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

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

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50 Van Natta ____ (1998)

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

The SAIF Corporation requests that we authorize payment for an examination performed on its behalf by Dr. Ediger, audiologist.[1] For the following reasons, we find that the Board in its own motion authority does not have jurisdiction over this issue.

In *Raymond I. Frazier*, 50 Van Natta 280 (1998), we determined that we did not have jurisdiction over this claimant's initial hearing loss claim. In late 1997, claimant, now 90 years old, first filed an occupational disease claim for hearing loss, which he attributed to work-related noise exposure from 1951 to 1969. On February 12, 1998, the SAIF Corporation denied compensability of that claim. The appeal rights on SAIF's denial advised claimant that if he disagreed with SAIF's decision, he could request a hearing before the Board's Hearings Division. Nevertheless, although denying claimant's occupational disease claim, SAIF also interpreted that initial claim as a request for own motion relief and recommended that the request be denied.

There, as here, SAIF relied on claimant's pre-1966 work-related noise exposure to argue that the claim was within the Board's own motion jurisdiction. However, after examining the statutes governing the Board's own motion jurisdiction, we determined that our own motion jurisdiction does *not* extend to issues of compensability of initial claims, even pre-1966 claims. ORS 656.273(4); 656.278(1). Instead, we found that the Hearings Division has initial jurisdiction over such compensability issues. We determined that a prerequisite for own motion jurisdiction is the existence of a compensable claim for which the aggravation rights have expired. *Miltenberger v. Howard's Plumbing*, 93 Or App 475 (1988). Because claimant did not meet that prerequisite in that the initial compensability of the occupational disease claim had not yet been determined, let alone the expiration of aggravation rights (should that claim be found compensable), we concluded that the Board in its own motion authority did not have jurisdiction over claimant's occupational disease claim. *Frazier*, 50 Van Natta at 281.

Here, SAIF requests reimbursement for a medical report related to claimant's claim. Specifically, SAIF argues that "since this was a cost incurred for diagnostic work up on a pre-66 claim, jurisdiction lies with the Workers' Compensation Board." However, contrary to SAIF's argument and as our prior order clearly explained, claimant's *initial* hearing loss claim is *not* within our own motion jurisdiction, even if that claim involved some pre-1966 work-related noise exposure. In other words, if we have no jurisdiction over claimant's claim, we have no authority to authorize any payments related to that claim, whether those payments are for hearing aids requested by claimant or medical report fees requested by SAIF.

We note that medical report fees have been found compensable where the reports were reasonable and necessary for determining whether a causal relationship existed between the current condition and the *compensable* injury. *See Brooks v. D & R Timber*, 55 Or App 688, 692 (1982); *Cordy A. Brickey*, 44 Van Natta 220 (1992). However, the operative word is "compensable" and, here, there is no "compensable" occupational disease claim to support a medical report fee.

Because claimant's initial occupational disease claim is not a compensable own motion claim, we have no jurisdiction over SAIF's request to award it any costs related to that occupational disease claim. Accordingly, we dismiss SAIF's request for own motion relief.

IT IS SO ORDERED.

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[1] Although SAIF submits a copy of Dr. Ediger's January 22, 1998 report with its request for authorization for reimbursement, it does not indicate the fee for this examination and report. Nor does it submit a copy of an invoice from Dr. Ediger. However, given our decision that we do not have jurisdiction over this issue, we need not address this omission.

In the Matter of the Compensation of
JULIE A. GADDIS, Claimant
WCB Case No. 97-03843
ORDER ON RECONSIDERATION
Ransom & Gilbertson, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Claimant requests abatement and reconsideration of our June 5, 1998 Order on Review that upheld the self-insured employer's denial of claimant's low back injury claim. In our order, we adopted and affirmed Administrative Law Judge (ALJ) Menashe's order that found that the medical evidence established that claimant's morbid obesity was a preexisting condition that combined with the work injury and concluded that claimant failed to meet her burden of proving a compensable injury under ORS 656.005(7)(a)(B). On reconsideration, claimant first raises the issue of compliance with the Americans with Disabilities Act (ADA).[1] In addition, claimant requests that this matter be reviewed by the Board *en banc*. Having received the employer's response to claimant's motion, we proceed with our reconsideration.

As a preliminary matter, we deny claimant's request for *en banc* reconsideration of this case. Although the Board may sit *en banc* in rendering a decision, it may also sit in panels. *See* ORS 656.718(3). When sitting in panels, a majority of the particular panel may issue the Board's decision. *Id.* Whether a case is reviewed *en banc* is a matter that the Board decides on its own motion. Such review may not be initiated by a party. After reviewing this case, claimant's request for *en banc* review is denied. *See, e.g., Ralph L. Witt*, 45 Van Natta 449 (1993) (*on recon*); *Kurt D. Cutlip*, 45 Van Natta 79 (1993) (on recon).

At hearing and on review, the sole issue was the compensability of claimant's low back injury claim. Claimant first raised the issue of compliance with the ADA in her request for reconsideration, contending that ORS 656.005(7)(a)(B) violates the ADA. Issues which are raised for the first time on Board review are not considered. *See Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991). Likewise, we do not consider new issues for the first time on reconsideration. *See Kenneth D. Nichols*, 45 Van Natta 1729 (1993). In accordance with these holdings, we are not inclined to consider the issue of compliance with the ADA.

In any event, we have previously held that we lack jurisdiction to consider a claimant's ADA challenge to the worker's compensation statutes. *Sandra J. Way*, 45 Van Natta 876 (1993), *aff'd on other grounds Way v. Fred Meyer, Inc.*, 126 Or App 343 (1994). We continue to hold, for the reasons expressed in *Sandra J. Way*, that the Board is not the proper forum for claimant's ADA challenge. Furthermore, the court recently rejected a similar challenge to ORS 656.005(7)(a)(B) and ORS 656.005(24) and concluded that those statutes were neither in violation of nor preempted by the ADA. *Bailey v. Reynolds Metals*, 153 Or App 498 (1998); *Brown v. A-Dec, Inc.*, 154 Or App 244 (1998).

Accordingly, our June 5, 1998 order is withdrawn. On reconsideration, we adhere to and republish our June 5, 1998 order in its entirety, as supplemented herein. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] We note that claimant states that she will seek a declaratory judgment, and a preliminary and permanent injunction against the Board in the United States District Court for the District of Oregon "to end the ongoing and prevent the future violation of the [ADA]" by the Board and the State of Oregon. The Board makes no comment regarding claimant's future course of action, other than to say that it is a matter between claimant and her counsel.

In the Matter of the Compensation of
CARLA I. DURHAM, Claimant
WCB Case No. 97-07902
ORDER ON REVIEW
John M. Hoadley, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Podnar's order that set aside its partial denial of claimant's fibromyalgia condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings with the following exception. In lieu of the findings in paragraph three on page two of the ALJ's order, we find that the employer ultimately accepted a disabling neck strain and left shoulder strain.

We make the following additional finding. Claimant developed cervical pain following a physical therapy treatment in mid-December 1995.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant's fibromyalgia is a compensable consequence of her accepted left shoulder and neck condition under ORS 656.005(7)(a)(A). To establish a compensable consequential condition under that provision, claimant must prove that it is more probable than not that her work injury is the major contributing cause of the fibromyalgia. In concluding that claimant's fibromyalgia is compensable, the ALJ relied on the opinions of Drs. Spady and Krohn. We do not agree with the ALJ's reliance on Dr. Spady, as his opinion does not address the relevant major contributing cause standard and is not phrased in terms of a probable causal relationship. Nevertheless, we conclude that Dr. Krohn's opinion establishes the requisite probable causal relationship. We rely on Dr. Krohn because he is an expert in diagnosing and treating the type of complaints at issue in this case, and he has provided a well-reasoned, persuasive basis for his conclusion. We find the contrary opinions of Drs. Pierson, McKillops and Williams to be conclusory and poorly reasoned.

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

ORDER

The ALJ's order dated January 27, 1998 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,000, payable by the employer.

In the Matter of the Compensation of
JOHN P. HILFERTY, Claimant
WCB Case No. 97-05739
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for a low back condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant contends that his work as an auto mechanic is the major contributing cause of his low back condition, consisting of degenerative disc disease, disc herniations at L3-4, L4-5 and L5-S1, and acute lumbosacral strain. Based on the opinion of examining neurosurgeon, Dr. Rosenbaum, the ALJ found that claimant did not prove compensability.[1] Claimant challenges this conclusion, asserting that the opinion of his treating osteopath, Dr. Rambousek, satisfied his burden of proof.

Dr. Brett, consulting neurosurgeon, indicated that "certainly [claimant's] work activities have been a contributing factor to the development of his degenerative disc disease and disc pathology at L4-5 and L4-S1, but I do not feel there is any work injury which has become the major contributing factor to his current pathology or symptoms." (Ex. 19-2).

Dr. Rosenbaum diagnosed a disc herniation at L3-4 and "asymptomatic" disc protrusions at L4-5 and L5-S1. (Ex. 21-3). Dr. Rosenbaum thought that the L3-4 disc protrusion "began spontaneously and is non-work related on either the basis of an injurious event or an occupation [sic] illness." (*Id.*)

Dr. Rambousek answered "yes" to a letter written by claimant's attorney asking whether the major contributing cause of claimant's "degenerative disc disease" was his past 20 years of employment as an auto mechanic, including the period of work with the employer. (Ex. 23-1). Dr. Rambousek also answered "yes" to whether the major contributing cause of the disc protrusions at L4-5 and L5-S1 was "repetitive lifting, bending, and twisting" that "lead to the degenerative disease." (*Id.*) Dr. Rambousek added that "repetitive lifting, bending & twisting will lead to both [degenerative disc disease and herniated discs] and his work is the major cause (51% or greater) of both." (*Id.* at 2).

In response, Dr. Rosenbaum reported that claimant's "degenerative changes are most appropriately determined to be age related." (Ex. 24-2). Dr. Rosenbaum also indicated disagreement with Dr. Rambousek's opinion that physical activity caused degenerative disc disease, noting that no there was no "controlled study which has been able to implicate in any reasonable fashion degenerative disk disease to work activity." (*Id.* at 3).

With regard to the disc protrusions, Dr. Rosenbaum continued to think that the only one causing symptoms was at L3-4. (*Id.* at 4). Because claimant experienced the spontaneous onset of low back pain during a nonwork incident, Dr. Rosenbaum found no indications that work activity was the major contributing cause of the disc herniation. (*Id.*)

We first note that the record contains no medical opinion supporting a causal relationship between claimant's work activities and any disc herniation or protrusion at L3-4. Consequently, claimant did not prove compensability of this condition.

---

[1] Claimant has worked as an auto mechanic for many years; his present employer is SAIF's insured. At hearing, claimant indicated that he was relying on the last injurious exposure rule. Thus, claimant must initially show that his employment was the major contributing cause of his occupational disease. ORS 656.802(2); *Bennett v. Liberty Northwest Ins. Corp.*, 128 Or App 71, 74-76 (1994).

Absent persuasive reasons to the contrary, we generally defer to the treating physician's opinion. *See Weiland v. SAIF*, 64 Or App 810, 813 (1983). Here, we find the conclusory nature of Dr. Rambousek's opinion to constitute a persuasive reason for not deferring to it. Dr. Rambousek merely stated that repetitive lifting, bending and twisting activities were the major contributing cause of the degenerative disc disease and disc protrusions at L4-5 and L5-S1 without specifically explaining how such activities resulted in the development of the conditions.

Furthermore, Dr. Rambousek's opinion is rebutted by Dr. Brett, neurosurgeon, who indicated that work activities were only a contributing cause, and Dr. Rosenbaum, neurosurgeon.

At best, we find the opinions in equipoise. As such, claimant failed to carry his burden of proving the compensability of his low back condition.

ORDER

The ALJ's order dated March 18, 1998 is affirmed.

In the Matter of the Compensation of
SCOTT A. KENYON, Claimant
WCB Case Nos. 97-05487 & 97-04301
ORDER ON REVIEW
Robert J. Guarrasi, Claimant Attorney
Lundeen, et al, Defense Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Brazeau's order that: (1) upheld the denial of the SAIF Corporation, on behalf of Magnum Manufacturing, Inc., of claimant's current combined L5-S1 disc degeneration and need for treatment; (2) declined to award temporary disability benefits subsequent to the Department's Order Terminating Designation of Paying Agent Pursuant to ORS 656.307; and (3) declined to award penalties and attorney fees arising out of allegedly unreasonable claim processing by Liberty Northwest, on behalf of employer Safari Motor Coaches. On review, the issues are compensability, temporary disability, penalties and attorney fees.

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

Claimant, age 32 at the time of hearing, has suffered a series of compensable back strains over the last several years. In April 1991, Liberty, on behalf of L.K. Walker, Inc., accepted a disabling lumbar strain arising out of a fall at work on March 14, 1991. The claim was closed on August 21, 1991 with no award of permanent disability.

A December 10, 1992 MRI showed mild bulging discs at L4-5 and L5-S1, but no disc herniations.

On December 29, 1993, claimant twisted his back while working for Safari Motor Coaches. On January 11, 1994, Liberty accepted a claim for a lumbar strain. A January 24, 1994 MRI revealed the same mild disc bulges previously identified. Claimant was declared medically stationary on March 18, 1994, and the claim was closed pursuant to a July 11, 1994 Determination Order which awarded temporary disability only.

On October 22, 1996, claimant reinjured his low back while employed by SAIF's insured, Magnum Manufacturing, Inc. A repeat MRI on December 9, 1996 revealed the same bulging discs, unchanged since January 1994. SAIF accepted a disabling L5-S1 sprain on January 14, 1997.

Claimant's low back and radicular symptoms continued. In February 1997, Dr. Karasek performed a 3 level discogram which revealed normal L3-4 and L4-5 discs with diffuse degeneration at the lumbosacral level (L5-S1) with a posteriorly directed central fissure in the midline. Dr. Karasek referred claimant to Dr. Kitchel, who had previously treated claimant in 1994. Dr. Kitchel recommended surgical intervention.

In April 1997, Dr. Kitchel opined that claimant's underlying L5-S1 disc degeneration was the major cause of his current condition and need for surgery. Thereafter, SAIF closed claimant's lumbar strain claim and issued a denial of his current combined L5-S1 disc condition. Claimant requested reconsideration, contending that the claim had been prematurely closed.[1]

Dr. Kitchel performed claimant's L5-S1 anterior lumbar interbody fusion surgery on May 12, 1997.

Relying on the opinions of attending surgeon, Dr. Kitchel, and Dr. Smith (who performed a records review), the ALJ concluded that claimant's degenerative disc disease is the major contributing cause of his current disc condition and need for treatment and that his 1991, 1993 or 1996 work injuries did not cause or worsen this condition.

On review, claimant contends that Dr. Kitchel's opinion is unpersuasive and also that the opinions of Drs. Fuller, Reimer, Karasek and Schepergerdes establish that his October 1996 injury was the major cause of his current condition and need for surgery in May 1997. We find to the contrary.

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

Here, we find no persuasive reason not to rely on the assessment of Dr. Kitchel, who treated claimant both before and after his October 1996 injury and performed the fusion surgery in May 1997. In his November 18, 1997 deposition, Dr. Kitchel opined that claimant's October 1996 injury made claimant symptomatic again, but that the pushing incident at work did not cause any traumatic insult to the L5-S1 disc. (Ex. 80-8). Dr. Kitchel also opined that claimant's L5-S1 disc disease was progressive and idiopathic and unrelated to his work activity. (Ex. 80, pp. 17-23). He concluded that the major contributing cause of claimant's ongoing low back and buttock pain and his need for surgery in May 1997 was the underlying degenerative disc disease at L5-S1 rather than the muscloligamentous strain sustained in October 1996. (Ex. 80-9).

Although, in March 1997, Dr. Kitchel initially attributed claimant's symptoms to his work injury, he later explained in deposition that claimant's strain resolved after a few months, leaving the degenerative disc disease as the primary cause of claimant's symptoms and need for surgery in May 1997. (Ex. 80, pp. 9-13, 21). Like Dr. Kitchel, Smith also opined that claimant had progressive idiopathic degeneration of the L5-S1 disc which was the major cause of his current condition and need for treatment. (Ex. 78).

In light of the complete, well-reasoned opinion of Dr. Kitchel, we find the contrary opinions of Drs. Karasek, Schepergerdes, Fuller and Reimer conclusory and insufficient to sustain claimant's burden of proof.[2] *See Moe v. Ceiling Systems*, 44 Or App 429 (1980) (rejecting conclusory medical opinion). Indeed, although Dr. Karasek opined that the October 1996 injury precipitated claimant's need for surgery, he also deferred to Dr. Kitchel's assessment, noting that Dr. Kitchel had treated claimant both before and after his October 1996 injury. (Ex. 65). Consequently, we agree with the ALJ that claimant's current L5-S1 disc condition is not compensable.

ORDER

The ALJ's order dated March 19, 1998 is affirmed.

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[1] SAIF's Notice of Closure was affirmed pursuant to a "Statutory Affirming Order" issued by the Department on June 27, 1997. Although claimant also requested a hearing challenging the Department's order, he has conceded that if SAIF's denial is upheld, this challenge and the premature closure issue become moot.

[2] Dr. Schepergerdes is claimant's family doctor. Drs. Fuller and Reimer evaluated claimant on one occasion in June 1997 at Liberty's request.

In the Matter of the Compensation of
JUDY M. LUSBY, Claimant
WCB Case No. 97-07905
ORDER ON REVIEW
Lavis & Dibartolomeo, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Davis' order that affirmed an Order on Reconsideration that rescinded a Determination Order. On review, the issue is premature claim closure.

We adopt and affirm the ALJ's order, with the exception of the last full paragraph on page 7, and with the following supplementation.

Claimant's low back claim was closed by Determination Order on July 29, 1997 with an award of temporary disability compensation from November 19, 1991 through May 12, 1997 and an award of 5 percent (6.75 degrees) scheduled permanent disability for the loss of use or function of the left foot. The Determination Order found claimant medically stationary as of May 12, 1997. The Determination Order relied on Dr. Misko's concurrence with Dr. Snodgrass' May 12, 1997 examination report, in which he found that claimant was medically stationary. (Ex. 38).

