 4, 1991. On June 4, 1992, before any hearing occurred, claimant withdrew that request, and on June 18, 1992, the Board issued an order dismissing "the matter" (*i.e.*, the request that the scope of acceptance be expanded to include the cervical condition).

On January 13, 1993, a determination order was issued, closing the thoracic compression claim and awarding **<152 Or App 551/552>** claimant three percent unscheduled permanent partial disability. An order on reconsideration confirmed that award, and plaintiff filed a request for hearing challenging that result. On September 3, 1993, before the requested hearing occurred, the parties negotiated a settlement. Pursuant to a Stipulation and Order, employer agreed that claimant was entitled to eight percent unscheduled permanent disability "for injury to her thoracic spine." The Stipulation and Order further provided:

"The parties agree to settle all issues raised or raisable at this time as follows:

"* * * * *

"The Request for Hearing is dismissed with prejudice, as are all issues raised or raisable."

In August 1994, Brett again performed cervical surgery on claimant, for which she made no claim. Claimant did not seek treatment again until July 1995, when she saw a different doctor, Dr. Hoggard, to whom she complained of "severe pain in her mid-back and neck radiating to her chest and hands." Hoggard referred claimant to Dr. Bell, who diagnosed symptoms of cervical radiculopathy and noted that claimant's pain was a recurrence of a past problem.

On August 23, 1995, claimant filed a claim for her "back." Employer denied the claim, and claimant requested a hearing, during which, as the Board found:

> "claimant clarified the conditions for which she was filing a claim. Claimant alleged that her compensable conditions consisted of cervical and thoracic degenerative disc disease, cervical and lumbosacral strain, and myofascial pain."

With respect to cervical degenerative disc disease,[1] claimant presented evidence that her work activities for over 36 years as a waitress, including her work for employer, were the major contributing cause of her cervical degenerative disc disease and that employer was responsible under the last injurious exposure rule.

**152 Or App 553>** The administrative law judge (ALJ) determined that the September 3, 1993, Stipulation and Order barred claimant's claim. In particular, the ALJ concluded that the compensability of the cervical condition could have been addressed before the parties executed that Stipulation and, consequently, the claim was precluded as "raised or raisable" at that time.

Claimant sought review. The Board concluded that the Stipulation did not bar the cervical condition claim. In particular, it determined that the compensability of the cervical condition could not have been raised prior to the date the Stipulation was executed because (1) no doctor had linked claimant's cervical disc condition with work activities at the time of the Stipulation, and (2) claimant's cervical claim, which she brought on an occupational disease theory, "arises out of a different factual transaction than the November 1991 injury claim." Proceeding to the merits, the Board determined that claimant's cervical disc condition was compensable and that employer was responsible under the last injurious exposure rule.

Employer seeks review of the Board's order. Employer's sole assignment of error challenges the Board's determination that the September 3, 1993, Stipulation was not preclusive.[2] Thus, the dispute reduces to the scope and application of the 1993 Stipulation's "all issues raised or raisable" language. Neither party contends that the Stipulation is ambiguous, and we agree that it is not. Accordingly, its proper construction is a matter of law. *Good Samaritan Hospital v. Stoddard*, 126 Or App 69, 72-73, 867 P2d 543, *rev den* 319 Or 572 (1994).

The Stipulation purports to preclude relitigation of all "*issues*"--not "claims"--raised or raisable as of September 1993. In the context of the entire agreement, "issues" refers necessarily to matters relating to the broader subject of the settlement. That subject could, reasonably, be described as either (a) claimant's injury--*i.e.*, the "injury to her thoracic **<152 Or App 553/554>** spine," or (b) the November 4, 1991, on-the-job lifting incident. *See generally Drews v. EBI Companies*, 310 Or 134, 146-47, 795 P2d 531 (1990) (claim preclusion focuses on whether prior proceeding was based on the same transaction: "A worker who is aware that it is possible that her physical condition is the product of either an occupational disease or a job-related traumatic injury may not bring two successive compensation claims seeking the same relief *for the same condition*." (emphasis supplied)).

We need not decide whether the referent of "all issues" was claimant's injury, the work incident, or both, because, in all events, claimant's present claim would not be precluded under any of those readings. Claimant's current claim for degenerative cervical disc disease is unrelated to her thoracic compression fracture. *Compare SAIF v. Wolff*, 148 Or App 296, 299-300, 939 P2d 630, *adhered to on recons* 151 Or App 398, ___ P2d ___ (1997) (stipulation dismissing all issues raised or raisable with respect to the claimant's accepted knee condition barred the claimant from seeking compensation for

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[1] Neither party raises any issues on review with respect to claimant's other alleged conditions.

[2] Employer does not contest the Board's determination as to compensability and responsibility.

related knee condition that was diagnosed before stipulation was executed). Nor does that claim, an occupational disease claim, arise from the November 4, 1991, incident. Rather it arises from the cumulative effect of 36 years of being a waitress.[3] Consequently, in pursuing her current cervical condition claim, claimant was not litigating an "issue raised or raisable" in the context of the 1993 Stipulation.

The fact that claimant sought to expand insurer's original acceptance to include the cervical condition as an industrial injury resulting from the November 4, 1991, incident does not alter the analysis or the result. Claimant unilaterally withdrew that request 15 months before the September 1993 Stipulation. The Stipulation may have foreclosed any resuscitation of that industrial injury claim, in that it arose out of the November 4, 1991, incident. But nothing in the Stipulation, or in any other evidence in the record, **<152 Or App 554\555>** suggests that the Stipulation contemplated, much less foreclosed, an occupational disease claim for cervical degenerative disc disease. *Compare Safeway Stores, Inc. v. Seney*, 124 Or App 450, 454, 863 P2d 528 (1993) ("Both employer and claimant believed that the November injury was covered by the settlement.").

Finally, employer's reliance on *Stoddard and Seney* is misplaced. Those cases are materially distinguishable. In *Stoddard*, the claimant suffered a compensable injury to her wrist, which the employer accepted. Thereafter, after the claimant complained of continued pain in her forearm, her doctor diagnosed radial nerve entrapment and requested authorization for surgery from the employer's claim processor. Before authorization was given, or a denial was rendered, the claimant and the employer negotiated a settlement on the wrist claim. Subsequently, the employer denied the nerve entrapment claim, asserting that it was resolved by the settlement. The Board disagreed, but we reversed. We held that the settlement expressly dismissed all issues related to the wrist claim, and, because the Board found that the nerve entrapment was related to the wrist injury, the settlement barred any claim for the nerve entrapment. 126 Or App at 73 (characterizing stipulated settlement as resolving "all issues *that relate to the January 1990 injury*"). (Emphasis supplied.)

The crucial difference between this case and *Stoddard* is that, there, after the stipulation was executed, the claimant made another claim based on the settled wrist claim. The claimant actually argued that the nerve entrapment was caused by the original wrist injury after the stipulation was negotiated. Here, claimant's 1995 cervical claim has no relationship to the settled 1991 thoracic compression claim. There was no finding by the Board, and there is no evidence in the record, linking the cervical condition with the 1991 injury. Nor does claimant, as did the claimant in *Stoddard*, contend that the two are connected in any way.

In *Seney*, the claimant compensably injured his right shoulder while working as a truck driver. His claim was accepted and, eventually, a determination order was issued awarding permanent partial disability. The claimant **<152 Or App 555/556>** requested a hearing. The parties began settlement negotiations, after which the claimant suffered another shoulder injury that his doctor characterized as an aggravation of the former injury. The claimant requested temporary disability benefits but the employer denied his entitlement to benefits. Subsequently, the parties negotiated a stipulated settlement resolving all issues "raised or raisable" and resolving the appeal of the determination order. Thereafter, the claimant's doctor "reversed his previous opinion" and stated that the "aggravation" episode was actually a new injury. The referee and the Board concluded that the stipulation did not bar the new injury claim.

We reversed. We reasoned that both parties believed, before the execution of the settlement, that the reinjury was an aggravation of the former injury, and that both parties believed that the aggravation was negotiated as part of the settlement. *Seney*, 124 Or App at 454. Thus, the claimant could not recharacterize his claim and escape the bar of the stipulation. In this case, as noted, there is no evidence that either party understood the Stipulation to encompass the current occupational disease claim.

The 1993 Stipulation does not bar claimant's occupational disease claim for cervical degenerative disc condition.

Affirmed.

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[3] There is no suggestion in the record that the November 4, 1991, incident somehow contributed to claimant's cervical condition.

Cite as 152 Or App 624 (1998) February 25, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Bradley B. Rogers, Claimant.

**Bradley R. ROGERS**, *Petitioner,*
v.
**CASCADE PACIFIC IND.** and EBI Companies, *Respondents.*
(95-11898; CA A94923)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 23, 1997.
Michael Strooband argued the cause for petitioner. With him on the brief was Bischoff, Strooband & Ousey, P.C.
Howard R. Nielsen and Zimmerman, Rice & Nielsen filed the brief for respondents.
Before Deits, Chief Judge, and Warren and Haselton, Judges.
DEITS, C. J.
Affirmed.
Haselton, J., dissenting.

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**152 Or App 626>** Claimant seeks review of a Workers' Compensation Board (Board) order holding that his cervical spine condition is not compensable as a consequence of his compensable lower back strain. ORS 656.005(7)(a)(A). We affirm.

The material facts, as found by the Board, are as follows: In November 1993, claimant injured his back while he was using a pipe wrench at work. The insurer accepted a disabling low back strain on December 14, 1993. On December 29, Dr. Macha performed a laminotomy and discectomy on claimant. A few weeks after the surgery, Macha recommended that claimant begin a post-laminectomy flexibility and strengthening program and sent him to a physical therapist for exercise instruction. Claimant fell at work in February 1994 and exacerbated his low back strain. After claimant had recuperated, Macha advised him to resume his exercise program at home.

After performing a physical examination on April 8, 1994, Macha determined that claimant was medically stationary. Macha recommended that claimant keep his back and abdominal muscles conditioned, because he was at risk for recurrent back pain in the future. Claimant's claim was closed by Determination Order on May 2, 1994. He was awarded temporary disability and 17 percent unscheduled permanent partial disability.