Claimant requested reconsideration, contending that her claim had been prematurely closed, among other challenges to the closure notice. With her request for reconsideration, claimant submitted a letter from Dr. Nash dated July 18, 1997, in which he stated that claimant was not yet medically stationary. (Exs. 40, 41). By letter to the Department, the insurer objected to reconsideration of the medically stationary date on the basis that Dr. Misko, not Dr. Nash, was claimant's attending physician. Alternatively, the insurer argued that, if Dr. Nash was found to be claimant's attending physician, his report indicated that he was using an incorrect definition of "medically stationary" and therefore was inadequate to establish that claimant was not medically stationary at the time of claim closure. (Ex. 42).

By an Order on Reconsideration dated September 17, 1997, the Department rescinded the Determination Order as premature, based on the findings that: (1) claimant's attending physician at the time of claim closure was Dr. Nash; (2) Dr. Nash had not concurred with Dr. Snodgrass' report; and (3) the medical evidence, including Dr. Nash's July 18, 1997 report, established that claimant was not medically stationary at the time of claim closure. Relying on the opinion of Dr. Nash, the ALJ affirmed the Order on Reconsideration.

On review, the insurer first contends that Dr. Misko, not Dr. Nash, is claimant's attending physician, as Dr. Misko has been the primary surgeon, with Dr. Nash assisting, on four of claimant's most recent surgeries. The insurer argues that, therefore, we should rely on Dr. Misko's opinion that claimant was medically stationary. We do not agree.

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). In addition, we must establish the identity of claimant's attending physician at the time of claim closure. *Arcella M. Villagomez*, 49 Van Natta 184 (1997).

Claimant was initially referred to Dr. Nash for evaluation of her 1986 compensable low back condition in September 1989. (Ex. 10A). Thereafter, Dr. Nash began to direct her low back treatment, and, in May 1990, performed surgery. In January 1993, Dr. Nash performed a subtotal facetectomy, foraminotomy, and neurolysis at L3-4, L4-5 and L5-S1 on the left. (Exs. 11A, 12, 18). Dr. Nash continued to supervise claimant's care.

Dr. Misko, with Dr. Nash assisting, performed fusion surgery with Steffee plates in July 1993. Claimant was followed by Dr. Misko after the surgery. In January 1994, Dr. Misko, with Dr. Nash assisting, removed the Steffee plates and performed a laminectomy and removal of a disk at L3-L4. (Exs. 20, 21). In January 1996, Drs. Loeden and Misko, with Nash assisting, performed a diskectomy and fusion with bone graft at L3-4 and inserted an internal bone stimulator. (Exs. 22, 23).

On February 29, 1996, Dr. Misko reported that claimant could perform sedentary work with no bending or lifting after finishing therapy. (Ex. 24). On August 5, 1996, Dr. Loehden reported that, after removing claimant's spinal fusion stimulator, claimant should be ready to return to work in two weeks. He referred the insurer to either Dr. Misko or Dr. Nash for disability evaluation. (Ex. 25).

On October 9, 1996, Dr. Misko noted that claimant's fusion was maturing, but that she was complaining of increasing leg pain. He recommended a 3-D CT scan, L2-L4, to be certain claimant had nothing above her fusion and to check the L3-4 fusion. Misko stated: "I am leaving that up to Dr. Nash and she is to follow-up with him." (Ex. 27).

The scan was performed, and Dr. Misko reviewed it for Dr. Nash. Misko stated that the fusion at L3-4 was solid, but not greatly matured. He opined that no further surgery was indicated at that point (December 1996) and recommended flexion-extension films in about three months to check on the L3-4 fusion. (Ex. 28).

On February 17, 1997, the insurer wrote to Dr. Nash requesting a closing report to include a stationary date, permanent work restrictions and rating of permanent disability. Nash replied that claimant was currently being evaluated by Dr. Misko and that his report would soon be available. (Ex. 29). The insurer then wrote to Dr. Misko asking that he and Dr. Nash "get together and decide what is going on," and requesting a closing report. Dr. Misko told the insurer to refer questions to Dr. Nash. (Ex. 30).

On May 6, 1997, Dr. Nash performed a closing evaluation. Dr. Nash did not state that claimant was medically stationary, but his findings suggested permanent limitations. (Ex. 33). On May 12, 1997, Dr. Snodgrass performed a closing evaluation for the insurer, which Dr. Misko concurred with on May 23, 1997. (Exs. 34, 35). On May 18, 1997, Dr. Nash wrote to claimant's attorney, stating that, at the time of his May 6, 1997 evaluation, claimant had ongoing complaints of back and lower extremity pain, objective neurologic findings, and that claimant was in need of further diagnostic evaluation. He declared that claimant "is not, in the recent past or as of this date, medically stationary." (Ex. 37).

At the time of claim closure and thereafter, we find that Dr. Nash was claimant's attending physician. *See* ORS 656.005(12)(b); *Arcella M. Villagomez*, 49 Van Natta at 187. In sum, the record indicates that Dr. Nash had been claimant's primary care physician and surgeon since 1989. Moreover, although Dr. Misko had been the lead surgeon for some of claimant's more recent surgeries, Dr. Nash was a member of the surgical team and Dr. Misko's subsequent evaluations of claimant's progress were directed to Dr. Nash. Moreover, Dr. Misko indicated on at least two occasions that Dr. Nash was the primary care physician. (Exs. 27, 30). Finally, there is no "change of attending physician" form in the record to show an intention that Dr. Misko had taken over as claimant's primary care physician. Therefore, the record establishes that Dr. Nash, not Dr. Misko, was claimant's attending physician at the time of claim closure.

We next turn to the insurer's contentions that Dr. Nash did not offer an adequate explanation for changing his opinion after his closing examination of May 9, 1997, and that he was not using the correct definition of "medically stationary."

After our review of the record, we agree with the ALJ that, even though Dr. Nash performed a closing examination on May 9, 1997, his findings at that examination and his subsequent reassessment of claimant's most recent (November 15, 1996) diagnostic imaging studies support his changed opinion. At that examination, Dr. Nash noted claimant's continuing complaints of back and lower extremity pain, including severe cramping pain involving the left lower extremity, significant positive objective neurologic findings (absent left knee reflex, dermatomal sensory loss, marked depression of the left ankle reflex), and residual foraminal narrowing at L3-4 and L4-5 bilaterally, which indicated to him the necessity for further diagnostic evaluation. (Exs. 33, 37, 41). Dr. Misko's recommendation to Dr. Nash in December 1996 that the maturation of claimant's fusion should be evaluated in about three months with additional films (which had not been done) also lends support to Dr. Nash's May 1997 change of opinion. (Ex. 28). Finally, we do not read Dr. Nash's opinion that claimant is "not medically stationary" as indicative of a misapprehension of the correct definition of the term, given the above medical reasons for his ultimate opinion that claimant was not medically stationary at the time of his examination or thereafter.

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

ORDER

The ALJ's order dated February 25, 1998 is affirmed. For services on review, claimant is awarded an assessed attorney fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
JOHN E. POWELL, Claimant
WCB Case No. 97-07199
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Garaventa's order that directed the SAIF Corporation to recalculate claimant's temporary total disability rate using wages of $2,075 per month. Claimant contends that his temporary disability rate should include a reasonable value for non-monetary compensation. On review, the issue is temporary disability rate.

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

The ALJ found that claimant's "wage" should be based on a salary of $1,400 plus $675 for the rental value of the home provided by the employer. The parties do not dispute these amounts. The ALJ also found that claimant had not established a reasonable value for any of the other non-monetary compensation he received. On review, claimant contends that he has established a reasonable value for an increased wage. SAIF argues that the additional items that claimant wishes to have included in the wage rate calculation were either incidental to his employment or should be included as part of the value of the home and not be valued separately. We agree.

Temporary total disability benefits are based on the daily wage the worker was receiving at the time of injury. "Wages" are "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, and includes * * * tips."

Claimant contends that the provision of water, sewer and garbage disposal should be valued in addition to the rental value of the home. Based on our review of the record, we are persuaded that water, sewer and garbage disposal were provided with the home and are, therefore, included in the rental value of the home.

Claimant also contends that the value of the firewood he was given in order to reduce his heating bills should be valued in addition to the rental value of the home. The evidence indicates that the firewood was not an agreed-upon part of claimant's remuneration, as the employer's offer of all the wood he needed to reduce his electric heating bill was not exercised until after claimant had begun to work and after he had received his first electric bill.

Finally, claimant contends that the shop storage and use allowed by the employer, as well as the use of the employer's vehicle and the provision of meat, should be valued separately. Again, these benefits were incidental to claimant's employment and were not an agreed-upon part of claimant's remuneration. (Tr. 14, 15, 18, 33).

We recognize that claimant's testimony that he received these benefits is unrebutted. Nevertheless, claimant has not established that they were either a part of the reasonable value of his housing or were an agreed-upon part of claimant's remuneration under the contract of hiring. Consequently, we concur with the ALJ's recalculation of claimant's temporary total disability rate.

ORDER

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

In the Matter of the Compensation of
GARNET D. TOLL, Claimant
WCB Case No. 97-04148
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
Hoffman, Hart, et al, Defense Attorneys

Reviewed by Board Members Moller, Bock, and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Galton's order that: (1) set aside its denial of claimant's right wrist condition as premature; and (2) set aside its denial of claimant's occupational disease claim for right elbow epicondylitis. On review, the issues are premature denial and compensability. We modify in part and affirm in part.

FINDINGS OF FACT

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

Prior to beginning work for the employer in August 1995, claimant had been diagnosed and treated for recurrent de Quervain's tendinitis affecting her right wrist and thumb. (Exs. 2, 3, 4, 6, 7, 8). In January 1996, claimant was treated by Dr. O'Meara for a recurrence of that condition. (Ex. 9).

In May 1996, claimant sought treatment for right arm pain, which Dr. O'Meara diagnosed as right lateral epicondylitis. (Ex. 9A). In November 1996, claimant sought treatment for lateral epicondylitis and a recurrence of de Quervain's tendinitis. (Exs. 10, 12).

In March 1997, Dr. O'Meara noted that claimant's de Quervain's tendinitis was stable, but that the right lateral epicondylitis was worsening. He referred claimant to Dr. Watanabe for evaluation of the recurrent lateral epicondylitis. (Ex. 12). On April 2, 1997, claimant filed a claim for right elbow tendinitis. (Ex. 12A). Dr. Watanabe recommended surgery for right lateral epicondylitis that had been refractory to treatment for a year. (Ex. 13A, 14).

On May 2, 1997, claimant was examined by Dr. Button, who diagnosed claimant's condition as "symptom magnification/functional overlay" and recommended against elbow surgery. Although he was skeptical about the diagnosis of de Quervain's tendinitis, as claimant was asymptomatic on examination, Button opined that it preexisted and was not worsened by claimant's work. (Ex. 15).

On May 13, 1997, the employer issued a denial of claimant's "upper extremity condition, lateral epicondylitis, and de Quervain's tendinitis of the right wrist." (Ex. 16).

In August 1997, both Dr. O'Meara and Dr. Watanabe opined that claimant's de Quervain's tendinitis was related to her employment.

CONCLUSIONS OF LAW AND OPINION

Premature Denial

Claimant filed an occupational disease claim for "right elbow tendinitis." The employer issued a denial of claimant's "upper extremity condition, lateral epicondylitis, and de Quervain's tendinitis of the right wrist." At hearing, claimant asserted that she had never made a claim for de Quervain's tendinitis. The insurer argued that there was a claim for de Quervain's tendinitis of the right wrist that was formally denied.

The ALJ concluded that claimant did not file a claim for de Quervain's tendinitis and therefore set aside that portion of the insurer's denial of that condition as premature. On review, the insurer argues that its denial of de Quervain's tendinitis was not premature and should be reinstated for a decision on the merits. We agree.

Claimant can establish that the denial was premature if she can show that no claim for de Quervain's tendinitis was made. *William H. Waugh*, 45 Van Natta 919 (1993). A "claim" is 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). The request for compensation does not have to take any particular form. A physician's report requesting medical services for a specified condition in addition to medical treatment being provided for the accepted condition constitutes a claim.[1] *Safeway Stores, Inc. v. Smith*, 117 Or App 224, 227 (1992).

Here, the record does not support a finding that the insurer's denial of de Quervain's tendinitis was premature. Prior to starting work for the employer in August 1995, claimant had been receiving treatment from Dr. O'Meara for recurrent de Quervain's tendinitis affecting her right wrist and thumb. In January 1996, claimant was treated by Dr. O'Meara for a recurrence of that condition.

In May 1996, claimant sought treatment for right arm pain which Dr. O'Meara diagnosed as right lateral epicondylitis. In November 1996, claimant sought treatment for both lateral epicondylitis and a recurrence of de Quervain's tendinitis. By March 1997, Dr. O'Meara noted that claimant's de Quervain's tendinitis was stable, but the right lateral epicondylitis was worsening. He referred claimant to Dr. Watanabe for evaluation of the recurrent lateral epicondylitis.

Claimant filed a claim for right elbow tendinitis and Dr. Watanabe recommended surgery for that condition. Subsequently, both Drs. O'Meara and Watanabe related claimant's de Quervain's tendinitis to her employment activities.[2]

Notwithstanding claimant's assertion that she had not filed a claim for right de Quervain's tendinitis, the reports from Dr. O'Meara constituted a claim, which the insurer had a legal duty to accept or deny. *See William H. Waugh*, 49 Van Natta at 920; *Michael C. Holt*, 44 Van Natta 962 (1992) (ALJ correctly declined to set aside the employer's denial based on the claimant's attorney's assertion that no claim had been made, where the treating doctor had made a claim which the carrier had a duty to accept or deny).

Compensability

The insurer argues that claimant failed to carry her burden to establish a compensable occupational disease of either her right wrist or her right elbow under ORS 656.802.

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.

---

[1] We are cognizant that the receipt of a medical claim billing for the provision of, or requesting permission to provide, medical treatment for a "new medical condition" claim after claim acceptance is not a claim under ORS 656.262(7)(a). However, under the circumstances of this case, which involves the denial of an initial claim, ORS 656.262(7)(a) is inapplicable.

[2] In a July 21, 1997 letter to Dr. O'Meara, claimant's counsel indicated that claimant did not feel that her de Quervain's tendinitis was related to her work for the employer. Dr. O'Meara apparently disagreed.

"(e) Preexisting conditions shall be deemed causes in determining major contributing cause under this section."[3]

Here, the uncontroverted evidence indicates that claimant's de Quervain's tendinitis preceded the onset of her initial claim for that condition. *See* ORS 656.005(24) (defining "preexisting condition"). Thus, to the extent that claimant's occupational disease claim is based on the worsening of her preexisting de Quervain's tendinitis, claimant must prove that her employment conditions were the major contributing cause of her combined condition and a pathological worsening of the disease. ORS 656.802(2)(b).

Although both Dr. O'Meara and Dr. Watanabe each found claimant's de Quervain's tendinitis to be work related, neither physician opined that claimant's work conditions had contributed to a pathological worsening of that condition. (Exs. 16H, 19). Accordingly, claimant has not established the compensability of her de Quervain's tendinitis of the right wrist/thumb.

In contrast, there is no evidence that claimant's right elbow lateral epicondylitis preceded the onset of her initial claim for that condition, which arose in May 1996. Consequently, claimant must prove only that her work conditions were the major contributing cause of the right elbow epicondylitis condition.

The ALJ concluded that Dr. O'Meara's opinion satisfied claimant's burden of proving compensability of right elbow epicondylitis. The insurer argues that Dr. O'Meara'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).

After our *de novo* review of the record, we agree with the ALJ that the opinion of Dr. O'Meara, as buttressed by those of Dr. Watanabe and Dr. Throop, is more persuasive than that of Dr. Button.

Dr. Button, who examined claimant for the insurer, diagnosed claimant's condition as "symptom magnification/functional overlay," based on his clinical assessment of "inconsistencies" during evaluation and exaggerated pain response to manipulation of her right elbow. Dr. Button expressed doubt that claimant had lateral epicondylitis, based on the same clinical observations. He also doubted that there was a causal relationship between the "supposed elbow epicondylitis" and claimant's work activities, reasoning that claimant's youth, health and trimness would not predispose her to that condition, nor would her work as a grocery checker, as lateral epicondylitis is "not a common condition in grocery workers." He also voiced the suspicion that claimant was "leveraging for secondary gain." (Ex. 15).

Dr. O'Meara, claimant's long-time treating physician, opined that the major contributing cause of claimant's lateral epicondylitis of the right arm was due to her repetitive activities at work. He also eliminated claimant's history of thoracic outlet syndrome as noncontributory to her current dysfunction. Finally, in regard to Dr. Button's evaluation of claimant's condition being due to functional overlay, Dr. O'Meara stated that, during his treatment of claimant since 1992, she consistently impressed him as a dedicated hard worker, sincere and honest, and without any evidence of secondary gain. (Exs. 16DA, 16G).

Dr. Watanabe also opined that claimant's work activity at the employer was the major contributing cause of her right lateral epicondylitis. He stated that he did not find any symptom magnification, functional overlay, motivation for secondary gain, or any inconsistencies in claimant's presentation. (Ex. 19).

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[3] 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 * * * ."

Another opinion on the existence and causation of claimant's condition was provided by Dr. Throop, orthopedic surgeon, who examined claimant and reviewed her medical records. Dr. Throop stated that claimant's bone scan showed objective findings of chronic epicondylitis, but not of arthritis, and, after eliciting elbow pain from testing, opined that the diagnosis of right lateral epicondylitis was correct. Dr. Throop also found no secondary gain on the part of claimant and, through questioning, eliminated her prior work history and off-the-job activities as possible causes of her right arm condition. Finally, based on claimant's description of her job, he attributed the cause of her epicondylitis to persistent overuse at work. (Exs. 21A; 23-19, -23).

In contrast to the persuasive opinions of Dr. O'Meara, Dr. Watanabe and particularly Dr. Throop, we are not persuaded by Dr. Button's opinion that claimant did not have right lateral epicondylitis, and that, if she did, it was due to symptom magnification, functional overlay, and secondary gain. Accordingly, we conclude that claimant has established compensability of her right lateral epicondylitis.

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

ORDER

The ALJ's order dated December 18, 1997 is reversed in part and affirmed in part. That portion of the order that set aside the insurer's denial of claimant's right de Quervain's tendinitis condition as premature is reversed and that portion of the denial is reinstated and upheld. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded a fee of $1,500, to be paid by the insurer.

Board Member Hall concurring in part and dissenting in part.

I concur with the majority's opinion that claimant's epicondylitis condition is compensable. However, because I disagree with the majority's conclusion that the insurer's denial of claimant's claim for de Quervain's tendinitis was not premature, I respectfully dissent from the majority's opinion on that issue.