In early March 1995, claimant again suffered an exacerbation of his low back strain as a result of lifting 50 pound bags of concrete at work. Macha advised claimant not to work for a few days, prescribed some medication, and referred him to a physical therapist for four to six sessions of flexing and strengthening exercises. The physical therapist recommended a renewed exercise program, and claimant told the therapist that he could do the exercises at work. On March 13, 1995, the physical therapist reported that all goals had been met and that claimant would be receiving no further physical therapy. On March 30, 1995, Macha found that claimant's condition had progressed to its pre-exacerbation status, but he advised claimant to continue his exercise program.

**152 Or App 627>** Claimant regularly performed his exercises, including abdominal "crunches,"[1] at work before his shift started and during breaks. On August 17, 1995, claimant sought medical treatment for pain and stiffness in his cervical spine and for numbness in his hand. He reported to Macha that he had hyper-extended his neck while performing crunches as part of his exercise program.[2] Macha diagnosed neck pain and a possible herniated disc. A cervical MRI scan showed minor cervical spondylosis at C6-7 with possible disc bulging, but there was no significant disc herniation.

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[1] Claimant described "crunches" as "laying [*sic*] on your back with your knees bent, and--and crunching up."

[2] Employer concedes that claimant's performance of the "crunches" was the major cause of claimant's cervical spine condition.

On October 19, 1995, employer issued a partial denial of claimant's cervical spine condition. Claimant requested a hearing on the denial and, after hearing, the administrative law judge (ALJ) set aside the denial. The ALJ concluded that the performance of the crunches was reasonable and necessary medical treatment that was integral to maintaining claimant's recovery from his low back strain and, relying on our holding in *Barrett Business Services v. Hames*, 130 Or App 190, 881 P2d 816, *rev den* 320 Or 492 (1994), held that the cervical condition was compensable as a consequence of the low back strain pursuant to ORS 656.005(7)(a)(A).[3]

The Board reversed the ALJ, holding that the cervical condition was not a compensable consequential condition because it did not arise as a "direct result of reasonable and necessary medical treatment for a compensable injury." The Board explained:

> **152 Or App 628>** "[W]e find the causal relationship in this case between claimant's compensable low back injury and his cervical injury to be too tenuous and indirect to render the latter a compensable consequence of the former under ORS 656.005(7)(a)(A). Since claimant was doing his 'abdominal crunch' exercises on his own as a preventative measure, several months after claim closure and without any direct medisupervision, we conclude that claimant's home exercise program does not constitute 'medical treatment' for his compensable low back injury for purposes of the *Hames* analysis."

Claimant argues that the Board erred in concluding that his cervical injury did not result from reasonable and necessary treatment for his compensable injury and, consequently, in holding that the injury was not compensable under ORS 656.005(7)(a)(A). Claimant contends that the Board's error resulted from its misapplication and misunderstanding of this court's decision in *Hames*. He asserts that there is no significant distinction between the type of physical therapy that occurred in *Hames*, which we concluded was reasonable and necessary medical treatment, and the physical therapy that claimant was performing for his low back injury here.

We conclude that the Board did not err in holding that claimant's cervical injury was not a compensable consequential injury under ORS 656.005(7)(a)(A). As we discussed in our decision in *Hames*, and later in *Robinson v. Nabisco, Inc.*, 143 Or App 59, 923 P2d 668 (1996), *rev allowed* 325 Or 247 (1997), the legislature amended ORS 656.005(7)(a)(A) in 1990 to require that, in order for an injury or disease to be compensable as a "consequence" of a compensable injury, it must be proven that the compensable injury is the major contributing cause of the consequential condition. That amendment was a change from prior law under which a claimant could recover for injuries that would not have occurred "but for" the claimant's compensable condition. *Fenton v. SAIF*, 87 Or App 78, 741 P2d 517, *rev den* 304 Or 311 (1987). We noted further, in both *Hames* and *Robinson*, however, that, in amending ORS 656.007(7)(a)(A), the legislature did not intend to change the law relating to the compensability of injuries occurring during reasonable and necessary medical **<152 Or App 628/629>** treatment. We held that injuries occurring *during* reasonable and necessary medical treatment are considered a natural consequence of a compensable injury and, accordingly, the compensable injury is deemed to be the major contributing cause of the new condition. As we explained in *Hames*:

> "[W]here 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. In such instances, the compensable injury itself is properly deemed the 'major contributing cause of the consequential condition.' ORS 656.005(7)(a)(A)." 130 Or App at 196-97.

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

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

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

Claimant and the dissent believe that our decision in *Hames* is controlling here. In *Hames*, the claimant dislocated his shoulder at work. Because of that injury, the claimant's shoulder was, necessarily, replaced in its joint and immobilized. *Hames*, 130 Or App at 192. That, in turn, caused the claimant to develop a condition commonly called "frozen shoulder." To treat that condition, the surgeon prescribed "extremely aggressive" physical therapy to improve the range of shoulder motion. During the course of the physical therapy, which involved rigorous manipulation of claimant's shoulder and arm, his right ulnar nerve was injured. We concluded that the ulnar injury resulted from reasonable and necessary medical treatment and, therefore, was a compensable consequential condition under ORS 656.005(7)(a)(A).

Claimant asserts that our decision in *Hames* is controlling here because there is no significant difference between the physical therapy in *Hames* and the activities that claimant was undertaking here. His view is that, similar to the physical therapy in *Hames*, claimant's exercises here were reasonable and necessary medical treatment. As noted above, the Board concluded that claimant's activities that resulted in this injury were not reasonable and necessary medical treatment. The Board gave two reasons for that conclusion. First, it stated that claimant did the exercises on his own without medical supervision. Second, the Board found that the exercises were not a curative *treatment* to aid claimant's recovery but, rather, were a preventative measure.

**152 Or App 630>** Claimant argues that the reasons given by the Board do not support its conclusion that this was not reasonable and necessary medical treatment. We disagree. The fact that claimant did the exercises on his own and without direct medical supervision is not, in itself, determinative. As the dissent to the Board's opinion correctly points out, there are numerous instances where medical treatment may occur without direct medical supervision. However, the fact that the exercises were not curative but, as found by the Board, were done solely as a preventative measure, supports the Board's conclusion. At the time that claimant was injured during these exercises, he had been found medically stationary by his doctor. The doctor stated that claimant had returned to his pre-exacerbation condition and claimant's physical therapist had indicated some months earlier that no further physical therapy was necessary. Claimant was doing the exercises to remain conditioned in his back and abdomen in order to avoid future injuries. We agree with the Board that such activities do not constitute reasonable and necessary medical treatment for purposes of determining if the injury is a consequential condition of a compensable injury. The Board did not err in upholding employer's denial of claimant's claim for compensation for his cervical injury.

Affirmed.

**HASELTON, J.**, dissenting.

This case is materially indistinguishable from *Barrett Business Services v. Hames*, 130 Or App 190, 881 P2d 816, *rev den* 320 Or 492 (1994). In particular, claimant's exercise program was "reasonable and necessary medical treatment" for his compensable low back condition. Accordingly, I dissent.

In *Hames*, the claimant dislocated his shoulder at work. Because of that injury, the claimant's shoulder was, necessarily, replaced in its joint and immobilized. That, in turn, caused the claimant to develop a condition commonly called "frozen shoulder." To treat that condition, the surgeon prescribed "extremely aggressive" physical therapy to improve the range of shoulder motion. That treatment was reasonable and necessary. During the course of the physical treatment, which involved rigorous manipulation of the **<152 Or App 630/631>** claimant's shoulder and arm, his right ulnar nerve was injured. We concluded that the ulnar injury was a compensable consequential condition under ORS 656.005(7)(a):

> "[W]here 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. In such instances, the compensable injury itself is properly deemed the 'major contributing cause of the consequential condition.' ORS 656.005(7)(a)(A)." *Id.* at 196-97.

In so holding, we emphasized that: (1) There was no dispute as to the compensability of the original shoulder injury; (2) the compensable injury was the sole reason that the claimant engaged in physical therapy; (3) the aggressive physical therapy was "reasonable and necessary treatment" of that compensable injury; and (4) the physical therapy was the major contributing cause of the ulnar nerve

condition. *Id.* at 194-95. Thus, the ulnar nerve injury "flowed directly and inexorably from the shoulder injury." *Id.* at 195. Compare *Roseburg Forest Products v. Zimbelman*, 136 Or App 75, 900 P2d 1089 (1995) (discussing *Hames*: Where the decedent claimant's estate sought compensation for heart attack and contended that depression precipitated by the underlying compensable condition had caused the heart attack, estate must demonstrate that (1) original compensable condition was major contributing cause of the depression and (2) the depression was the major contributing cause of the heart attack).

The circumstances here parallel those in *Hames* in three material--and ultimately conclusive--respects. First, the reason that claimant's doctor, Macha, instructed him to perform strengthening exercises, including crunches, was to address symptoms associated with the compensable low back condition and, specifically, to forestall stiffness and pain. Claimant testified that he was advised by his doctor and his physical therapist to perform "crunches," among other exercises, regularly. Claimant also indicated that Macha directly participated with the therapist in instructing him how to correctly perform each exercise, including crunches. Thus, the original compensable condition was the sole reason that claimant performed the exercises.

**152 Or App 632>** Second, as in *Hames*, it is undisputed that the exercises, including the crunches, were reasonable and necessary treatment for the underlying compensable condition. In particular, Macha indicated that the exercises he prescribed for claimant are commonly prescribed for persons with low back injuries because they strengthen the back and help prevent future injuries. Macha told claimant that it was important to perform those exercises regularly and permanently to avoid recurrent pain,

Finally, as in *Hames*, 130 Or App at 192 n 1, there is no suggestion in the record that the manner in which claimant performed the crunches was unreasonable or inappropriate. There is no evidence that claimant deviated, much less materially deviated, from Macha's specific instructions on the method of performing the exercises.

Conversely, the considerations that employer argues--and the majority invokes--to distinguish this case from *Hames* are unpersuasive. It is true, as the majority notes, that the exercises here were palliative, not "curative." However, that is a distinction without a difference. The majority does not explain why, or how, that is germane to the issue of whether the treatment was reasonable and necessary. As noted, the purpose of the "crunches" was to address, and forstall, stiffness and pain associated with the low back condition. At the risk of stating the obvious, not all medical treatment is curative, because not all injuries, conditions, and diseases are curable. For some conditions, the best, and sometimes the only, medical treatment is palliative treatment.