The statute defines a "claim" as a written *request* for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge. Although claimant had been treating for de Quervain's syndrome, the right arm pain she experienced in May 1996 was diagnosed by Dr. O'Meara as right lateral epicondylitis. Even though she continued to be treated for both conditions, claimant did not make a "claim," as defined by the statute (a written request for compensation) for de Quervain's syndrome, particularly in light of Exhibit 12A, her specific written request for compensation for "right elbow tendinitis."

Because I believe that claimant is the "master of her claim," when she specifically requested compensation for right elbow tendinitis, the scope of her claim was right elbow tendinitis only. Moreover, claimant has made it quite clear that no claim is or had been made for de Quervain's syndrome. Therefore, I believe her unambiguous statement outweighs the ambiguous chart notes, which do not reflect a "request" for that condition under the statute.

Because I conclude that the majority applied the plain words of the statute too broadly, I respectfully dissent.

In the Matter of the Compensation of
THERESHA HARRISON, Claimant
WCB Case No. 97-09591
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) found that claimant's occupational disease claim for a current neck condition is not precluded by prior litigation; and (2) set aside its denial of claimant's current neck condition. On review, the issues are *res judicata* and compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant worked for the employer as a telephone referral specialist between October 1995 and May 1997. Her job involved receiving telephone calls through a headset and computer data entry.

Claimant has a long history of severe headaches. In April 1996, she sought treatment for neck pain, which she felt was related to her work. An MRI revealed minimal bulging discs at C5-6 and C6-7.

Claimant filed a claim for neck pain and a neck strain, which the employer denied on November 22, 1996. A hearing was held. A prior ALJ upheld the employer's denial, finding that claimant's work exposure was not the major contributing cause of her neck pain. The order was not appealed.

In May 1997, claimant became an accounts receivable assistant. In this position, claimant spent 5 hours of her 8 hour work shift entering computer data. Her neck symptoms increased and she sought treatment in July 1997. An August 1997 myelogram and CT scan revealed a herniated disc at C6-7. On November 17, 1997, the employer denied claimant's current claim. Claimant requested a hearing.

The ALJ found that the prior litigation did not preclude the current claim, because claimant's condition worsened after affirmance of the denial of the 1996 claim. We agree. *See e.g., Mary L. Miller*, 46 Van Natta 369, 370 (1994) (Where the claimant's condition changed since a prior denial, the current claim was not precluded); *Howard W. Lankin*, 35 Van Natta 849 (1983), *aff'd mem* 69 Or App 53, *rev den* 298 Or 470 (1984) (Uncontested denial of heart condition not a bar to future litigation of job-related worsening of that condition). Accordingly, we adopt the ALJ's "Conclusions of Law and Opinion," except for the last paragraph, and proceed to the merits.

To prove her occupational disease claim for a current neck condition, claimant must establish that her work activities were the major contributing cause of a pathological worsening of her preexisting condition.[1] ORS 656.802.

The medical evidence supporting the claim is provided by Dr. Hill, treating surgeon. Dr. Hill opined:

> "According to [claimant's] history: using a phone and tilting her neck started the onset of her pain and symptoms. *Based on that history*, it is my feeling that her work was the major contributing factor requiring her treatment." (Ex. 32, emphasis added).

Dr. Hill also stated:

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[1] As explained above, claimant's neck condition was not compensable as of the February 1997 hearing. (*See* Ex. 17). Because claimant's present claim for a herniated cervical disc condition is based on a worsening of her prior neck condition, we treat the prior condition as a preexisting condition under ORS 656.802(2)(b). *See Brown v. A-Dec, Inc.*, 154 Or App 244 (1998); *Miller, 46 Van Natta* at 371 (To prove an occupational disease after an unappealed denial, the claimant was required to establish that work activities were the major contributing cause of a pathological worsening of the preexisting condition since the prior denial).

"It would appear that [claimant's] symptoms started while she was working and her condition was aggravated by her work. I feel that her condition and need for treatment was [sic] necessitated by her work situation." (Ex. 18-2).

We do not find Dr. Hill's causation opinion persuasive. First, we grant no special deference to Dr. Hill's opinion concerning causation because we perceive no special advantage gained by Dr. Hill due to his status as claimant's treating surgeon. Further, Dr. Hill offers no explanation as to how claimant's work activities using a phone and tilting her neck resulted in a pathological worsening of her preexisting degenerative condition. Moreover, Dr. Hill's opinion is based on the temporal relationship between claimant's symptoms and her work activities. *See Danny R. Fuller*, 48 Van Natta 774, 775 (1996) (Medical opinion unpersuasive because based almost entirely on a temporal relationship between work accident and onset of the claimant's symptoms). Finally, Dr. Hill does not explain the relative contributions of claimant's preexisting condition and her work activities. *See* ORS 656.802(2)(e). Under these circumstances, we do not rely on Dr. Hill's conclusion, because we find it inadequately explained. *See Somers v. SAIF*, 77 Or App 259 (1986). Accordingly, in the absence of persuasive medical evidence supporting the claim, we conclude that the denial must be upheld.

ORDER

The ALJ's order dated February 27, 1998 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

July 9, 1998 Cite as 50 Van Natta 1351 (1998)

In the Matter of the Compensation of
AUDREY J. BIGELOW, Claimant
Own Motion No. 98-0273M
OWN MOTION ORDER
Malagon, Moore, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable cervical strain and C6-7 spondylosis. Claimant's aggravation rights expired on April 13, 1982. SAIF opposes authorization of temporary disability compensation, contending that: (1) claimant's current condition does not require surgery or inpatient hospitalization; (2) claimant's current condition is not causally related to the accepted condition; (3) SAIF is not responsible for the current condition; (4) surgery or hospitalization is not reasonable and necessary for the compensable injury; and (5) 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 April 7, 1998, claimant underwent insurer-paid medical examinations (IME) wherein her physical and psychological conditions were evaluated. Drs. Farris and Bald concluded there were no objective physical findings which would warrant the need for surgery for claimant's current neck condition. Dr. Klecan opined that from a psychiatric perspective, "[claimant] is not a surgical candidate." No further medical documentation is contained in the record. Thus, the record submitted to us fails to demonstrate that claimant requires surgery or hospitalization for treatment now or in the near future. Further, SAIF contends that claimant's current neck condition is neither compensably related to the accepted condition nor is it responsible for claimant's current condition. Finally, SAIF contends claimant was not in the work force at the time of the current worsening. Claimant has not responded to SAIF's contentions.

Inasmuch as the dispute between the parties remains unresolved, we are not authorized to reopen claimant's 1976 injury claim for the payment of temporary disability benefits. *See* ORS 656.278(1)(a). Should claimant's circumstances change, and SAIF accept the compensability of and responsibility for claimant's current neck condition and surgery is subsequently recommended and determined to be reasonable and necessary, claimant may again seek own motion relief.

Accordingly, claimant's request for temporary disability compensation is denied.

IT IS SO ORDERED.

July 8, 1998 Cite as 50 Van Natta 1352 (1998)

In the Matter of the Compensation of
GEOFFREY R. LEWIS, Claimant
WCB Case No. 97-04909
ORDER ON REVIEW
Robert J. Thorbeck, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Biehl, Bock, and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Myzak's order that upheld the SAIF Corporation's denial of claimant's claim for a toxic exposure 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 worked as a bioscience research technician for SAIF's insured. On February 11, 1997, claimant's work involved cleaning a building which contained insecticides, herbicides and fungicides in liquid, powder and granular forms. Claimant and his co-workers moved the chemicals and cleaned the room. Claimant also scraped paint from the ceiling and walls to prepare them for repainting. The room was dusty and the work stirred up dust.

Claimant wore protective clothing, including a charcoal respirator mask. The mask leaked. Claimant also wore goggles part of the time, but he took them off when they became fogged.

During the job, claimant experienced fatigue and eye irritation. At about 3 p.m., after working, claimant felt "flat," disoriented, confused, and "funny in the eyes." He experienced eye irritation, tearing, coughing, and wheezing on his way home. That evening, claimant noticed a "yellowish-whitish" powder in his nostrils. He had difficulty concentrating. By the next morning, claimant had a sore throat, sore neck, fatigue, dizziness, tinnitus, headache, sinus congestion, bright yellow phlegm and sputum, a chemical taste in his mouth, and vision abnormalities.

Claimant continued working. He sought medical treatment from Dr. Huff, his regular physician in early March, 1997. By that time he was about 70 percent recovered. Dr. Huff referred claimant to Dr. Stringham, who examined claimant once and ordered tests. Dr. Stringham opined that claimant's work exposure caused the symptoms for which he sought treatment.

Dr. Huff also referred claimant to Oregon Health Science University, where he was examined by Drs. Berlin and Burton on May 9, 1997. Dr. Quarum examined claimant on May 29, 1997. By that time, claimant believed that he was 95 percent recovered.

Claimant filed a claim for exposure to pesticide-contaminated dust. (Ex. 1). SAIF denied the claim for "injury to [claimant's] respiratory system," stating that there was insufficient evidence of "a diagnosable condition relating to the chemical exposure." (Ex. 13). Claimant requested a hearing.

Claimant identified the issues at hearing to include compensability of all conditions related to exposure and medical services for those conditions. (Tr. 4).

The ALJ found that claimant failed to prove medical causation, explaining that

> "the dispute in the medical evidence comes down to medical opinions disputing compensability on the basis that there is a void or vacuum in the medical literature regarding the specific multiple chemical exposure facts of this case versus a medical

opinion supporting compensability based on this claimant and his exposure and history in particular and the expert's actual experience with toxic exposures, singly and in combination." (O&O p. 3).

The ALJ concluded that the claim was not compensable, reasoning that

"when there is expert opinion noting a vacuum in the medical literature, the injured worker cannot meet his burden of proof with a fact-specific, condition-specific, well-reasoned expert opinion based on actual experience and complete information." (Id. at pp. 4-5, citing Kelly A. Nielson, Deceased, 49 Van Natta 800, 801 (1997)[1]).

We disagree with the ALJ's reasoning and conclusions.

Claimant bears the burden of establishing, by medical evidence supported by objective findings, that his work exposure was the major contributing cause of an occupational disease. *See* ORS 656.802(1)(a)(A); 656.802(a) & (d).

SAIF argues that claimant's headache, tinnitus, and fatigue symptoms were not verifiable objective findings under ORS 656.005(19). We agree with regard to those symptoms. However, we note that Dr. Stringham reported: "On a clinical basis, [claimant] has an exposure." (Ex. 19). Dr. Stringham's opinion in this regard is supported by claimant's additional symptoms, which included irritated eyes, sinus congestion, and production of bright yellow phlegm and sputum. Because the latter symptoms are observable and verifiable, they are "objective" under the statute. *Tony D. Houck*, 48 Van Natta 2443 (1996).[2]

SAIF also argues that the opinion of Dr. Stringham, treating physician, is less persuasive than those of Drs. Berlin, Burton, and Quarum. We disagree.

Dr. Stringham opined that claimant's work exposure to toxic chemicals was the major cause of his subsequent symptoms. (Exs. 7, 14, 19). He reached this conclusion based on 25 years of experience with toxic exposure cases, including extensive involvement "with issues regarding toxic exposure to phenoxyherbicides" used by forest workers who were exposed to toxic chemicals singly or in combination. (Ex. 14-1). Dr. Stringham also considered the nature of the chemicals that claimant handled, (Ex. 7); the consistency between claimant's symptoms and those observed in the forest workers he had seen;[3] and the fact that claimant's symptoms generally subsided after he was away from the chemicals. (Ex. 14-1). He noted that claimant "developed symptoms in a time frame consistent to [sic] the exposure" and found the absence of blood biochemical abnormalities consistent with this type of exposure. (Exs. 19, 14-1). Based on his "medical knowledge and experience and [claimant's] straightforward presentation and [the doctor's] clinical evaluation of [claimant]," Dr. Stringham reiterated that claimant's "symptoms most likely fit a case of multiple toxic exposure to chemicals at a low dose." (Ex. 14-2; *see* Ex. 19).

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[1] In Nielson, we found the treating doctor's opinion (relating the claimant's acute myelogenous leukemia (AML) condition to Tegretol treatment) unpersuasive in part because his conclusion did not logically follow from his premise. The doctor reasoned that, because Tegretol treatment is known to cause aplastic anemia, it probably caused claimant's AML.

We found that the claimant's AML was not the same condition as aplastic anemia. Accordingly, it did not logically follow that Tegretol caused claimant's AML. In addition, we found the treating doctor's opinion inconsistent with the claimant's clinical course (specifically, his notably short latency period). For these reasons, we declined to rely on the treating doctor's opinion concerning causation. Nielson, 49 Van Natta at 801.

The present case differs from Nielson significantly. The treating doctor's opinion relating claimant's symptoms to the exposure is not based on an illogical premise. The toxic nature of the chemicals is not disputed. Claimant's clinical course was *consistent* with his undisputed toxic exposure. Under these circumstances, we find no persuasive reason to discount the opinion of Dr. Stringham, treating physician, in this case.

[2] The dissent apparently dismisses these symptoms as not being ". . . observable," despite the record.

[3] These symptoms included "malaise, headache, nausea, occasional tinnitus, sometimes visual disturbances, etc." (Ex. 14-1).

Dr. Stringham acknowledged that little is known about toxic chemicals acting in combination. However, we do not find that the persuasive value of his opinion depends on such knowledge (despite SAIF's argument in this regard).[4] On the contrary, we find Dr. Stringham's opinion persuasive because it is well-reasoned and based on an accurate and complete history regarding claimant's work exposure and his subsequent symptoms. *See Somers v. SAIF*, 77 Or App 259 (1986).

Drs. Berlin and Burton opined that the three types of chemicals present in the shed where claimant worked on February 11, 1997 were organophosphates, chlorophenoxy compounds and irritants. (Ex. 11D-3). They concluded that claimant was probably not exposed to the former two compounds, based on a belief that he did not have contemporaneous "significant lacrimation, rhinorrhea and possibly respiratory symptoms," headaches, or effects on color vision at the time of his exposure. (*Id*). We do not find these opinions particularly persuasive, because claimant *did* have headache, vision abnormalities, eye irritation, sinus congestion, phlegm, and other respiratory symptoms soon after his exposure.

Dr. Quarum examined claimant on May 29, 1997 and opined that claimant's work exposure was not the main contributing cause of his current condition "at this time." (Ex. 12-6). We do not find Dr. Quarum's opinion helpful in evaluating causation, because it is undisputed that most of claimant's symptoms had resolved by the time of this examination. Moreover, Dr. Quarum focused on claimant's tinnitus (without addressing the more contemporaneous symptoms which dissipated quickly after the exposure). We also note that Dr. Quarum's opinion that tinnitus would be inconsistent with claimant's exposure is directly contradicted by Dr. Stringham. As we have explained, we find Dr. Stringham's opinion persuasive.[5]

In summary, because we find that Dr. Stringham's reasoning and conclusions are based on a more accurate history and are more consistent with claimant's clinical course, we find his opinion more persuasive than those of Drs. Berlin, Burton, and Quarum. (*See also* Exs. 4, 11). Accordingly, we conclude that the claim is compensable. *See William G. Brown*, 50 Van Natta 96 (1998) (Where the treating doctor's opinion was the most consistent with the claimant's history, it was the most persuasive); *Donna C. Kuzelka*, 49 Van Natta 775 (1997) (same).

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

ORDER

The ALJ's order dated October 13, 1997, as amended October 15, 1997, is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on review, claimant is awarded a $4,000 attorney fee, to be paid by SAIF.

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[4] In reaching this conclusion, we again note that Dr. Stringham had previous experience with victims of exposures to similar toxic chemicals (singly *and* in combination) whose exposure-related problems were similar to claimant's symptoms.

[5] We also note that Dr. Quarum expressly acknowledged that claimant's complaints were "not uncommon in any type of chemical exposure." (Ex. 16A-2).

Member Moller dissenting.

The majority errs in finding this occupational disease claim compensable, because there are no objective findings "in support of medical evidence," as required by ORS 656.005(19).

The majority apparently relies on claimant's reporting that he had observable symptoms after his work exposure. However, claimant first sought treatment three weeks after his exposure. At that time, he complained only of tinnitus, headache, and fatigue. (Ex. 4, *see* Ex. 7-2). The existence of these symptoms is purely subjective. There are no examination findings which would qualify as objective findings in this record. To the contrary, Dr. Huff, who first examined claimant, reported "[t]his is a difficult one to assess as there's no objective data." (Ex. 11).

Claimant was next examined by Dr. Stringham, who had multiple tests performed. The results of the tests were all normal. (Ex. 7-3). Dr. Stringham further noted "no significant ongoing problems" other than the subjective symptoms previously noted.

Because no medical expert made findings which were "reproducible, measurable, or observable," claimant's claim must fail for lack of objective findings *supporting* the medical evidence relating the alleged need for treatment to the work exposure. Based on this record, claimant's reporting alone is insufficient to satisfy the statute's requirement for objective findings "in support of medical evidence."

I would also find that compensability is not established because the claim is not supported by a preponderance of the medical evidence. For these reasons, I must respectfully dissent.

July 8, 1998 Cite as 50 Van Natta 1355 (1998)

In the Matter of the Compensation of
CALVIN SMITH, Claimant
WCB Case Nos. 97-06626 & 97-04423
ORDER ON REVIEW
Mark W. Potter, Claimant Attorney
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Herman's order that: (1) set aside its denial of claimant's occupational disease claim for a right wrist condition; and (2) awarded a $7,500 attorney fee under ORS 656.386(1). On review, the issues are compensability and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability of Right Wrist Condition

We adopt the ALJ's opinion and conclusions on this issue. (*See* Exs. 21, 25, 32).

Attorney Fees

The ALJ awarded a $7,500 assessed attorney fee under ORS 656.386(1), noting that considerable legal services were rendered on claimant's behalf. The employer argues that the ALJ's fee assessment was excessive because "this case was nothing out of the ordinary." (Appellant's Brief, p. 8). Claimant responds that the ALJ's fee was appropriate because of the medical complexity of the case and the considerable services provided.

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

Our review of the record reveals the following information. The issue in dispute was the compensability of claimant's right wrist condition.