Nor is it material that claimant's doctor did not actually oversee and personally supervise claimant's daily exercise routine. By hypothetical, but principled, extension, employer's argument in that regard would mean that, if a physician prescribed medication to address a compensable condition and the claimant suffered injurious side effects as a result of taking the medication, the consequential injuries would be compensable if the claimant took the medication in the physician's presence, but not if the claimant did so at home. To the extent that employer's concern is that there may be a greater potential for a claimant to perform exercises **<152 Or App 632/633>** improperly when not under a physician's direct personal supervision, that concern is addressed by determining whether a claimant did, in fact, perform the exercises in the prescribed fashion. As noted, there is no suggestion in this record that claimant deviated from Macha's directions.

Finally, the indefinite duration of claimant's exercise program does not mean that that treatment was not reasonable and necessary. If a claimant's medical condition is chronic, and the physician prescribes a reasonable and necessary course of medical treatment, an injury that "directly and inexorably" flows from that treatment, even after the claim has closed, should be compensable, just as any other consequential condition would be. *See Hames*, 130 Or App at 195. Duration of treatment does not mean remoteness of causation.

*Hames* controls. Claimant's exercise program was a reasonable and necessary treatment for his compensable low back strain. Because the Board never reached and addressed whether claimant's performance of the crunches was, in fact, the major contributing cause of claimant's cervical spine injury, ORS 656.005(7)(a)(A), this case should be remanded to the Board to consider that issue.

Cite as 152 Or App 780 (1998) February 25, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Nancy L. Pendergast-Long, Claimant.

**SAIF CORPORATION** and Murphy Plywood Company, *Petitioners,*
v.
**Nancy L. PENDERGAST-LONG**, *Respondent.*
(Agency Nos. 95-12710 and 95-0408M;
CA A96056 (Control) and A96299) (Cases Consolidated)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 28, 1997.
David L. Runner argued the cause and filed the briefs for petitioners.
Dale C. Johnson argued the cause for respondent. With him on the briefs was Malagon, Moore, Johnson & Jensen.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
ARMSTRONG, J.
Affirmed.

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**152 Or App 782>** SAIF seeks review of an order of the Workers' Compensation Board that awarded claimant compensation for a back condition that required surgery. SAIF contends that claimant sought compensation for medical services only and, therefore, that the Hearings Division did not have jurisdiction over SAIF's denial of that claim. We disagree with SAIF's portrayal of the claim and, accordingly, affirm.

Claimant suffered a compensable back injury in 1986. She injured her back again in 1987 while working for the same employer. Her claims for those injuries were consolidated as a single claim under the 1986 injury. In January 1990, the 1986 claim was closed with an award of 15 percent unscheduled permanent partial disability (PPD). The PPD award was contested and, after a hearing, was adjusted to 16 percent unscheduled PPD to claimant's back and five percent scheduled PPD to her right leg. In 1992, claimant sought compensation for her current care and treatment of her back injury, which was denied. Claimant contested the denial, and the matter was resolved through a disputed claim settlement. In 1995, claimant underwent diagnostic studies that revealed a herniation of her L5-S1 disc. The examining physician recommended fusion of the lumbar spine from L4 to S1, which was done on September 22, 1995.

In conjunction with the surgery, claimant filed a request for compensation and temporary total disability (TTD) benefits. Because claimant's aggravation rights on the original injury had expired in March 1991, SAIF submitted the request for TTD benefits to the Board's own motion division.[1] On November 7, 1995, SAIF issued a denial of benefits. The denial letter stated in relevant part:

> "[W]e have determined that we are unable to pay for treatment *or disability* related to disc herniation L4-5 and L5-S1 with posterolateral interbody fusion at those levels because of the following reason(s):
>
> **152 Or App 783>** "*The January 15, 1986 injury is not the major contributing cause of your disc herniation L4-5 and L5-S1* with posterolateral interbody fusion at those levels."

(Emphasis supplied.)

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[1] ORS 656.278(1)(a) allows the Board to exercise its own motion authority to reopen a claim for additional TTD benefits when the Board finds that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization.

Claimant requested a hearing on the denial, which was held on April 4, 1996. After the hearing, the administrative law judge (ALJ) issued an opinion and order upholding SAIF's denial of the claim, concluding that the claim was precluded by the 1992 disputed claim settlement. As an alternate ground for his decision, the ALJ concluded that claimant had not proved that the condition requiring the lumbar fusion was related to the 1986 injury. Claimant requested review by the Board, which reversed the ALJ's order, concluding that the claim was not precluded by the 1992 settlement and that the 1986 injury was the major contributing cause of the claimant's current condition requiring surgery. The Board reaffirmed its decision in a December 1996 order on reconsideration. On January 16, 1997, the Board issued an own motion order granting claimant TTD benefits for the period beginning with her hospitalization for surgery, to continue until claimant was medically stationary.