Approximately 32 exhibits were received into evidence, including four physicians' letters generated by claimant's counsel. Two physicians were deposed. The deposition transcripts are approximately 23 and 35 pages long. The hearing lasted about 30 minutes (*see* Tr. i, 28), with a transcript of approximately 28 pages. Claimant and his fiancée testified. Closing arguments were subsequently taken by telephone. When compared with other compensability disputes normally

reviewed by this forum, this case involved issues of average legal complexity and above average medical complexity.[1] The claim's value and the benefits secured are substantial, in that claimant's compensation will include reimbursement for surgery as well as the benefits that arise from such a procedure. The parties' respective counsels presented their positions in a thorough manner. No frivolous issues or defenses were presented. Finally, there was a risk that claimant's counsel's efforts might have gone uncompensated, considering the employer's vigorous defense and the unusual nature of claimant's condition.

Based upon our application of each of the previously enumerated factors and considering the parties' arguments, we conclude that $5,000 is a reasonable and appropriate attorney fee for services at the hearings level in this case. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the record), the value of the interest involved, and the risk that claimant's counsel might go uncompensated.[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 $2,000, 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. Claimant is not entitled to an attorney fee for services related to the attorney fee issue. *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated February 19, 1998 is modified in part and affirmed in part. That portion of the order that awarded a $7,500 assessed attorney fee is modified. In lieu of the ALJ's attorney fee award, claimant is awarded a $5,000 attorney fee, payable by the self-insured employer. The remainder of the order is affirmed. For services on review, claimant is awarded an assessed attorney fee of $2,000, payable by the employer.

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[1] We note that the employer's attorney stated at hearing that the medical causation issue is "complex." (Tr. 10). We also note that the record does not include a statement of services from claimant's counsel.

[2] We do not apply a contingency factor or "multiplier" in a strict mathematical sense. *See e.g., Lois J. Schoch*, 49 Van Natta 788, 790, n 1 (1997); *Lois J. Schoch*, 49 Van Natta 170, 173, n.1 (1997). Instead, in conjunction with the other relevant factors discussed above, the risk that claimant's counsel might go uncompensated for services rendered in this proceeding has been considered in our ultimate determination of a reasonable attorney fee.

In the Matter of the Compensation of
JANET F. BERHORST, Claimant
Own Motion No. 98-0129M
OWN MOTION ORDER OF ABATEMENT
Malagon, Moore, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our June 29, 1998 Own Motion Order on Reconsideration, in which we declined to reopen her claim for the payment of temporary disability compensation because she failed to establish that she was in the work force at the time of disability.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
JOAN BEAVER, Claimant
Own Motion No. 97-0310M
OWN MOTION ORDER DENYING REVIEW OF CARRIER CLOSURE
Liberty NW Ins. Corp., Insurance Carrier

Claimant requests review of the insurer's March 11, 1998 Notice of Closure which closed her claim with an award of temporary disability compensation from September 23, 1997 through January 14, 1998. The insurer declared claimant medically stationary as of January 14, 1998.

Claimant submitted her request for review on June 3, 1998, 84 days after the mailing of the Notice of Closure. To be considered, the request for review must be filed with the Board within 60 days from the date of mailing of the notice of closure, or within 180 days after the mailing date if claimant can establish good cause for the failure to file the request within 60 days. *See* OAR 438-012-0060(1).

Here, claimant does not submit evidence to show good cause why her request for review of the March 11, 1998 Notice of Closure was not made within the 60-day appeal period. If the request for review of a closure notice is not timely filed, it is incumbent upon claimant to establish that there was good cause for failure to file the request within 60 days after the mailing date of the notice of closure.

From review of the record, it would appear that claimant did not seek review of her closure until her condition apparently worsened, which was beyond the 60-day appeal period.[1] Therefore, claimant's request is untimely, and the closure is final by law.

IT IS SO ORDERED.

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[1] If claimant's compensable condition has worsened to the extent that surgery and/or inpatient hospitalization is eventually required, she may again request reopening of her claim for the payment of temporary disability. *See* ORS 656.278(1).

Further, it appears from claimant's request that she is unclear as to her rights and benefits under the Workers' Compensation laws. The Workers' Compensation Board is an adjudicative body that addresses issues presented to it by disputing parties. Because of that role, the Board is an impartial body and cannot extend legal advice to either party. However, since claimant is unrepresented, she may wish to contact the Workers' Compensation Ombudsman, whose job it is to assist injured workers regarding workers' compensation matters:

Workers' Compensation Ombudsman
Dept. of Consumer & Business Services
350 Winter Street, NE
Salem, OR 97310
Telephone: 1-800-927-1271

In the Matter of the Compensation of
RENO S. CLARK, Claimant
WCB Case No. 97-03585
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller, Bock and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that upheld the insurer's denial of his injuries related to a truck driving accident. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated January 12, 1998 is affirmed.

Board Member Hall dissenting.

I disagree with the majority's conclusion that the insurer has carried its burden of proof on the issue of causation and, therefore, I respectfully dissent. As set forth in my dissents in *Carolyne D. Florea*, 47 Van Natta 2020 (1995), *Ronald Martin*, 47 Van Natta 473 (1995), and *Scott S. Fromm*, 47 Van Natta 1476 (1995), I believe that the majority errs by allowing evidence of claimant's impairment to influence our separate determination of whether that impairment was the major cause of the accident that resulted in claimant's injury. By statute, the test has two elements: impairment and causation. Both elements must be satisfied.

By adopting and affirming the ALJ's order, the majority errs by relying on the opinion of Dr. Larsen to find that the insurer has carried its burden of proving causation. Although Dr. Larsen is qualified to establish impairment, he is *not* qualified to offer an opinion on causation. This is not a question of "magic words." Rather, Dr. Larsen is simply unqualified to offer an opinion on the *mechanical* (physical) cause of how and why this truck tipped over. Furthermore, even assuming Dr. Larsen is qualified on causation, he offers only the *possibility* that the accident would have been avoided had claimant not been impaired. Dr. Larsen testified that if claimant had been less impaired, the accident "may" have been avoided. (Ex. 45A-22). That testimony is speculative and is not legally sufficient.

Likewise, Officer Reese is not qualified as an accident reconstructionist and it was error, as a matter of law, to allow him to offer an opinion on causation. The question of causation of this truck driving accident is *not* within the realm of lay-witness observation. Instead, the insurer could have, and should have, employed an accident reconstructionist expert to establish its burden of proof.

In this case, there were no eyewitnesses to the accident and the only evidence regarding how the injury occurred came from claimant. On this record, even with the objectionable testimony, we simply do not know why this truck tipped over. We are left to speculate. I submit that the majority erred by relying on the opinion of Dr. Larsen and Officer Reese to find that the insurer carried its burden of proving causation. Because the majority persists in combining the two elements of impairment and causation, I must dissent.

In the Matter of the Compensation of
KATHRYN C. LOEKS, Claimant
Own Motion No. 96-0571M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Kemper Ins. Co., Insurance Carrier

Claimant requests reconsideration of our May 18, 1998 Own Motion Order Reviewing Carrier Closure, which denied review of the carrier closure as the request was untimely. With her request, claimant contends that she did not timely file her original request for review of the insurer's January 29, 1998 because "all that was going on in my personal life, the time frame had gotten away from me." On June 16, 1998, we abated our prior order to allow the insurer sufficient time to respond to claimant's motion. On reconsideration, we adhere to the conclusion reached in our May 18, 1998 order. We base this decision on the following reasoning.

In our May 18, 1998 order, we did not consider persuasive claimant's argument that she did not timely file for review of the January 29, 1998 Notice of Closure because she relied on the insurer representative's statement that she was not entitled to any further compensation. Claimant once again, raises this allegation in her request for reconsideration. She states that the insurer representative informed her that she "was not entitled to any further compensation." However, the record does not contain documentation and/or evidence that would show that the insurer representative told the claimant not to file for review nor do we find that the insurer representative's statement misled claimant about her appeal rights. By claimant's own admission, she did not seek review of the closure until she had "experienced enough discomfort to prompt me to send a letter."[1] Thus, we continue to find that claimant's reliance on the insurer representative's statements does not constitute good cause for her failure to timely file.

Additionally, claimant contends that she did not timely request review because in the year following her surgery she has had to deal with many stressful situations. Claimant states that "[b]ecause of my personal situation, trying to work, move, care for 4 children, exercise and my office being in a briefcase, I did not respond to this in a timely manner."

A request for review of a carrier's closure must be filed within 60 days after the mailing date of the notice of closure, or within 180 days after the mailing dated if the claimant establishes good cause for the failure to file the request within 60 days after the mailing date. OAR 438-012-0060(1). The test for determining if good cause exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect" recognized under ORCP 71B and former ORS 18.160. *Anderson v. Publishers Paper Co.*, 78 Or App 513, 517, *rev den* 301 Or 666 (1986). Lack of diligence does not constitute good cause. *Cogswell v. SAIF*, 74 Or App 234, 237 (1985). Claimant has the burden of proving good cause. *Id.*

Claimant contends, that due to the stresses in her home environment, she was unable to timely file her request for review. She asserts that her having to attend to her children's needs, her job, her move and exercise program establish good cause for her untimely filed request for review. We do not agree.

We have previously found that a claimant's preoccupation with other concerns during the time allotted to request review or appeal a denial, does not prevent him/her from the relatively simple task of filing a request for review. At best, we have found that the other concerns may have distracted a claimant from filing. Based on this reasoning, we have concluded that the claimant's lack of diligence does not constitute good cause. *James Minter*, 48 Van Natta 979 (1996); *William B. Potts*, 41 Van Natta 223 (1989).

While we may empathize with claimant, that her home situation during the appeal period may have been trying and demanding, we do not find this constitutes good cause for failure to timely file her request for review. Claimant does not contend that she did not understand the appeal rights outlined in the notice of closure nor does she provide medical evidence supporting a conclusion that she was

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[1] We reiterate our previous statement to claimant that if her compensable condition has worsened to the extent that surgery and/or inpatient hospitalization is eventually required, she may again request reopening of her claim for the payment of temporary disability. *See* ORS 656.278(1).

physically or mentally incapable of conducting her personal business affairs. Under these circumstances, we conclude that claimant's failure to timely file the request for review was due to her lack of diligence which does not qualify as good cause.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our May 18, 1998 order in its entirety. The parties' rights of reconsideration and appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JONI M. VARAH, Claimant
WCB Case No. 97-06270
ORDER ON RECONSIDERATION
Gatti, Gatti, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our June 15, 1998 Order on Review that reversed the Administrative Law Judge's (ALJ's) order which declined to award an assessed fee pursuant to ORS 656.386(1). Citing *Stephenson v. Meyer*, 150 Or App 300 (1997), SAIF contends that there was no "claim" for compensation. Therefore, it asserts claimant's counsel was not entitled to an assessed fee under ORS 656.386(1) when it modified its acceptance of a "thoracolumbar muscular back strain, resolved" to eliminate the word "resolved."

On review, SAIF argued that, because its acceptance of a "resolved" condition was not an "express" denial within the meaning of *amended* ORS 656.386(1), the ALJ properly refused to award an attorney fee under that statute. However, SAIF did not allege at hearing or in its appellate briefs that, if its acceptance of a "resolved" condition was a denial, no attorney fee was available because no "claim" for compensation had been made. Because SAIF raises this issue for the first time on reconsideration, we are not inclined to address it at this late date. *See Vogel v. Liberty Northwest Ins. Corp.*, 132 Or App 7, 13 (1994) (Board has discretion whether to address issue raised for the first time in reconsideration request); *Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991); *Estella M. Cervantes*, 49 Van Natta 336, 336-37 (1997); *Annette E. Farnsworth*, 48 Van Natta 508, 509 (1996).

Moreover, even if we addressed this issue, we would reject SAIF's argument. Specifically, we disagree with SAIF's assertion that no "claim" was made. Unlike *Stephenson*, where the claimant conceded there was no "claim," SAIF's acceptance of a "resolved" thoracolumbar muscular strain condition was made in response to a "claim" for a back injury filed by claimant on April 19, 1997 by form 801. (Ex. 1). As noted in our prior order, the express inclusion of the word "resolved" in a carrier's acceptance of a claim constitutes a denial of further benefits under a claim; *i.e.*, a prohibited "prospective denial." *See Evanite Fiber Corp. v. Striplin*, 99 Or App 353 (1989). Because such a denial constituted an express denial for the purposes of ORS 656.386(1), claimant's attorney was entitled to an assessed fee pursuant to that statute when SAIF modified its acceptance notice to eliminate the word "resolved." *Galbraith v. L. A. Pottsratz Construction*, 152 Or App 790, 795 (1998).

Accordingly, we withdraw our June 15, 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.

In the Matter of the Compensation of
CANDICE MARSDEN, Claimant
WCB Case No. 97-09825
ORDER ON REVIEW
Burt, Swanson, Lathen, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Hall and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that declined to award additional temporary disability benefits. On review, the issue is temporary disability benefits. We reverse.

FINDINGS OF FACT

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

On May 12, 1994, claimant was compensably injured. The SAIF Corporation accepted claims for lumbar and thoracic strains. Subsequently, claimant made a claim for adjustment disorder, depression, thoracic outlet syndrome, and right brachial plexopathy conditions, contending these were components of her original injury. On June 16, 1995, SAIF issued a partial denial of those conditions. Claimant requested a hearing on the denial. At that time of this partial denial, claimant's original claim was in open status.

On July 12, 1995, the accepted portions of claimant's claim were closed by Determination Order, awarding temporary disability benefits through February 21, 1995, the date claimant was found medically stationary. The Determination Order also awarded 19 percent unscheduled permanent disability.

Only SAIF requested reconsideration, contesting the permanent disability award. On September 13, 1995, an Order on Reconsideration reduced the unscheduled permanent disability award to 11 percent and affirmed the Determination Order in all other aspects. Neither party appealed the Order on Reconsideration, which became final by operation of law.

On February 6, 1997, an Opinion and Order issued that upheld SAIF's partial denial of claimant's claims for adjustment disorder and depression conditions. However, this order also set aside the partial denial as to the claims for thoracic outlet syndrome and right brachial plexopathy conditions. SAIF requested review. On September 2, 1997, the Board adopted and affirmed the February 6, 1997 order, which became final by operation of law.

On October 6, 1997, SAIF issued a modified notice of acceptance to include bilateral thoracic outlet syndrome and right brachial plexopathy and reopened claimant's claim. (Exs. 18, 19). That same day, SAIF notified claimant that it was sending her a time loss check in the amount of $6,016.63, which covered the period from July 13, 1995,[1] the day after claimant's claim was closed by Determination Order, to September 30, 1997. (Ex. 20).

Subsequently claimant asked SAIF to pay time loss from February 21, 1995 through July 12, 1995. (Ex. 22). When SAIF refused, claimant requested the hearing that is the subject of the current review.

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant claimed entitlement to procedural time loss[2] from February 21, 1995 through July 12, 1995.[3] SAIF's sole argument against claimant's claim was that the issue of claimant's

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[1] SAIF's letter regarding the payment of time loss contains a typographical error in that it identified the time period covered by the check as "July 13, 1997, the day after your claim closed by Determination Order, to September 30, 1997." (Ex. 20, emphasis added). However, the correct time period is July 13, 1995 to September 30, 1997. (Exs. 9, 20, 22).

[2] Claimant's claim was open at the time of hearing; therefore, the issue at hearing and on review is entitlement to procedural time loss, not substantive time loss, which is determined at claim closure.

[3] Prior to the hearing, the parties agreed that the matter could be submitted on the documentary record and written closing arguments. Neither party submitted briefs on review. Therefore, we rely on the parties' written closing arguments in determining their positions on review.

entitlement to procedural time loss was barred by *res judicata* (claim preclusion). SAIF relied on *Sandra Miles*, 48 Van Natta 553 (1996), in support of its argument. The ALJ agreed with SAIF and, applying *Sandra Miles*, held that claimant's claim for procedural time loss was barred by *res judicata*. We disagree.

After our decision in *Sandra Miles*, and prior to the hearing request in this matter, the legislature adopted ORS 656.262(7)(c). HB 2971, 69th Leg., Reg. Sess. (July 25, 1997). Pursuant to ORS 656.262(7)(c), "[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." ORS 656.262(7)(c) applies to this case.[4] SAIF apparently realized the applicability of ORS 656.262(7)(c) because it reopened claimant's claim after the new medical conditions were found compensable after claim closure. (Ex. 19). However, SAIF refused to pay procedural time loss before the date of the prior claim closure.

In *Mario R. Castaneda*, 49 Van Natta 2135 (1997), we interpreted ORS 656.262(7)(a)[5] and (c) in regard to entitlement to procedural time loss when a new medical condition is accepted post-closure. In *Castaneda*, the claimant had an accepted low back strain condition that was closed by a Determination Order that became final by operation of law. After claim closure, the claimant filed a new medical condition for an L4-5 disc bulge, which the insurer denied. This denial was subsequently set aside by an Opinion and Order that became final by operation of law.

Although the insurer issued a modified notice of acceptance to include the L4-5 disc condition, it did not begin paying temporary disability benefits authorized by the attending physician. In refusing to pay these benefits, the insurer argued that the claimant's claim for temporary benefits was barred by *res judicata*, based on the prior Determination Order and Opinion and Order. We adopted the ALJ's ruling rejecting this *res judicata* argument. We also found that the claim was in open status because, pursuant to the clear language of ORS 656.262(7)(c), the insurer had a duty to reopen the claim and pay whatever additional benefits were due for the L4-5 disc condition.

Finally, we rejected the insurer's argument that it had no obligation to pay procedural temporary disability benefits until the claimant perfected an aggravation claim under ORS 656.273. After examining the text and context of ORS 656.262(7)(a) and (c) and the relevant legislative history, we concluded that procedural temporary disability benefits for conditions accepted after claim closure should be determined under ORS 656.262(4). We also found that, to the extent that our conclusion was inconsistent with our prior decisions in other cases, including *Sandra Miles*, 48 Van Natta at 554, those prior cases were distinguishable because they were not subject to the requirements of ORS 656.262(7)(c).

In addition, in *James L. Mack*, 50 Van Natta 338 (1998), we held that, in determining whether a claim is prematurely closed, only the medically stationary status of the *accepted* claims at the time of closure are considered. In *Mack*, a new medical condition (reactive depression) was accepted after claim closure. The claimant requested a hearing on the reconsideration order issued in regard to that closure, contending that his claim had been prematurely closed. We reversed the ALJ's order that found the claim prematurely closed.

We acknowledged that prior case law had held that "pre-closure" references to injury-related psychological problems had previously been held sufficient to require the consideration of whether that condition was medically stationary prior to claim closure. However, relying on *Anthony J. Telesmanich*, 49 Van Natta 49, 51 (1997), *on recon* 49 Van Natta 166 (1997) (where additional conditions are accepted after issuance of an Order on Reconsideration, the proper procedure at hearing on that reconsideration order is to rate the conditions accepted at the time of the reconsideration order and remand the later

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[4] 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 arose after the effective date of HB 2971, ORS 656.262(7)(c) applies to this case.

[5] 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 notice of such claims[.] Notwithstanding any other provision of this chapter, the worker may initiate a new medical condition claim at any time."

accepted conditions to the carrier for processing according to law) and the legislature's addition of ORS 656.262(7)(c), we found that subsequent changes in the law required that determination of whether a claim had been prematurely closed must focus only on those conditions accepted at the time of closure. In other words, the evaluation of a "post-closure" accepted condition had to await the reopening and processing of the claim for that new condition.

In *Mack*, we declined to address the claimant's concerns about the impact such a limitation might have on the future processing of his claim because those matters were not currently before us. However, we noted 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." *James L. Mack*, 50 Van Natta at 339 fn 3.

Thus, based on the above discussion, we find that claimant's post-closure accepted claim must be evaluated in its own right and her claim for procedural temporary disability benefits related to that claim is not barred by *res judicata*. Furthermore, as we found in *Castaneda, Sandra Miles*, the case relied on by SAIF in support of its *res judicata* argument, is distinguishable based on the subsequent enactment of ORS 656.262(7)(c).

Accordingly, because SAIF's sole argument against claimant's claim for procedural temporary disability benefits was that the claim was barred by *res judicata*, and we have rejected that argument, we find that claimant is entitled to procedural temporary disability benefits for the period from February 21, 1995 through July 12, 1995.[6] *See Mike Freeman*, 49 Van Natta 1322 (1997) (where the insurer's sole challenge to the claimant's claim for time loss was that the authorizing physician was not claimant's attending physician and the Board rejected that argument, the Board awarded time loss beginning the date of that physician's authorization).

Finally, claimant's attorney is awarded an "out-of-compensation" fee payable from the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney. ORS 656.386(2); OAR 438-015-0055(1).

ORDER

The ALJ's order dated April 17, 1998 is reversed. The SAIF Corporation is directed to pay claimant temporary disability benefits from February 21, 1995 through July 12, 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 attorney.

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[6] A claimant is not entitled to receive double the statutory sum of temporary disability for the same period of time loss because she has two separate disabling injuries. *Fischer v. SAIF*, 76 Or App 656, 661 (1985); *Petshow v. Portland Bottling Co.*, 62 Or App 614 (1983), *rev den* 296 Or 350 (1984). Therefore, if a period of temporary disability for a new medical condition that was accepted post-closure overlaps a period of temporary disability previously awarded at the prior closure, an offset could be made to avoid a duplicate payment. ORS 656.268(15)(a); OAR 436-060-0170(2). Here, there is no overlapping *award* of temporary disability because the prior closure awarded temporary disability through February 21, 1995 and the award of procedural temporary disability in the present case begins from that date.

In the Matter of the Compensation of
DAVID R. MELTON, Claimant
WCB Case No. C8-01426
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Warren John West, Claimant Attorney
Liberty NW Ins Corp, Insurance Carrier

Reviewed by Board Member Hall and Moller.

On June 22, 1998, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for his compensable injury. We approve the proposed disposition.

The first page of the CDA indicates a "full release" of all non-medical service benefits including permanent disability benefits. However, page 2, paragraph 8 of the agreement provides:

> "The total amount of permanent disability benefits awarded on the claim is 40 percent (128 degrees) unscheduled permanent partial disability. Out of this award $4,751.34 has been paid and, as of May 29, 1998 $17,742.53 is owed to claimant. The parties stipulate and agree that the balance of the outstanding permanent partial disability will be paid by lump sum to claimant, after approval of this Claim Disposition Agreement. This lump sum payment may be offset by any permanent disability installment payments paid after May 29, 1998 to the date of Claim Disposition Agreement approval."

Although the CDA provides for a "full" release of permanent disability benefits on the first page, the portion of the agreement quoted above indicates that the balance of the unpaid permanent disability award will be paid in a lump sum after the CDA is approved. Thus, because the agreement indicates that claimant is not releasing the unpaid balance of the permanent disability award, we interpret the parties' CDA as providing for a "partial" rather than a "full" release of permanent disability benefits.[1]

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] In other words we interpret the CDA as providing for the payment of the unpaid permanent disability benefits to be in addition to the $20,000 in proceeds. Furthermore, we interpret the CDA as confirming claimant's release of any future permanent disability benefits payable under this claim, with the exception of the unpaid balance of the 40 percent unscheduled permanent disability award.

In the Matter of the Compensation of
JAMES I. WEATHERS, Claimant
WCB Case No. 93-09767
ORDER ON REMAND
Victor Calzaretta, Claimant Attorney
Rick Dawson (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. SAIF v. Weathers, 151 Or App 510 (1997). The court has reversed our prior order, James I. Weathers, 48 Van Natta 1144 (1996), that had affirmed an Administrative Law Judge's (ALJ's) order that set aside the SAIF Corporation's denial of claimant's occupational disease claim for a mental disorder and assessed a penalty for an unreasonable denial. Explaining that the proper test for determining the compensability of claimant's mental disorder claim is whether the manner and circumstances of claimant's transfer caused his mental illness and whether those circumstances are generally inherent in every transfer, the court concluded that we erred in focusing on whether claimant's employer had violated his union contract and whether the employer's conduct was reasonable. Consequently, the court has remanded for reconsideration.

FINDINGS OF FACT

We republish the Findings of Fact set out in the "supplementation" portion of our June 5, 1996 Order on Review. James I. Weathers, 48 Van Natta at 1144.

CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the relevant facts.

Claimant worked as a corrections officer in the employer's Salem correctional facility. Following an injury in 1990, claimant began a period of trial service as an "underfill" corrections counselor in that same facility. In July 1992, claimant was reclassified as a corrections counselor. On several occasions over the next year, claimant was advised that the total time performing the counselor job (including the two years he had spent training or underfilling that position) would be credited in calculating his seniority.

In April 1993, the employer sought the union's opinion on calculating seniority, and was told that underfill time should not be considered. Following this communication, the employer revised its seniority list and in July 1993, notified claimant that he was due to be permanently transferred to the Portland facility. Claimant became depressed and sought treatment from a psychiatrist.

The ALJ found, inter alia, that employment conditions producing claimant's mental disorder were conditions other than those generally inherent in every working situation or reasonable business decision. See ORS 656.802(3). The ALJ also found that the employer's actions in transferring claimant were unreasonable. Consequently, the ALJ set aside SAIF's denial.

On review, we found that the parties agreed that claimant's depression was related to his transfer at work. We examined the union contract in order to determine whether the transfer was reasonable, and concluded that the employer's actions were in violation of the contract and, thus, were unreasonable. Consequently, we affirmed the ALJ's order which found the mental disorder claim was compensable.

SAIF requested judicial review. The court remanded, explaining that whether the employer violated the union contract was not determinative. Moreover, the court noted that we found that the employer acted unreasonably. However, the court reasoned that, rather than a test of reasonableness, the correct test is whether the manner and circumstances of the transfer caused the mental illness and whether those circumstances are generally inherent in every transfer.

Here, as we previously noted, claimant's treating doctor opined that the transfer was the major cause of claimant's mental disorder. Furthermore, there is no contrary medical opinion. Accordingly, it is undisputed that the manner and circumstances of the transfer caused claimant's major depressive episode.

We next determine whether the circumstances surrounding the transfer are generally inherent in every transfer. Memos from the employer in 1992 initially led claimant to believe that he was not in jeopardy of being transferred. However, in 1993, the employer changed its stance and agreed with the union that, for purposes of seniority, no credit would be given to workers in underfill positions. Claimant was notified of the transfer in a letter dated June 14, 1993. A July 19, 1993 memo provided that the transfer would be effective July 20, 1993.

We conclude that the facts of this case do not demonstrate circumstances that are generally inherent in every transfer. Specifically, claimant was first led to believe that he was not in danger of being transferred. However, claimant was later transferred, with only one day's notice, based on the employer changing its position after its contact with the union.[1] Under the circumstances, we conclude that, regardless of whether the employer violated the union contract in refusing to consider claimant's "underfill" work for purposes of seniority, the manner and circumstances of the transfer caused the mental illness. Moreover, because the facts and circumstances surrounding the transfer are not generally inherent in every transfer, we continue to conclude that claimant has established a compensable mental disorder claim. ORS 656.802.

Accordingly, on reconsideration from the Court of Appeals, as modified and supplemented herein, we republish our prior order which affirmed the ALJ's order that set aside SAIF's denial of claimant's occupational disease claim for his mental disorder. In so doing, we note that the ALJ's attorney fee award of $5,000 and our prior attorney fee award of $1,500 are also republished.

In cases in which a claimant finally prevails after remand from the Court of Appeals, the Board shall approve or allow a reasonable attorney fee for services before every prior forum as authorized under ORS 656.307(5), 656.308(2), 656.382 or 656.386. ORS 656.388(1). In accordance with the aforementioned statute, we award attorney fees for claimant's counsel's services before the court and on remand.

Here, SAIF appealed our order to the court and, after reconsideration on remand, we have found that the compensation awarded to claimant should not be disallowed or reversed. Accordingly, claimant's attorney is entitled to an assessed fee for services before the court and on remand. ORS 656.382(2).

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services before the court and Board on remand is $4,000, to be paid by SAIF. ORS 656.388(1). This amount is in addition to the prior attorney fee awards granted for claimant's counsel's services at hearing and on review. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's brief on remand), the complexity of the issue, and the value of the interest involved).

IT IS SO ORDERED.

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[1] SAIF contends that claimant had received advance notice that he might be transferred to Portland. Specifically, SAIF points to chartnotes of Dr. Mead and communications that claimant "intercepted." However, we conclude that the exhibits relied on by SAIF do not establish that claimant had such notice. As claimant points out, SAIF acknowledges that the letters were not "written to" or "intended to be seen by claimant." Appellant's Brief on Remand, pg. 7. Additionally, Dr. Mead's chartnote does not conclusively establish that claimant was aware that he would be transferred. Finally, as claimant argues, the ALJ found that, based on demeanor, claimant was a credible witness. We have found no reason to disturb the ALJ's credibility finding. Consequently, we accept claimant's testimony on the issue.

In the Matter of the Compensation of
HENRY A. CRAFTS, JR., Claimant
WCB Case No. 96-06674
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Black's order that upheld the self-insured employer's denial of claimant's occupational disease claim for right elbow and shoulder conditions. With its brief, the employer contests that portion of the ALJ's order that found that claimant's claim was timely filed. On review, the issues are timeliness and compensability.

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

We agree with the ALJ that claimant's right arm and shoulder problems preexisted the claimed work exposure. (*See* Exs. 5, 27, 28, 29A-16-17; 29A-40; Tr. 65-66). Moreover, even assuming (without deciding), that claimant did not have preexisting condition or conditions within the meaning of ORS 656.802(2)(b), we would uphold the employer's denial because we agree with the employer that the medical evidence arguably supporting the claim is not persuasive. In this regard, we note that Dr. Hirons, treating physician, repeatedly reported claimant's history that his right upper extremity symptoms began off work and that he had hurt himself at home. (*Id*). Although Dr. Hirons stated that claimant later aggravated his problems at work, he did not consider or evaluate the relative contribution of the initial off-work "injury" in forming his ultimate causation opinion. (*See* Ex. 28, 29A-19-20, 29A-43). Under these circumstances, we conclude that Dr. Hirons' opinion is inadequately explained and therefore insufficiently persuasive to establish that claimant's work activities were the major contributing cause of his right arm and shoulder conditions or a worsening thereof.[1] *See Donald Rowland, Jr.*, 50 Van Natta 1122 (1998) (Because a finding of major causation requires a comparison between off-work and work-related causes and the doctor performed no such analysis, his conclusions were insufficiently supported); *Richard A. Longbotham*, 48 Van Natta 1257, 1258 (1996) (same) (citing *Dietz v. Ramuda*, 130 Or App 397 (1994)); *see also Willard A. Hirsch*, 49 Van Natta 1311, n. 1 (1997) (Court of Appeals' interpretation of ORS 656.005(7)(a)(B) in *SAIF v. Nehl*, 148 Or App 101 (1997), not applicable to occupational disease claim).

We find Dr. Jansen's conclusions unpersuasive for the same reason, noting she formed her causation opinion without the benefit of claimant's history that his right upper extremity problems began at home *before* the claimed work exposure. (*See* Exs. 38-1, 39, 40-12, 40-16, 40-22, 40-37). Because we cannot say that Dr. Jansen's opinion is based on an accurate and complete history, we find her opinion unpersuasive. *See Debra A. Long*, 50 Van Natta 1131 (June 16, 1998) (Physician's opinion unpersuasive without accurate and complete history) (citing *William D. Brizendine*, 50 Van Natta 21 (1998) (same)). Accordingly, in the absence of persuasive supporting medical evidence, we conclude that the claim must fail.

ORDER

The ALJ's order dated March 10, 1998 is affirmed.

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[1] Likewise, we find Dr. Hirons' opinion that claimant's work "would be 51 percent more likely to be the cause of the *perpetuation* [of his problem]" insufficient to establish major causation under ORS 656.802. (Ex. 29A-20, emphasis added; *see* Exs. 32-2, 33-2). We also note Dr. Hirons' agreement with the employer's attorney's statement that there is "nothing other than subjective data on which to be able to relate [sic] claimant's problems." (Ex. 29A-49).

In the Matter of the Compensation of
JOHN P. DAUGHERTY, Claimant
WCB Case No. 97-07364
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by the Board *en banc.*

Claimant requests review of that portion of Administrative Law Judge (ALJ) Podnar's order that modified an Order on Reconsideration to disallow a temporary disability award for the period from February 28, 1996 through April 1, 1996.[1] On review, the issue is temporary disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings," with the exception of the last paragraph.

CONCLUSIONS OF LAW AND OPINION

The ALJ held that claimant had not established his substantive entitlement to temporary disability benefits for the period from February 28, 1996 through April 1, 1996. Reasoning that claimant's attending physician did not authorize temporary disability for that period of time, the ALJ concluded that claimant was not substantively entitled to temporary disability benefits under ORS 656.245(2)(b)(B). The ALJ therefore modified the Order on Reconsideration to disallow the temporary disability award.

On review, claimant argues that the ALJ lacked jurisdiction to disallow the Order on Reconsideration award of temporary disability because the SAIF Corporation did not file a timely cross-request for hearing challenging the reconsideration order. We disagree. Though SAIF did not file a timely cross-request for hearing, it is undisputed that claimant timely filed a request for hearing on the reconsideration order and that he did not withdraw his hearing request. Based on claimant's timely hearing request, the ALJ was authorized to address any issue regarding the reconsideration order.[2] *See Duncan v. Liberty Northwest Ins. Corp.*, 133 Or App 605, 608 (1995); *Gay Collins*, 49 Van Natta 1819, 1820 (1997). It therefore was unnecessary for SAIF to file a cross-request for hearing in order to challenge the temporary disability awarded by the reconsideration order. *See id.*

On the merits, claimant contends that the ALJ erred in requiring his attending physician's time loss authorization to support his substantive award of temporary disability. We agree and reverse the ALJ's order.

As SAIF acknowledges on review, we have previously held that, while a claimant's procedural entitlement to temporary disability is contingent on the attending physician's authorization, there is no similar requirement for determining substantive entitlement to temporary disability. *Michael C. Leggett*, 50 Van Natta 226, 228 (1998); *Kenneth P. Bundy*, 48 Van Natta 2501 (1996). Rather, we have held that the claimant's substantive entitlement to temporary disability is determined at the time of 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 his condition became medically stationary.

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[1] The order portion of the ALJ's Opinion and Order does not explicitly "modify" the Order on Reconsideration and, instead, states that "claimant's requested relief be and hereby is denied." However, inasmuch as the parties have treated the ALJ's order as effectively modifying the reconsideration order, we interpret the order in that manner.

[2] There is a statutory limitation on the issues that may be raised at hearing regarding an Order on Reconsideration. ORS 656.268(8) and 656.283(7) provide that only issues that were raised at the reconsideration proceeding may be raised at hearing, unless the issue "ar[ose] out of the reconsideration order." Here, inasmuch as the temporary disability in dispute was awarded for the first time by the reconsideration order, we conclude that the temporary disability issue arose out of the reconsideration order and SAIF could properly raise the issue at hearing.

Id.; *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); *Lebanon Plywood v. Seiber*, 113 Or App 651, 654 (1992).[3]

SAIF argues that the procedural-substantive distinction for temporary disability has been legislatively overruled by the 1995 legislative amendments and that such a distinction is no longer valid. However, the Court of Appeals recently rejected that argument and reaffirmed the distinction in *Santos v. Caryall Transport*, 152 Or App 322, 326-27 (1998), and *Shaw v. Rebholz*, 152 Or App 328, 333 (1998). In *Shaw*, the court clarified the distinction between the ("procedural") entitlement to temporary disability during the pendency of an open claim and the ("substantive") entitlement to temporary disability at the time of claim closure. *Id.* at 333. *See also Sergio Madrigal*, 50 Van Natta 959 (1998).

Turning to the merits of this case, we conclude that a preponderance of the evidence in the record proves that claimant was at least partially disabled due to the compensable injury from February 28, 1996 through April 1, 1996. The record shows that Dr. Tarbet released claimant from work for the period from February 28, 1996, (Exs. 13-16), through April 1, 1996, (Ex. 19). There is no evidence to the contrary. Therefore, claimant is substantively entitled to temporary disability for that period of time, and the reconsideration order shall be affirmed.

Because claimant has successfully defended against SAIF's cross-request for reduction of the reconsideration order award of temporary disability, his attorney is entitled to an assessed attorney fee for services at hearing. *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 at hearing is $2,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated December 12, 1997 is reversed in part and affirmed in part. That portion of the order that modified the Order on Reconsideration is reversed. The Order on Reconsideration is affirmed in its entirety. The remainder of the ALJ's order (that declined to assess penalties) is affirmed. For services at hearing, claimant's attorney is awarded an assessed attorney fee of $2,000, payable by SAIF. Claimant's attorney is also awarded an attorney fee of 25 percent of the additional compensation created by this order, not to exceed $3,800, payable by SAIF out of compensation and directly to claimant's attorney.