SAIF contends that the Hearings Division did not have jurisdiction over the claim, and, therefore, could neither affirm nor reverse SAIF's November 7, 1995, denial of it. Specifically, SAIF argues that claimant had requested payment for medical services only and that such requests are under the exclusive jurisdiction of the Director of the Department of Consumer Services. As support for its argument, SAIF relies on our decision in *SAIF v. Shipley*, 147 Or App 26, 934 P2d 611, *rev allowed* 326 Or 57 (1997), where we interpreted ORS 656.245(6) to mean that a claim for medical services that is denied for reasons other than the denial of compensability of the condition for which medical treatment is sought is subject to the exclusive jurisdiction of the Director. Claimant argues in response that *Shipley* does not apply to her claim, because her claim was for more than medical services and because the November 7, 1995, denial specifically stated that the claim was not compensable because the January 15, 1986, injury was not "the major contributing cause" of her current condition. We agree with claimant. Although SAIF attempts to **<152 Or App 783/784>** portray claimant's request as one for medical services only, it is clear that SAIF originally viewed the request as seeking benefits for an aggravation of the original injury or for a new condition arising as a consequence of the original injury. Claimant has argued from the beginning that the condition for which she sought medical treatment was a worsening or consequence of the original injury. That is the type of dispute that ORS 656.283 assigns to the Hearings Division.[2] We conclude, therefore, that the Board had jurisdiction over the claim.[3]

Affirmed.

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[2] ORS 656.283 assigns to the Hearings Division jurisdiction to review "any matter concerning a claim, except matters for which a procedure for resolving the dispute is provided in another statute, including ORS 656.245[.]" ORS 656.245(6) provides, in turn:

> "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 provision of ORS 183.310 to 183.550."

The dispute at issue is a matter concerning a claim, and it does not come within the disputes that ORS 656.245(6) assigns to the Director for decision.

[3] SAIF also petitioned for review of the Board's own-motion order, arguing that, because the Board had no jurisdiction over the claim, it could not grant TTD benefits because that grant is, of necessity, tied to the underlying claim. Because we conclude that the Board had jurisdiction of the claim, it had authority to award TTD benefits on it.

Cite as 152 Or App 790 (1998) February 25, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Michael J. Galbraith, Claimant.

**Michael J. GALBRAITH**, *Petitioner,*
v.
**L.A. POTTSRATZ CONSTRUCTION** and SAIF Corporation, *Respondents.*
(95-03825; CA A91990)

In Banc
Judicial Review from Workers' Compensation Board.
Argued and submitted February 14, 1997; resubmitted in banc November 13, 1997.
Ernest M. Jenks argued the cause and filed the brief for petitioner.
David L. Runner argued the cause and filed the brief for respondents.
ARMSTRONG, J.
Reversed and remanded.
Warren, J., dissenting.

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**152 Or App 792>** Claimant seeks review of a denial of an award of attorney fees under ORS 656.386(1). That statute requires an award of attorney fees when an attorney is instrumental in getting an insurer or self-insured employer to rescind a denial of a workers' compensation claim before an administrative law judge (ALJ) has issued a decision on the claim.[1] The Workers' Compensation Board denied an award of attorney fees to claimant on the ground that the insurer had not denied the claim at issue in this proceeding. We reverse.

The undisputed facts are as follows. In 1992, claimant was injured in a construction accident that resulted in paraplegia. SAIF accepted claimant's claim for the injury, and, in a December 1993 Notice of Closure, claimant received an award of 100 percent loss of use of both legs and 82 percent unscheduled disability.

On November 4, 1994, claimant fell from his wheelchair onto his right hip, fracturing his right hip and femur. He received treatment for his injuries and copies of his medical reports were forwarded to SAIF as a claim for compensation. SAIF paid claimant's medical expenses under his prior paraplegia claim but did not respond to the new claim. On March 27, 1995, claimant filed a hearing request, asserting a *de facto* denial of his claim. SAIF filed its "Response to Request for Hearing" on May 17, 1995. In that response, SAIF checked the box on the form corresponding to the statement: "There is no known basis for an award of penalties/ attorney fees." SAIF also checked the box marked "Other" and, in the space provided, wrote, "The claimant is entitled to no relief."

The hearing was held on June 19, 1995. At that time, SAIF notified the ALJ that it had accepted the claim. The **<152 Or App 792/793>** only issue remaining before the ALJ was whether claimant was entitled to reasonable attorney fees under ORS 656.386(1). Finding that there had been "no express denial of compensation," the ALJ denied claimant's request for attorney fees. On review, a divided Board affirmed the ALJ's decision, three to two. The majority concluded that claimant had failed to establish that his claim had been "denied" under the terms of the statute:

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[1] ORS 656.386(1) provides, in part:

"In all cases involving denied claims * * * where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge, a reasonable attorney fee shall be allowed. For purposes of this section, a 'denied claim' is a claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation."

> "There is no evidence in this record that SAIF 'refused to pay' any compensation. In addition, there is no evidence of a 'denied claim' as contemplated by the statute. * * *
>
> "* * * To the contrary, the record establishes that all benefits for claimant's fractured femur were paid under his compensable paraplegia claim. Furthermore, * * * there is no concession that a fee should be awarded and no acknowledgment in the record that SAIF questioned the causal relationship of the femur fracture to the compensable injury. Likewise, there is no evidence in the record that SAIF questioned the causation of claimant's right femur fracture. Under such circumstances, the record does not establish that SAIF refused to pay compensation on the express ground that the femur fracture was not compensable or did not give rise to an entitlement to any compensation. Consequently we conclude that a 'denied claim' has not been established."

(Footnote omitted.)

We review the Board's legal conclusions for errors of law. ORS 183.482(8)(a). We conclude that SAIF's response to claimant's hearing request constituted an express denial of compensation of claimant's fracture injuries that satisfied the denial requirement for an award of attorney fees under ORS 656.386(1).

SAIF stated in its response to claimant's hearing request that "claimant is entitled to no relief." SAIF now argues that that statement was not an express denial of claimant's claim as contemplated by the legislature when it amended ORS 656.386(1) to define a "denied claim" as one that "an insurer * * * refuses to pay on the express ground that the injury * * * does not give rise to an entitlement to any compensation." We are at a loss to understand how **<152 Or App 793/794>** SAIF's statement can be understood as anything but an express denial of the claim under that definition.

Claimant suffered a compensable injury that left him without the use of his legs. He later suffered a nonwork-related injury, the fractured right hip and femur at issue here. His attending physician determined that the fractures were "clearly related to his paraplegia and caused substantially by the paraplegia." Claimant's compensation claim was, therefore, a claim for a consequential condition and not a claim for further payment under the earlier paraplegia claim. Claimant was thus entitled to have SAIF accept or deny the new claim. SAIF did neither within the time period specified by ORS 656.262(6), but it did pay for claimant's medical treatment under the paraplegia claim. Having received no response to his new claim, claimant requested a hearing, on the ground that there had been a *de facto* denial of that claim. SAIF's response to that request was that claimant was entitled to no relief on his claim. Claimant proceeded in the face of that denial, and only then did SAIF accept the claim.

The Board found significance in the fact that SAIF had paid claimant's medical bills. That flies in the face of a legislative directive depriving the payment of medical bills of any significance. ORS 656.262(10).[2] Payment of medical expenses is only one aspect of a claim, however. Because the fracture injuries are compensable only as consequences of the first, work-related, injury, claimant could not recover for any further loss in earning capacity occasioned by those injuries or for any later worsening or aggravation of them unless they, too, were accepted. It is for that reason that the "relief' to which claimant was entitled was the acceptance of the claim and not merely the payment of accrued expenses. By taking the position that claimant was not entitled to have his claim for the fracture injuries accepted as compensable, SAIF **<152 Or App 794/795>** necessarily refused to pay any benefits on those injuries other than the previously paid medical expenses.

This case is legally indistinguishable from *Kimberly Quality Care v. Bowman*, 148 Or App 292, 939 P2d 629 (1997). There, the claimant requested a hearing on a *de facto* denial of two conditions. The employer had paid the claimant's medical bills for those conditions on a prior, accepted claim, but it had not accepted the conditions. In response to the hearing request, the employer filed a check-the-box

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[2] ORS 656.262(10) provides, in pertinent part:

> "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."

response that said that claimant had not sustained a work-related injury or disease. The employer later accepted the claim for those conditions but resisted an award of attorney fees under ORS 656.386 for one of the conditions, on the ground that it had not expressly denied that condition.

The Board disagreed with that contention and the employer petitioned for review. On review, the employer argued that it had not denied the claim for the disputed condition, as a denied claim is defined under ORS 656.386(1), because it had paid all the medical bills for that condition and, hence, had not refused to pay compensation for it. We rejected that argument:

> "Although employer had not refused to pay compensation up to the time claimant put the compensability of the conditions at issue, its notation on the response form was an express denial of the conditions on the ground that they were not related to the employment. *It carried with it an implicit refusal to pay compensation in the future.* * * * Although the check-the-box notation did not satisfy the requirements for a denial set forth in ORS 656.262(9), it nonetheless unequivocally expressed employer's denial of compensability."

*Kimberly Quality Care,* 148 Or App at 295 (emphasis supplied). Here, SAIF noted on the check-the-box form that claimant "is entitled to no relief." That notation also carried with it an implicit refusal to pay compensation in the future. We see no reason why we should decide this case differently from our decision in *Kimberly Quality Care.*[3]

**152 Or App 796>** Reversed and remanded.

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[3] Because we conclude that SAIF's response to claimant's request for hearing was an express denial for purposes of ORS 656.386(1), we need not address claimant's other arguments concerning the effect of ORS 656.386(1) on the application of ORS 656.262(6)(a), which requires an insurer or self-insured employer to respond in writing to a claim for compensation, with either an acceptance or denial of the claim, within ninety days.

**WARREN, J.**, dissenting.

The issue in this case is whether there was a denied claim pursuant to ORS 656.386(1). Because I believe the Board was correct in holding there was not a denied claim, I dissent.