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[3] SAIF cites to the Director's rule, OAR 436-060-0020(6), which provides that a substantive award of temporary disability may not be allowed without an attending physician's authorization. Because we have concluded that the statutes do not require the attending physician's authorization to support substantive temporary disability, we give no effect to the rule. *See Cook v. Workers' Compensation Dept.*, 306 Or 134, 138 (1988).

Board Member Moller dissenting.

For the reasons set forth in my dissenting opinion in *Kenneth P. Bundy*, 48 Van Natta at 2506-08, I remain persuaded that, by enacting ORS 656.262(4)(f) and 656.268(3)(d), with regard to the issue before us here, the legislature eliminated the procedural-substantive distinction for temporary disability and required that the attending physician authorize *any* award of temporary disability.

In the Matter of the Compensation of
CHANCEY F. JAMES, Claimant
WCB Case No. 97-08809
ORDER ON REVIEW
Flaxel & Nylander, Claimant Attorneys
Zimmerman, Nielsen, et al, Defense Attorneys

Reviewed by the Board *en banc*.

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

FINDINGS OF FACT

We adopt the ALJ's findings of fact (with the exception of the ultimate finding of fact), and briefly summarize the pertinent facts as follows:

Claimant compensably injured his left knee on February 13, 1996. On March 13, 1996, the insurer accepted a left knee strain. Claimant's physician subsequently diagnosed internal derangement of the knee and, on April 3, 1996, Dr. Studt performed a partial medial meniscectomy.

On July 25, 1997, the insurer issued a Notice of Closure, which awarded temporary disability and 5 percent (7.5 degrees) scheduled permanent disability based on the surgery. On September 16, 1997, claimant requested reconsideration of the Notice of Closure. That same day, claimant also wrote the insurer requesting acceptance of "internal derangement tear of the medial meniscus left knee" in addition to the left knee strain.

An October 10, 1997 Order on Reconsideration found the claim had been prematurely closed and rescinded the Notice of Closure. Meanwhile, having received no response to his request to expand the notice of acceptance, claimant requested a hearing on October 29, 1997, alleging a "de facto" denial of an additional condition.

The insurer accepted the additional condition on November 25, 1997. The parties went to hearing on the issue of claimant's counsel's entitlement to an attorney fee only.

CONCLUSIONS OF LAW AND OPINION

Noting that no formal denial had been issued and that no benefits associated with claimant's knee injury had been withheld, the ALJ determined that claimant had not established a denied claim for purposes of *former* ORS 656.386(1).[1] The ALJ further found that this case was not governed by the provisions of HB 2971, which amended the definition of a "denied claim" in ORS 656.386(1) as of July 25, 1997.

On review, claimant asserts that *amended* ORS 656.386(1) is applicable and that he is entitled to an attorney fee based on the insurer's failure to timely respond to his September 16, 1997 request for acceptance of an additional condition. We agree.

In both the former and current versions of ORS 656.386(1), a claimant is entitled to recover a reasonable attorney fee in cases involving "denied claims" where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the ALJ. As the ALJ noted, prior to July 25, 1997, 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 any compensation."

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[1] In so holding, the ALJ relied on *Michael Galbraith*, 48 Van Natta 351 (1996). We note, however, that the court has since reversed our decision, *Galbraith v. L.A. Pottsratz Const.*, 152 Or App 798 (1998), and determined that a carrier's response to a request for hearing asserting that the claimant was "entitled to no relief" constituted an "express denial" of compensation, entitling the claimant to an attorney fee under ORS 656.386(1).

In HB 2971, however, the 1997 Legislature amended the definition of "denied claim" to include "[a] claim for compensation for a condition omitted from a notice of acceptance, made pursuant to ORS 656.262(6)(d), which the insurer or self-insured employer does not respond to within 30 days."[2] *Amended* ORS 656.386(1)(b)(B). While this particular provision was not made retroactive, *see Stephenson v. Meyer*, 150 Or App 300, 304 n 3 (1997), it became effective on its July 25, 1997 passage. *See* HB 2971, 69th Leg., Reg. Session, Sec. 4 (July 25, 1997).

In this case, claimant made his written claim for a tear of the left knee medial meniscus pursuant to ORS 656.262(6)(d) on September 16, 1997,[3] after the effective date of HB 2971. Because *amended* ORS 656.386(1) was *in effect* at the time of claimant's "claim for compensation for a condition omitted from the notice of acceptance," the statute is applicable.[4]

We reject the insurer's contention that the amendments to ORS 656.386(1) apply only to those claims with dates of injury occurring after July 25, 1997. Section 4 of HB 2971 provides that "[t]his Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this Act takes effect on its passage." Section 4 does not mention "date of injury" nor does it specifically restrict the applicability of ORS 656.386(1)(b) to denied claims for injuries occurring after the Act's effective date.[5] Considering the legislature's express intent that the amended attorney fee statute "take[] effect on its passage," the absence of any reference to dates of injury in the implementation section and the specific references in *amended* ORS 656.386(1)(b)(A), (B) and (C) to "[a] claim for compensation" and/or "[a] claim for an aggravation or a new medical condition,"[6] we decline to limit the statute's application in the manner proposed by the insurer.[7] Consequently, we conclude that *amended* ORS 656.386(1) applies prospectively to all claims for compensation, aggravation or new medical conditions presented on or after the statute's July 25, 1997 effective date, regardless of the date of injury.

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[2] ORS 656.262(6)(d) provides, in pertinent part, that a claimant who believes that a condition has been incorrectly omitted from a notice of acceptance must first communicate his or her objections to the notice in writing to the carrier. Thereafter, the carrier has 30 days from receipt of the communication to respond or revise the notice.

[3] The insurer does not contest claimant's contention that his September 16, 1997 letter to the insurer constituted an objection to the notice of acceptance pursuant to ORS 656.262(6)(d) rather than a "new medical condition" claim pursuant to ORS 656.262(7)(a).

[4] Indeed, because claimant's ORS 656.262(6)(d) claim was made subsequent to the Act's July 25, 1997 effective date and claimant's attorney fee cause of action arising out of the "denied claim" accrued while the statute was in effect, we are not applying the amended attorney fee statute "retroactively." *See, e.g., Fromme v. Fred Meyer*, 306 Or 558 (1988). In that case, while the claimant's petition for judicial review was pending, the legislature amended ORS 656.236(2) to prohibit charging workers' compensation claimants with costs on judicial review. The court held that applying the amended statute to the pending case did not amount to a "retroactive application" because the action that triggered the right to recover costs, *i.e.*, prevailing on appeal, occurred after the effective date of the amendment. *See also* Webster's Ninth New Collegiate Dictionary (1987), which defines "retroactive" as "made effective as of a *date prior to enactment*, promulgation or imposition." (Emphasis added).

[5] For example, compare Section 4 of HB 2971 to Section 66(2) of SB 369 (Or Laws 1995, ch 332, Secs. 66(2)), which specifically provides that the 1995 amendments to ORS 656.204, 656.265 and 656.210(2)(a) "apply only to injuries occurring on or after the effective date of this Act."

[6] Like *former* ORS 656.386(1), *amended* ORS 656.386(1)(b)(A) defines a "denied claim" as "a claim for compensation" which the carrier refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to compensation. *Amended* ORS 656.386(1)(b)(B) and (1)(b)(C) expand the definition to include "a claim for compensation for a condition omitted from a notice of acceptance, made pursuant to ORS 656.262(6)(d)," to which the carrier does not respond within 30 days and "a claim for an aggravation or a new medical condition, made pursuant to ORS 656.262(7)(a)," to which the carrier does not respond within 90 days.

[7] The insurer cites ORS 656.202 in arguing that the date of injury controls. ORS 656.202(2) provides that "[e]xcept as otherwise provided by law, payment of benefits for injuries or deaths under this chapter shall be continued as authorized, and in the amounts provided for, by the law in force at the time the injury giving rise to the right to compensation occurred." The statute does not refer to claims for attorney fees for prevailing over a denied claim. ORS 656.202 addresses "benefits for injury or death" and "compensation," but it is well established that "carrier-paid" attorney fees do not constitute "compensation" or payments for injury or death. *See, e.g., Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986) ("compensation" does not include attorney fees). Consequently, ORS 656.202(2) does not support the insurer's position.

Turning to the merits, it is undisputed that the insurer did not respond to claimant's September 16, 1997 ORS 656.262(6)(d) claim within 30 days. The insurer accepted the meniscus tear only after claimant's attorney requested a hearing alleging a "de facto" denial in late October 1997. This case therefore involves a "denied claim" under *amended* ORS 656.386(1)(b)(B), in which claimant's attorney was instrumental in obtaining a rescission prior to hearing. Consequently, claimant's counsel is entitled to a reasonable fee. ORS 656.386(1)(a).

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's "pre-hearing" services in obtaining the rescission of the "de facto" denial is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated. We note that claimant is not entitled to an attorney fee for his counsel's "post-rescission" services concerning the attorney fee award. *See Amador Mendez*, 44 Van Natta 736 (1992).

ORDER

The ALJ's order dated March 20, 1998 is reversed. For services prior to hearing, claimant's counsel is awarded an attorney fee of $1,000, payable by the insurer.

In the Matter of the Compensation of
TONYA L. KRISTENSEN, Claimant
WCB Case No. 97-06811
ORDER ON REVIEW
Michael A. Bliven, Claimant Attorney
Michael G. Fetrow (Saif), Defense Attorney

Reviewed by Board Members Haynes, Bock and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Bethlahmy's order that: (1) admitted a medical report (Ex. 12BB) from claimant's treating physician submitted by the SAIF Corporation despite claimant's objection; (2) denied claimant's request for a continuance of the hearing for cross-examination of her treating physician; and (3) upheld SAIF's denial of her injury claim for a right rotator cuff tear. In her brief, claimant also moves for remand. On review, the issues are remand, evidence and compensability.

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

Claimant contends that the ALJ erred in admitting Exhibit 12BB without allowing cross-examination or rebuttal, and seeks remand for the taking of additional evidence. We disagree, and deny claimant's request for remand.

Exhibit 12BB is a letter dated October 10, 1996 to SAIF from claimant's treating physician, Dr. Berselli. This document was furnished to claimant by SAIF in the course of regular discovery and, in fact, was initially submitted for "supplemental inclusion in the record" *by claimant*, in her November 3, 1997 supplemental exhibit packet. At the November 19, 1997 hearing, however, claimant objected to the admission of this exhibit and argued that if SAIF sought to offer it, she was entitled to cross-examine Dr. Berselli concerning the contents of the letter. In response, SAIF offered the exhibit and asserted that claimant had already obtained (and had submitted for the record) a September 1997 supplemental report by Dr. Berselli (Ex. 34), and that there was no need for a continuance for additional testimony. The ALJ admitted Exhibit 12BB and denied claimant's request for a continuance for cross-examination or rebuttal.

OAR 438-006-0091 provides that, although continuances are disfavored, an ALJ may continue a hearing "upon a showing of due diligence" if necessary to afford reasonable opportunity to cross-examine on documentary evidence, or for the party bearing the burden of proof to obtain and present final rebuttal evidence. *See* OAR 438-006-0091(2) and (3).

We review the ALJ's ruling on a motion for continuance for abuse of discretion. *See, e.g., Jerry D. Thatcher*, 50 Van Natta 888 (1998); *Sharron D. Lemley*, 49 Van Natta 1365 (1997); We also review the ALJ's evidentiary rulings for abuse of discretion. *James D. Brusseau II*, 43 Van Natta 541 (1991).

Here, we find no abuse of discretion in the ALJ's decision to admit Exhibit 12BB or to deny claimant's request for a continuance. As a report by claimant's treating doctor concerning the very condition at issue, Exhibit 12BB is highly relevant to the parties' dispute. In addition, because claimant was the party who initially offered Exhibit 12BB for inclusion in the record (but then sought to withdraw it on the day of hearing), she cannot claim unfair prejudice by the ALJ's decision to admit the document based on SAIF's offer at hearing. Indeed, until claimant chose to withdraw the exhibit at the hearing, it was claimant's expressed intention that the report would be included in the record as evidence; yet, claimant made no effort to seek cross-examination of Dr. Berselli or a rebuttal report until the day of hearing. Under these circumstances, claimant has not shown the requisite due diligence.[1] Moreover, in preparation for the hearing, claimant had already obtained another report from Dr. Berselli (Ex. 34), which was dated almost a year after Exhibit 12BB.

Furthermore, because the challenged exhibit was provided to claimant's counsel in the course of regular discovery and more than two weeks before the November 19, 1997 hearing,[2] we find this case distinguishable from *Eric Diaz*, 50 Van Natta 15 (1998), in which we held that the ALJ improperly refused to hold the record open for cross-examination or rebuttal evidence. In *Diaz*, relying on the "7 day rule" of OAR 438-007-0015(4), the ALJ admitted (over the claimant's objection) a report from the claimant's treating physician which the carrier had received three days prior to the hearing. The ALJ determined that the evidence contained in the challenged exhibit was cumulative because the parties had previously deposed the treating doctor regarding items discussed in the report. On review, we noted that the ALJ had properly admitted the challenged exhibit because the carrier had submitted it within seven days of receipt, as required by OAR 438-007-0015(4). We found, however, that because the insurer submitted the report for the first time at hearing, the claimant could not, with due diligence, have presented final medical evidence at hearing. We therefore remanded the matter to the ALJ to allow claimant the opportunity to cross-examine the treating doctor or rebut the late-produced evidence.

Conversely, in this case, claimant initially submitted the challenged report for inclusion in the record without requesting cross-examination of Dr. Berselli. Claimant had also procured another report from Dr. Berselli that was prepared approximately one year after Exhibit 12BB. Under such circumstances, we are persuaded that claimant could have, with due diligence prior to hearing, obtained a supplemental or clarifying report from Dr. Berselli and/or rebuttal evidence. Accordingly, we find no abuse of discretion in the ALJ's evidentiary ruling and, likewise, no compelling reason to remand. *See Compton v. Weyerhaeuser Co.*, 301 Or 641 (1986) (to merit remand for consideration of additional evidence, it must be clearly shown that material evidence was not obtainable with due diligence at the time of the hearing).

ORDER

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

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[1] The result in this case would likely be different if claimant had not submitted the exhibit for inclusion in the record prior to the hearing. In other words, if claimant had received Dr. Berselli's report in the course of regular discovery, but it had not been identified as an exhibit and submitted for inclusion in the record by either party until the day of hearing, claimant may have been entitled to a continuance for cross-examination or rebuttal evidence on SAIF's at-hearing offer of the exhibit.

[2] Dr. Berselli's October 1996 report (Ex. 12BB) was sent to claimant's attorney on October 22, 1997, nearly a month prior to the November 19, 1997 hearing. In addition, according to claimant's November 3, 1997 supplemental exhibit list, Exhibit 12BB was also a part of the record on reconsideration for purposes of the July 21, 1997 Order on Reconsideration concerning the closure and permanent disability rating of claimant's accepted right cervical strain and right rotator cuff strain conditions.

Member Hall specially concurring.

Although I concur in the result in this case, I write separately to emphasize that the decision in this case is based on an "abuse of discretion" standard. In other words, this decision does not establish a rule of law interpreting OAR 438-006-0081(5).

In the Matter of the Compensation of
DEBORAH F. MORGAN, Claimant
WCB Case Nos. 96-09436, 96-05758, 96-05757 & 96-04957
ORDER ON REVIEW
Bradley P. Avakian, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) set aside its partial denial of claimant's claim for right shoulder strain, overuse syndrome, tendinitis and/or impingement; and (2) awarded an assessed attorney fee of $3,700 for claimant's counsel's services at hearing. On review, the issues are compensability and attorney fees.

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

On review, SAIF cites *Schoch v. Leupold & Stevens*, 325 Or 112, *on remand* 49 Van Natta 788 (1997), and contends that the ALJ did not adequately explain the basis for the attorney fee award. Moreover, SAIF argues that the attorney fee awarded by the ALJ was excessive.

In *Russell L. Martin*, 50 Van Natta 313 (1998), we rejected a similar argument.[1] We found that an ALJ was not obligated to make specific findings regarding the rule-based factors in a case where there was no specific attorney fee request (or statement of services), and the parties had not submitted to the ALJ any argument as to how the rule-based factors should be weighed in determining a reasonable fee. Under such circumstances, we concluded that *Schoch* was distinguishable. *Martin*, 50 Van Natta at 314. *See also McCarthy v. Oregon Freeze Dry, Inc.*, 327 Or 84, *on recon* 327 Or 185 (1998) (Court of Appeals would satisfy its obligation to make findings under attorney fee statute by including a brief description or citation to the factor or factors relied on in denying an award of attorney fees; standing alone, absence of explanatory findings to support an award or denial of attorney fees is not a ground for reversal).

Here, there was no specific attorney fee request and no evidence that the parties argued the factors before the ALJ. Accordingly, it was sufficient for the ALJ to state that she had considered the rule-based factors, with particular emphasis on two of the factors (complexity and risk of no recovery).

On review, SAIF contends that the case only involved one witness and it is not clear how much of claimant's case development was directed toward several claims that were withdrawn at the time of hearing. However, as previously noted, a statement of services was not submitted and was not relied upon by the ALJ. Additionally, the ALJ did not emphasize the factor of time devoted to the case. Finally, after reviewing the record, we agree with the ALJ that the complexity of the case and the risk of no recovery justify a fee of $3,700. Consequently, we affirm the ALJ's attorney fee award.

Claimant's attorney is entitled to an assessed fee for services in defending against SAIF's request for review regarding the issue of compensability. *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 those services is $1,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant's attorney is not entitled to an assessed fee for defending the ALJ's fee award. *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated January 20, 1998 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by the SAIF Corporation.

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[1] We note that our *en banc* decision in *Martin* issued February 27, 1998. SAIF's appellant's brief was submitted to the Board on April 7, 1998. Inasmuch as *Martin* provides the Board's interpretation of the *Schoch* decision, an appellate forum would expect to receive for review a discussion of the reasoning expressed in *Martin*. Nonetheless, SAIF has neither discussed nor distinguished the *Martin* holding.

In the Matter of the Compensation of
CARLOTA PHILLIPS, Claimant
WCB Case Nos. 97-07999, 97-06956 & 97-03438
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Zimmerman & Nielsen, Defense Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

EBI Companies requests review of those portions of Administrative Law Judge (ALJ) Spangler's order that: (1) set aside its denial, on behalf of Dallas Care Center, of claimant's bilateral carpal tunnel syndrome (CTS); (2) upheld its "new injury or occupational disease" denial of the same condition; and (3) upheld Liberty Northwest Insurance Corporation's (Liberty) denial, on behalf of Independence Health Corporation, of the same condition. Claimant cross-requests review of those portions of the order that: (1) upheld EBI's "new injury or occupational disease" denial of the same condition; and (2) upheld Liberty's denial of responsibility for the same condition. On review, the issue is responsibility.

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

Claimant has a 1989 accepted nondisabling[1] claim for bilateral CTS with EBI. On review, EBI contends that responsibility should shift to Liberty, because claimant experienced a "new" CTS condition when employed at Liberty's insured. We disagree.

Here, of the three doctors who provided opinions on the causation of claimant's current CTS condition, both Dr. Button and Dr. Snodgrass opined that claimant had longstanding bilateral CTS, greater on the right, that had worsened gradually over the years. (Exs. 50, 58B). Their opinion is supported by Dr. Humphrey's initial diagnosis of bilateral CTS in 1989 and the electrical studies performed in 1991, which revealed mild CTS on the right, and again in 1996, which demonstrated a worsened bilateral CTS condition. (*Compare* Exs. 26, 26A and 41).

In contrast, Dr. Zirschky, who became claimant's treating physician in 1995, found that claimant had no significant positive CTS findings until October 1996. Dr. Zirschky opined that the major contributing cause of claimant's current bilateral CTS condition was her work as a CNA at Liberty's insured; however, he based his opinion on a faulty history. Moreover, Dr. Zirschky failed to evaluate the contribution from claimant's preexisting, long-standing wrist conditions and weigh them against the contribution from her work in 1996 to determine which cause was the major contributing cause of claimant's current CTS condition. (Exs. 53, 56).

Although we generally defer to the opinion of the treating physician, we find persuasive reasons not to do so in this case, as it is based on a faulty history, and he explicitly based his opinion on this understanding. *Weiland v. SAIF*, 64 Or App 810 (1983); *Miller v. Granite Construction Co.*, 28 Or App 473, 478 (1977) (doctors' opinions based on an inaccurate history entitled to little or no weight). Moreover, because he did not evaluate the relative contribution of the different causes of her current condition, we find additional reason not to find Dr. Zirschky'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).

Responsibility, therefore, remains with EBI, the carrier with the most recent accepted claim for the same bilateral CTS condition. ORS 656.308(1); *SAIF v. Yokum*, 132 Or App 18 (1994); *Smurfit Newsprint v. DeRosset*, 118 Or App 368 (1993), *on remand Armand J. DeRosset*, 45 Van Natta 1058 (1993).

Because the compensability issue was potentially at risk by virtue of our *de novo* review of the ALJ's order, claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2); *Larry W. Burke*, 49 Van Natta 1877, *on recon* 49 Van Natta 2002 (1997). After considering the factors set forth 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 EBI. 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] Contrary to the ALJ's finding, the claim was not subsequently reclassified as disabling.

ORDER

The ALJ's order dated January 5, 1998, as reconsidered March 4, 1998, is affirmed. For services on review, claimant's attorney is awarded a fee of $750, to be paid by EBI.

In the Matter of the Compensation of
GERALD POWERS, Claimant
WCB Case No. 97-10442
ORDER ON REVIEW
Patrick K. Mackin, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Menashe's order that set aside its partial denial of claimant's right wrist condition involving STT arthritis. Claimant cross-requests review of those portions of the ALJ's order that: (1) declined to assess a penalty for the insurer's allegedly unreasonable denial; and (2) assessed a 15 percent penalty for an untimely denial. On review, the issues are compensability and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant began working at the employer the last week of September 1996. On October 2, 1996, he suffered a puncture wound to his right ring finger. He developed an acute infection and sought emergency medical treatment on October 6, 1996. X-rays of his right hand revealed soft tissue swelling over the dorsum of the hand, but no periostitis. The x-rays also revealed prominent degenerative changes in the navicular multangular joints of the wrist. The emergency room physician diagnosed cellulitis, right hand. (Ex. 2).

Claimant saw Dr. Nolan for follow-up on October 15, 1996. Dr. Nolan reviewed x-rays of that date and concluded that the infection showed no joint involvement. (Ex. 2B). On October 29, 1996, Dr. Nolan reported that claimant's right hand had improved and that he was ready to return to regular work without restrictions. He also noted that claimant was showing signs and symptoms of bilateral carpal tunnel syndrome (CTS), for which he ordered electrodiagnostic evaluation. (Ex. 3).

Dr. Woods found electrophysiologic evidence of bilateral demyelinating ulnar neuropathies and bilateral medial nerve dysfunction. The latter was consistent with both bilateral CTS and an underlying sensory neuropathy and clinical correlation was advised. (Ex. 4-2).

On November 5, 1996, the insurer accepted a disabling "right ring finger puncture wound." (Ex. 5). On the same date, claimant reported to Dr. Nolan that, after he started employment with the insured, but prior to the October 2, 1996 injury, he had experienced tingling, numbness and pain in both hands, with worsening greater in the right hand than the left. (Ex. 6).

On November 8, 1996, Dr. Woods reported that claimant had been experiencing hand numbness for about a year and continuous, increasingly severe, right greater than left bilateral wrist and thenar eminence pain during the prior six months. Woods diagnosed non-work related small fiber polyneuropathy as the reason for the abnormal electrodiagnostic studies, and opined that claimant's hand and wrist symptoms were related to arthritic/multiple use microtrauma conditions. (Ex. 8-4).

On January 8, 1997, Dr. Utterback evaluated claimant's right wrist complaints. He observed that claimant was quite tender over the degenerative multangular joint in the area of the right wrist. Utterback opined that claimant would require arthrodesis surgery on the radial side of the wrist if he were to return to any type of manual labor. (Ex. 9).

On January 23, 1997, Dr. Nolan found significant bilateral scaphotrapezial trapezoidal arthritis (STT arthritis) at the right wrist and recommended fusion surgery to relieve claimant's right hand pain, which he felt was work-related. (Exs. 10A, 10B, 10E).

On August 8, 1997, claimant was examined for the insurer by Dr. Williams, who advised that the October 5, 1996 x-ray documented severe degenerative changes in the right wrist which preexisted and were totally separate from claimant's work-related infection. He did not think that the preexisting condition combined with the work injury or acute hand infection to cause the need for treatment, nor did he think that employment conditions at the employer caused a pathological worsening of the preexisting condition. (Ex. 11).

Dr. Nolan reviewed Dr. Williams' report and concurred in part, explaining that there were two separate conditions: (1) a hand infection, resulting from an injury, that had resolved; and (2) STT arthritis, a separate condition unrelated to the infection. However, he differed with Dr. Williams regarding causation of the arthritis, opining that the arthritis was related to claimant's framing activities at work. (Ex. 12).

On December 16, 1997, Dr. Nolan performed an intercarpal fusion of the right wrist. (Ex. 14). On December 24, 1997, as amended February 18, 1998, the insurer denied claimant's injury or occupational disease claim for his right wrist condition. (Ex. 15).

On January 31, 1998, Dr. Williams opined, in response to a letter from the insurer, that claimant's arthritic condition in the right hand preexisted his employment at the insured and that claimant's work activities as a framer were not the major cause of the degenerative changes or the pathological worsening of the preexisting condition. (Ex. 16).

On February 8, 1998, Dr. Nolan elaborated on his earlier opinion, stating that, although claimant's hand infection had resolved, the swelling and pain from that condition combined with the preexisting arthritic condition in the right hand to cause the need for treatment. He noted that there was evidence of relatively acute swelling and synovitis surrounding the arthritis during the December 1997 surgery, which, he opined, indicated a relatively recent exacerbation of the underlying arthritic process. (Ex. 18).

On February 17, 1998, claimant was examined for the insurer by Dr. McNeill, who opined that, because claimant is predominantly right-handed, his bilateral STT arthritis condition was unrelated to his work. (Ex. 21).

CONCLUSIONS OF LAW AND OPINION

Relying on the opinion of Dr. Nolan, the ALJ found that claimant's compensable work injury combined with his preexisting degenerative right wrist condition and that the compensable injury was the major contributing cause of the disability or need for treatment of the combined condition. On review, the insurer contends that the only medical evidence that supports claimant's claim is not persuasive. For the following reasons, we agree with the insurer.

In order to establish compensability under ORS 656.005(7)(a)(B), claimant must show that his July 2, 1996 injury was the major contributing cause of the disability or need for treatment of the combined condition. *SAIF v. Nehl*, 148 Or App 101, *on recon* 149 Or App 309 (1997); *Gregory C. Noble*, 49 Van Natta 764, 767 (1997), *aff'd mem* 153 Or App 125 (1998). 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. Furthermore, given the combination of the preexisting degenerative wrist condition and the October 2, 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).

Here, medical opinions regarding causation are provided by Dr. Williams, vascular neurosurgeon, Dr. Nolan, claimant's treating hand surgeon, and Dr. O'Neill, orthopedist.

Dr. Williams, who examined claimant and reviewed his medical history, including the degenerative changes revealed by the October 5, 1996 x-rays, reported that his current complaints were due to the severe degenerative changes in claimant's wrist which preexisted and were totally separate from claimant's work-related infection. Williams further opined that claimant's acute hand infection was separate and did not combine, exacerbate, or cause a pathological worsening of the preexisting severe degenerative changes present in the navicular multangular joint. (Ex. 11).

After reviewing Dr. Williams' report, Dr. Nolan agreed that claimant had two separate conditions: (1) a hand infection, resulting from the injury, which had resolved; and (2) STT arthritis, a separate condition, unrelated to the infection. However, Dr. Nolan disagreed in regard to causation, opining instead that the arthritis for which surgery was indicated was related to claimant's framing activities. (Ex. 12).

In a subsequent letter responding to the insurer's questions, Dr. Williams opined that, within reasonable medical probability, claimant's work activities as a framing and sheetrock carpenter were not the major cause of the degenerative changes noted in the x-rays of October 5, 1996, that the degenerative changes preexisted claimant's work at the employer, and that his work at the employer was not the major contributing cause of a pathological worsening of the preexisting condition. (Ex. 16).

In January 1998, Dr. Nolan elaborated on his earlier opinion. He now opined that claimant's puncture wound and infection in the right hand combined with and worsened claimant's preexisting arthritis in the right wrist, and that the injury was the major contributing cause of the need for treatment. He based his opinion on his assumptions that claimant had no symptoms or problems with either hand at the time he began working at the employer, and that, ever since the puncture wound, infection and swelling (which itself had resolved), claimant had complained of "new" pain in the right wrist. Nolan also stated that, after the infection cleared, further work-up revealed claimant's bilateral wrist arthritis. He then reasoned, in effect, that although the arthritis was bilateral, it was symptomatic only on the right because the puncture wound was on the right. Therefore, Dr. Nolan concluded that the work activity at the employer "in combination with claimant's preexisting condition" caused a pathological worsening of the arthritis in claimant's right wrist.

Dr. Nolan then explained the discrepancy between his two opinions by stating that claimant indeed had two separate and unrelated conditions, the hand infection which eventually resolved, and the STT arthritis, "however, the underlying arthritis condition was exacerbated and worsened by the 10-29-96 [sic] puncture to the right hand with subsequent swelling and pain. This then brought on and made the underlying arthritis [become] symptomatic * * * and require treatment." He again stated that his opinion was supported by the fact that the arthritis was bilateral, yet was completely asymptomatic in the left hand. (Ex. 18).

We do not find Dr. Nolan's ultimate opinion persuasive. First, the record establishes that claimant had experienced increasingly severe, right greater than left, bilateral wrist pain for at least three months prior to beginning work at the employer, and bilateral hand numbness for even longer. Moreover, as noted by Dr. Williams, the severe arthritic condition was actually revealed by x-ray when claimant first sought treatment for his infected hand in October 1996. (Exs. 2, 6, 8, 11-1). Thus, the assumptions upon which Dr. Nolan bolstered his changed opinion were based on an inaccurate history. Medical opinions that are not based on a complete and accurate history are not persuasive. *Miller v. Granite Construction*, 28 Or App 473, 476 (1977). Thus, although we generally give deference to the opinion of the attending surgeon, here there are persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810, 814 (1983); *Argonaut Insurance Co. v. Mageske*, 93 Or App 698 (1988).

Moreover, Dr. Nolan's report failed to assess the relative contribution of the preexisting condition to the need for treatment of claimant's right wrist, as required under *Deitz* and *Noble*. Instead, he offered a conclusory opinion, based on an inaccurate history, which he changed from his earlier opinion without explanation. For these reasons, we find that Dr. Nolan's opinions do not meet claimant's burden of proof.[1]

Penalties

As further confirmed by our decision regarding the compensability of the claim, we adopt and affirm the ALJ's conclusion that the insurer's denial was not unreasonable. Furthermore, we reject claimant's contention that he is entitled to "full penalties" for the insurer's untimely denial. Instead, we affirm the ALJ's assessment of a 15 percent penalty for an untimely denial.[2]

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[1] We note that neither Dr. Williams' nor Dr. O'Neill's opinions support compensability.

[2] As a result of our compensability decision, it is possible that no compensation was "then due" at the time of the insurer's denial. Should that be the case, the ALJ's penalty assessment would effectively be zero.

ORDER

The ALJ's order dated March 13, 1998 is reversed in part and affirmed in part. That portion of the order that set aside the insurer's partial denials of claimant's right wrist condition is reversed. The insurer's denials are reinstated and upheld. The ALJ's $3,000 attorney fee award is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
JOYCE L. REEDY, Claimant
WCB Case Nos. 96-03323 & 95-10848
ORDER ON REMAND
Carney, et al, Claimant Attorneys
Michael O. Whitty, Defense Attorney
Lundeen, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. *SAIF Corporation v. Reedy*, 153 Or App 122 (1998). Citing *amended* ORS 656.262(10), the court has reversed and remanded our prior order for reconsideration. In our prior order, *Joyce L. Reedy*, 49 Van Natta 643 (1997), we set aside SAIF's compensability and responsibility denials of claimant's lumbar spondylosis and degenerative disc disease based on the court's holding in *Deluxe Cabinet Works v. Messmer*, 140 Or App 548, *rev den* 324 Or 305 (1996).

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for the last paragraph.

CONCLUSIONS OF LAW AND OPINION

We briefly summarize the relevant facts. Claimant seeks to prove compensability of her lumbar spondylosis and degenerative disc disease at L4-5 and L5-S1. She has sustained four compensable low back injuries. Claimant compensably injured her low back in June 1986. On July 3, 1986, SAIF accepted an acute lumbosacral sprain/strain. (Ex. F). On July 11, 1986, Dr. Bachhuber performed a 2-level laminectomy at L4-5 and L5-S1. (Ex. G). A May 13, 1987 Determination Order awarded 10 percent unscheduled permanent disability. (Ex. L).

On February 9, 1988, claimant again compensably injured her low back. On April 11, 1988, SAIF accepted a lumbosacral strain. (Ex. 10). On September 29, 1988, Dr. Mason performed a lumbar laminectomy at L4-5. (Ex. 25). A June 12, 1989 Determination Order awarded claimant 29 percent unscheduled permanent disability. (Ex. 46). A February 16, 1990 Opinion and Order increased claimant's unscheduled permanent disability award to 41 percent. (Ex. 60).

On June 12, 1991, claimant was injured after slipping on a wet floor at work. Liberty Northwest Insurance Corporation (Liberty) accepted a left buttock contusion. (Tr. 15). The medical opinions indicated that claimant did not sustain any permanent disability as a result of the June 1991 injury. (Exs. 74, 75).

On March 14, 1992, claimant injured her tailbone, head and neck after slipping on a wet floor at work. Liberty accepted a sacral contusion and cervical strain on May 15, 1992. (Ex. 91). A May 27, 1992 Notice of Closure did not award any permanent disability. (Ex. 92).

Claimant returned to Dr. Mason on June 9, 1995 for treatment of low back and leg pain. (Ex. 93). SAIF and Liberty subsequently issued denials of compensability and responsibility. Claimant requested a hearing on the denials.

The ALJ concluded that the February 9, 1988 injury resulted in the pathological worsening and acceleration of claimant's degenerative lumbar condition and was the major contributing cause of her treatment in June 1995 and thereafter. The ALJ determined that SAIF was responsible for claimant's lumbar spondylosis and degenerative disc disease.

In our prior order, we affirmed the ALJ's order on different grounds. We found that claimant's unappealed 41 percent unscheduled permanent disability award for the 1988 injury included an award for lumbar spondylosis and degenerative disc disease. Relying on *Deluxe Cabinet Works v. Messmer*, 140 Or App at 548, we concluded that SAIF's failure to challenge the February 16, 1990 Opinion and Order on the ground that it included an award for the noncompensable lumbar spondylosis and degenerative disc disease conditions precluded it from denying that those conditions were part of the 1988 claim. On that basis, we set aside SAIF's denial.

After our prior order issued, the 1997 Legislature amended ORS 656.262(10). The statute now provides, in part:

> "Payment of permanent disability benefits pursuant to a determination order, notice of closure, reconsideration order or litigation order, or the failure to appeal or seek review of such an order or notice of closure, shall not preclude an insurer or self-insured employer from subsequently contesting the compensability of the condition rated therein, unless the condition has been formally accepted."

The court has reversed and remanded our order for reconsideration in light of the 1997 amendments to ORS 656.262(10). Consistent with the court's directions, we proceed with our reconsideration.

In *Keith Topits*, 49 Van Natta 1538 (1997), we held that the 1997 amendments to ORS 656.262(10) legislatively overruled the *Messmer* decisions. 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*, we conclude that SAIF is not precluded from denying claimant's lumbar spondylosis and degenerative disc disease under ORS 656.262(10). *See Judy A. Tucker*, 50 Van Natta 1062 (1998); *Patricia A. Landers*, 50 Van Natta 299 (1998). Accordingly, we proceed to analyze the merits.

Compensability

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).

The medical evidence indicates that claimant's lumbar spondylosis and degenerative changes preexisted her first injury in 1986 and, therefore, those conditions constitute "preexisting conditions" pursuant to ORS 656.005(24). (Exs. 104-2, 106-19, -26). The medical evidence also establishes that claimant's compensable injuries combined with the preexisting lumbar spondylosis and degenerative changes to cause or prolong her disability or need for treatment. (Exs. 104-1, 106-8, -13, -18). Therefore, we conclude that claimant must establish that a compensable injury was the major contributing cause of her disability or need for treatment of her current combined condition. ORS 656.005(7)(a)(B).