The majority opinion writes that "[t]his case is legally indistinguishable" from *Kimberly Quality Care v. Bowman,* 148 Or App 292, 939 P2d 629 (1997). 152 Or App at 795. This is incorrect. The relevant facts of *Kimberly Quality Care* make it easily distinguishable from this case. In *Kimberly Quality Care,* the claimant specifically requested written acceptance or denial of her claim along with a notice of hearing. In response to that request, the insurer responded by denying that the claimant had sustained a work-related injury or disease. The Board held that "the insurer answered claimant's request for hearing by denying her allegations on the express ground that these condition[s] are not compensable." *Emily M. Bowman,* 48 Van Natta 1199, 2000 (1996).[1]

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[1] The Board distinguished the different result from its earlier decision in this case:

> "We find this case distinguishable from *Michael J. Galbraith,* 48 Van Natta 351 (1996). In *Galbraith,* the carrier responded to the claimant's request for hearing by asserting that the worker was 'entitled to no relief.' Because there was no refusal to pay compensation on the express ground that the condition was not compensable or that claimant was not otherwise entitled to compensation, there was no 'denied claim' as required by ORS 656.386(1). Here, in contrast, the carrier's response to the request for hearing expressly denied that claimant had sustained a work-related injury or disease. Because the carrier's response in this case constitutes a refusal to pay compensation on the express ground that the condition is not compensable, it is a 'denied claim' within the meaning of ORS 656.386(1)." *Emily M. Bowman,* 48 Van Natta 1199, 2000 n 2.

We affirmed the Board's order in *Bowman* and wrote that insurer's "notation on the response form was an express denial of the conditions on *the ground that they were not related to the employment.*" *Kimberly Quality Care*, 148 Or App at 295 (emphasis supplied). The majority opinion errs by holding that the notation "claimant is entitled to no relief' suggests the same express denial embodied in the notation in **<152 Or App 796/797>** *Kimberly Quality Care*, which denied that the claimant had sustained a work-related injury or disease. This error becomes more apparent from the precise wording of ORS 656.386(1), which provides:

> "For purposes of this section, a 'denied claim' is a claim for compensation which an insurer or self-insured employer refuses to pay on the *express* ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation." (Emphasis supplied.)

Pursuant to this definition, a denied claim requires three components: (1) a claim; (2) refusal to pay compensation; and (3) an express denial. In its opinion, the majority fails to explain what an "express denial" is. "Express," in this context, means "directly and distinctly stated or expressed rather than implied or left to inference: *not dubious or ambiguous.*" *Webster's Third New Intl Dictionary* 803 (unabridged ed 1993) (emphasis supplied). In other words, an express denial is a denial that is directly and distinctly stated and not implied or ambiguous. Thus, the majority opinion necessarily holds that SAIF's notation on the hearing response form, "claimant is entitled to no relief," directly and distinctly (expressly) states SAIF's intent to refuse payment because the claim is not compensable or otherwise does not give rise to an entitlement to any compensation. Because I find SAIF's statement "ambiguous" and certainly not "express," I disagree.

The notation involved here has two possible, and plausible, interpretations. "[C]laimant is entitled to no relief" could mean that SAIF intended to deny the claim on the ground that claimant's fractured femur is not compensable or otherwise does not give rise to an entitlement to compensation; or, it could mean that, because SAIF had paid all of claimant's benefits under his paraplegia claim, there was nothing additional SAIF was then required to do to fulfill its obligations under the law. Both constructions are reasonable and ultimately create an ambiguity. That ambiguity, pursuant to ORS 656.386(1), should require this court to hold that it was not an express denial. Significantly, the notation in *Kimberly Quality Care* was not ambiguous and could only be interpreted to be an express denial.

**152 Or App 798>** Additionally, the majority opinion inadequately addresses the Board's finding: "There is no evidence in this record that SAIF 'refused to pay' any compensation." The record indicates that up to the time of hearing the insurer had paid all of claimant's medical bills.[2] The majority opinion, however, says that the notation "claimant is entitled to no relief" carries with it an implicit refusal to pay compensation in the future. 152 Or App at 795. That argument begs the question. If the notation constitutes a denied claim, then it certainly implies a refusal to pay compensation in the future. But as I have said, given the different inferences that can be drawn from the undisputed facts, there is substantial evidence that supports the Board's conclusion that what occurred in this case did not constitute an express denial.

Here, the evidence before the Board was that SAIF had paid all of the claimant's medical bills but had written "claimant is entitled to no relief" on a response to hearing form. Nothing in the record indicates that SAIF questioned the causation of the injury or expressly questioned its compensability. *Cf Kimberly Quality Care*, 148 Or App at 294-95. Additionally, nothing was owing to claimant at the time the notation was written. The notation is capable of an understanding consistent with a denial or of a description of the present status of claimant's rights. The notation was in the present tense and literally did not address the future at all. On these facts, the Board did not err in finding that SAIF did not refuse to pay compensation in the future. The majority opinion errs in not addressing the Board's findings on this issue.

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[2] The majority opinion asserts that there is no significance in SAIF's payments and that there is a "legislative directive depriving the payment of medical bills of any significance." 152 Or App at 794. The majority opinion cites ORS 656.262(10) as support. However, that section simply provides that payment of compensation, by itself, shall not be considered an acceptance of a claim. That statute certainly does not foreclose the Board's ability to consider the payment of medical bills when examining the record to determine whether the insurer had refused to pay compensation.

Because there is substantial evidence in the record to show that SAIF did not refuse to pay any compensation to claimant, and because this record does not indicate an express denial, I dissent.

Haselton, J., joins in this dissent.

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