Claimant was treated by Dr. Mason beginning July 28, 1988. (Ex. 17). On September 29, 1988, Dr. Mason performed a lumbar laminectomy at L4-5. (Ex. 25). She later returned to Dr. Mason on June 9, 1995 with complaints of bilateral hip and leg pain, greater on the left side. (Ex. 93-1). Dr. Mason reviewed an MRI scan and found some degenerative joint changes at the lower lumbar levels, but no evidence of any type of recurrent herniated disc problem. (Ex. 93-2).

On April 5, 1996, Dr. Mason reported to claimant's attorney that claimant's February 1988 injury and the subsequent surgery at L4-5 caused an acceleration of the degenerative process at that level. (Ex. 103). He felt that the February 1988 injury and surgery remained the major contributing cause of claimant's need for treatment in June and July 1995. (*Id.*)

Dr. Mason subsequently changed his opinion. In a June 20, 1996 concurrence letter from SAIF, Dr. Mason said that his diagnosis in June 1995 was lumbar spondylosis and post-operative scarring at L4-5, and it would be fair to characterize her condition as degenerative disc disease. (Ex. 104-1). He agreed that all of claimant's injuries and surgeries contributed to her disability and need for treatment with respect to her condition in June 1995. (*Id.*) Based on a June 1995 MRI, which was compared with

a 1991 diagnostic study, Dr. Mason agreed that claimant's condition had not pathologically changed between June 1991 and June 1995. (Ex. 104-2). He felt that claimant's June 1995 condition did not represent a new set of operative facts or findings as compared with June 1991. (*Id.*) Dr. Mason also agreed with the following:

> "You continue to believe that [claimant's] lumbar spondylosis and lumbar degenerative changes preexisted her injuries, including her first injury in 1986. You also believe that each of [claimant's] low back injuries has combined with her preexisting lumbar spondylosis. In the letter of April 5th, [1996 to claimant's attorney,] you opined that the injury and surgery in 1988 is the major contributing cause of her current disability and need for treatment. You no longer hold that opinion. It is now your opinion that in weighing all the factors that have contributed to claimant's combined condition (combined condition meaning the preexisting lumbar spondylosis plus all subsequent injuries and surgeries), the major contributing cause of her current disability and need for treatment is her preexisting lumbar spondylosis. This change of opinion was brought about by having access to *all* the medical records, and due to a more thorough review of the entire record." (Ex. 104-2; emphasis in original).

Although Dr. Mason's June 20, 1996 medical opinion differed from his earlier report to claimant's attorney, we find his change of opinion to be reasonable in light of his explanation that he had reviewed all of claimant's medical records and had performed a more thorough review of the record. *See Kelso v. City of Salem*, 87 Or App 630, 633 (1987) (medical opinion that provided a reasonable explanation for the change of opinion was persuasive).

Dr. Mason reaffirmed his June 20, 1996 opinion in a deposition. (Ex. 106-25). He explained that claimant had degenerative changes in her lumbar spine preexisting the 1986 injury. (Exs. 106-19, -26). In hindsight, based on the fact that claimant never really got relief from the 1988 surgery, Dr. Mason felt that the structural arthritic issues of the lumbar spine were the "main players" in producing claimant's pain in 1988 and also producing pain after the surgery. (Ex. 106-11). He explained:

> "She has had two surgeries to her lumbar nerve roots, and according to the patient, even from the first surgery that she never really had good relief of the nerve pain. So it's really fair to assume that the structural issues of the lumbar vertebra that were present even before her original injury, really is the major factor producing her current clinical symptoms." (Ex. 106-19).

Dr. Mason concluded that the preexisting lumbar arthritis was the major factor of claimant's current low back condition. (Ex. 106-22).

Dr. Mason's conclusion is consistent with Drs. Dordevich and Duff, who examined claimant on August 15, 1995 on behalf of Liberty. (Ex. 97). They concluded that claimant had chronic intermittent low back pain due to degenerative disc disease at L4-5 and L5-S1. (Ex. 97-4). They found no evidence of a new injury. (*Id.*) They felt that claimant's back complaints were due to natural aging and progression of preexisting degenerative disc disease. (Ex. 97-5). Dr. Mason concurred with their report. (Ex. 99).

Based on the opinion of Dr. Mason, as supported by Drs. Dordevich and Duff, we conclude that claimant has not established compensability of her lumbar spondylosis and degenerative disc disease at L4-5 and L5-S1.[1] Because claimant has not established a compensable claim, we need not address any issues of responsibility.

Accordingly, on reconsideration, the ALJ's order dated October 17, 1996 is reversed in part. The SAIF Corporation's June 21, 1996 denial is reinstated and upheld. The ALJ's attorney fee is also reversed. The remainder of the ALJ's order is affirmed.

IT IS SO ORDERED.

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[1] In light of our disposition, we need not address SAIF's argument that claimant's failure to appeal its August 16, 1991 denial establishes that her low back condition was not compensable to SAIF as of the date of the denial.

In the Matter of the Compensation of
MARK WHITAKER, Claimant
WCB Case No. 97-08418
ORDER ON REVIEW
Susan L. Frank, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Bock and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) declined to award an assessed attorney fee under ORS 656.386(1); (2) declined to award an attorney fee for allegedly unreasonable resistance to the payment of compensation under ORS 656.382(1); and (3) declined to award a penalty for allegedly unreasonable processing of claimant's injury claim pursuant to ORS 656.262(11). On review, the issues are attorney fees and penalties.

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

Claimant compensably injured his back on July 7, 1997. He sought treatment and completed a form 801 and a form 827. The self-insured employer's claims processor received the completed forms and set up its claim file on July 15, 1997.

Claimant's attorney contacted the claims processor on September 5, 1997. A copy of the claim file was sent to her.

On September 17, 1997, the claims processor called claimant's attorney and advised that the claim was still in deferred status. Later that day, the claims processor decided to accept the claim. The claims processor typed an acceptance letter on September 18, 1997, although it was dated September 17. On October 16, 1997, claimant's attorney filed a request for hearing alleging a "de facto" denial, as neither she nor claimant had received notice of acceptance.

On October 27, 1997, the Workers' Compensation Division received a copy of the acceptance letter along with a copy of a 1502 form, dated September 22, 1997, indicating that the claim had been accepted.

On November 26, 1997, the employer's counsel wrote to claimant's counsel regarding the request for hearing. The employer's counsel advised that the claim had been timely accepted by letter of September 17, 1997. In response, claimant's counsel stated that neither she nor claimant had received a copy of the acceptance. A copy of the acceptance was faxed to claimant's counsel on December 5, 1997.

On December 19, 1997, the employer's attorney filed a response to claimant's request for hearing denying, among other things, that claimant sustained a work-related injury or disease.

As of the date of hearing, the claims processor had not received any billings from Dr. Karvonen, who treated claimant for a lumbar strain and a cervicothoracic strain on five occasions in November 1997.

At hearing, the parties stipulated that the only issue was claimant's entitlement to penalties and attorney fees. The ALJ concluded that, although the processing of claimant's claim acceptance involved a series of delays, omissions and misstatements, claimant failed to prove an entitlement to attorney fees and/or penalties.

On review, claimant cites to *Galbraith v. L.A. Pottsratz Const.*, 152 Or App 790 (1998), and *Kimberly Quality Care v. Bowman*, 148 Or App 292 (1997), and asserts that his attorney is entitled to a fee under ORS 656.386(1) arising out of the employer's response to the hearing request. We disagree, for the reasons set forth below.

In *Bowman*, the same day the claimant wrote to the employer asking that certain conditions be formally accepted, he also filed a request for hearing alleging the "de facto" denial of those conditions.

The employer then submitted a "Response to Issues" containing a check-the-box notation that the claimant had sustained no work-related injury or disease. Almost a month later, the employer agreed to accept the disputed conditions. The court held that the carrier's response to the request for hearing unequivocally expressed the employer's denial of compensability and provided the basis for an attorney fee on the employer's rescission of that denial. 148 Or App at 295.

Similarly, in *Galbraith*, the claimant filed a request for hearing asserting a "de facto" denial of his claim. The carrier filed a response, which indicated that the claimant was "entitled to no relief." At the hearing a month later, the carrier advised the ALJ that it had decided to accept the claim and that the only issue remaining was whether an attorney fee was warranted. The court, citing *Bowman*, concluded that the carrier's response to the request for hearing constituted an "express denial" of compensation entitling the claimant to an attorney fee under ORS 656.386(1).[1] The court explained:

> "Claimant was * * * 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 * * *. 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." 152 Or App at 794.

In this case, unlike *Bowman* and *Galbraith*, the employer had already accepted the claim prior to claimant's request for hearing.[2] Although the employer's September 17, 1997 acceptance letter had not been received by claimant or his counsel at the time of the October 16, 1997 request for hearing, the employer had "unequivocally expressed" its acceptance of the claim to the Workers' Compensation Department and to claimant's attorney prior to filing its December 19, 1997 Response to Issues (which included an "x" mark indicating that it denied that claimant sustained a work related injury).[3] Because claimant's lumbosacral strain claim had already been accepted prior to the filing of claimant's hearing request, we find this case factually distinguishable from *Bowman* and *Galbraith* and decline to construe the employer's Response to Issues as a "denied claim" for purposes of ORS 656.386(1).

Claimant next contends that he is entitled to a penalty-related attorney fee under ORS 656.382(1) because the employer's failure to provide timely written notice of claim acceptance constituted an unreasonable resistance to the payment of compensation.[4] Under the circumstances of this case, we disagree.

Although the employer apparently failed to forward its September 17, 1997 notice of acceptance to claimant, it had accepted, and paid benefits under, the claim.[5] Because the employer cannot

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[1] For purposes of ORS 656.386(1), a "denied claim" includes "[a] claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation."

[2] Acceptance is an act whereby the carrier acknowledges responsibility for the claim and obligates itself to provide benefits under the law. *Gene C. Dalton*, 43 Van Natta 1191 (1991); *see also Nancy V. Storey*, 41 Van Natta 1951 (1989). Notice to the claimant is not required for a valid acceptance. *Id.*; *see also Patrick A. Getty*, 42 Van Natta 1197 (1990). Indeed, the question of whether notice of acceptance has been properly furnished is one of claims processing, not a question of whether or not a claim has been accepted. *Id.*

[3] As noted above, in late October 1997, the Workers' Compensation Division received a copy of the employer's September 17, 1997 acceptance letter and a 1502 form, dated September 22, 1997, indicating that the claim had been timely accepted. (Exs. 4, 5). By December 5, 1997, claimant's counsel had been notified of the acceptance and faxed a copy of the acceptance letter. (Exs. 6A, 6B).

[4] ORS 656.382(1) provides, in pertinent part, that "[i]f an insurer or self-insured employer * * * unreasonably resists the payment of compensation, the employer or insurer shall pay to the claimant or the attorney of the claimant a reasonable attorney fee."

[5] The record establishes that claimant was paid interim compensation and temporary disability and that the medical bills presented to the employer's claims processor prior to hearing were processed and paid in a timely fashion. (Ex. 2A; Tr. 26, 27, 32).

unreasonably resist the payment of compensation that has been paid, *SAIF v. Condon*, 119 Or App 194, *rev den* 317 Or 162 (1993), no basis exists for an attorney fee award under ORS 656.382(1). *See Michael E. Pelcin*, 47 Van Natta 1380 (1995) (in the absence of any evidence of unpaid compensation at the time the carrier failed to forward written notice of claim acceptance to claimant, no fee warranted under ORS 656.382(1)). Further, because the employer had not been presented with Dr. Karvonen's medical billings prior to the date of hearing,[6] it cannot be said, on this record, that the employer has unreasonably resisted payment of this or any other future compensation.[7]

Finally, claimant asserts he is entitled to a penalty under ORS 656.262(11) to the extent the employer has not paid for Dr. Karvonen's chiropractic treatments. We decline to address this issue because it is not ripe for adjudication. Pursuant to the Director's rules, the employer has 45 days from receipt to timely pay medical bills which are submitted in proper form and clearly show that the treatment is related to an accepted injury. *See* OAR 436-009-0030(2). Here, the record establishes that the employer was first presented with Dr. Karvonen's billing on the day of hearing and also that Dr. Karvonen provided treatment for both a lumbar strain and a cervicothoracic strain, when the employer has accepted only a lumbosacral strain. Therefore, as the ALJ noted, the employer's responsibility for all of this bill has yet to be addressed. To the extent claimant is dissatisfied with the employer's processing of Dr. Karvonen's bill, he may seek relief before the appropriate forum at the appropriate time.

ORDER

The ALJ's order dated February 13, 1998 is affirmed.

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[6] At the January 15, 1998 hearing, the claims processor was presented with a copy of Dr. Karvonen's January 7, 1998 billing, charging $370 for claimant's five treatments in November 1997. (Ex. 7, Tr. 28).

[7] We acknowledge receipt of claimant's "Offer of Supplemental Authority" on this issue while the case was on review. Claimant has offered a Workers' Compensation Division Order Denying Suspension of Compensation, issued June 9, 1998, in support of his contention that the employer's claim processing has been unreasonable. While, as a general rule, we may take administrative notice of agency orders involving the same claimant, *see. e.g., Brian M. Eggman*, 49 Van Natta 1835 (1997), we conclude that the proffered supplemental authority has little or no relevance to the issue before us. Indeed, the appropriateness of the employer's April 28, 1998 notice to claimant (regarding a May 11, 1998 insurer-arranged medical examination) has no bearing on the employer's claim processing conduct (*i.e.*, claim acceptance and payment of compensation) prior to the January 15, 1998 hearing.

In the Matter of the Compensation of
DEAN L. WATKINS, Claimant
WCB Case No. 97-05601
ORDER OF ABATEMENT
Bradley P. Avakian, Claimant Attorney
Scheminske, et al, Defense Attorneys

On June 5, 1998, we affirmed an Administrative Law Judge's (ALJ's) order that: (1) set aside its denial of claimant's right knee suprapatellar plica and chondromalacia conditions; and (2) awarded an assessed attorney fee of $3,500. Announcing that the parties have resolved their dispute, the insurer seeks withdrawal of our prior order to await receipt of the parties' proposed settlement.

In light of the insurer's announcement, we withdraw our June 5, 1998 order. On our receipt of the parties' proposed settlement, we will proceed with our review of the agreement. Meanwhile, the parties are requested to keep us advised of any further developments regarding this case.

IT IS SO ORDERED.

In the Matter of the Compensation of
SIDNEY A. BAER, Claimant
WCB Case No. 97-10145
ORDER ON REVIEW
Bottini, Bottini, et al, Claimant Attorneys
Michael G. Fetrow (Saif), Defense Attorney

Reviewed by Board Members Moller, Bock, and Hall.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) found that claimant's right shoulder injury claim was not barred; and (2) assessed a penalty for an allegedly unreasonable denial. On review, the issues are claim filing and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant worked for the employer as a carpenter for approximately three weeks beginning on August 28, 1997. During this period, claimant slipped and fell, injuring his right shoulder.

On December 8, 1997, claimant sought treatment for his right shoulder. On December 15, 1997, claimant filed a notice of claim with SAIF. On that same date, SAIF issued a denial.

CONCLUSIONS OF LAW AND OPINION

Claim Filing

ORS 656.265 provides, in relevant part:

"(1) Notice of an accident resulting in an injury or death shall be given immediately by the worker * * *, 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, claimant did not file his notice of claim until December 8, 1997, arguably more than 90 days after the accident.[1] Because notice was given within one year of the accident, however, the claim is not barred if the employer had knowledge of the injury.

Claimant testified that, at the "next break" after the accident, he told his supervisor, Ron Shuler, that he had slipped on some ice and fallen while working in a freezer. (Tr. 12). According to claimant, Shuler responded by saying that a lot of people had slipped in the freezer. (*Id.*)

Sidney Baird worked with claimant in the freezer. He testified that he witnessed the accident and confirmed that claimant slipped and fell while they worked in the freezer. (*Id.* at 42). Baird further explained that they both exited the freezer and claimant told him that claimant intended to tell Shuler about the accident. (*Id.* at 43). Baird did not witness claimant informing Shuler about the accident.

Shuler testified that claimant did not inform him about a slip and fall. (*Id.* at 54). According to Shuler, he would have filed a report if claimant had told him about an accident. (*Id.* at 56).

The ALJ found claimant and Baird to be credible. Although not statutorily required, the Board generally defers to the ALJ's credibility determination. *See Erck v. Brown Oldsmobile,* 311 Or 519, 526

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[1] We need not determine the date of claimant's injury nor the precise date claimant gave notice of his claim because of our determination concerning the employer's knowledge of the injury.

(1991). Because the ALJ's credibility finding was based upon the observation of claimant's demeanor, we defer to that determination. *See International Paper Co. v. McElroy*, 101 Or App 61 (1990).[2]

Based on claimant's credible testimony, we find a preponderance of evidence that he informed his supervisor of the accident shortly after its occurrence. Thus, we conclude that the employer had knowledge of the injury and the claim is not barred. *See* ORS 656.265(4)(a); *Argonaut Insurance v. Mock*, 95 Or App 1, 5 (1989) ("knowledge of the injury" should include enough facts as to lead a reasonable employer to conclude that workers' compensation liability is a possibility and that further investigation is appropriate).

Penalty

The ALJ also assessed a penalty on the basis that SAIF's denial was unreasonable. In particular, the ALJ found that SAIF did not have a legitimate doubt as to its liability because it did not conduct a "reasonable investigation" before issuing its denial. SAIF contests this conclusion, asserting that its denial was reasonable at the time it issued.

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.*

When claimant first saw his treating physician, he reported an injury date of August 20, 1997. (Ex. 3-1). That date was prior to claimant's employment with the employer. Furthermore, claimant did not file an accident report or otherwise provide written notification of the accident prior to filing the Form 801; he also did not identify any witnesses to the accident when he filed his claim.[3] (Ex. 4). Based on such circumstances, we conclude that SAIF had a legitimate doubt as to its liability when it issued its denial. Thus, SAIF's denial is not unreasonable and it is not liable for a penalty.

Assessed Attorney Fee

Because SAIF requested review and we found that compensation for the right shoulder claim should not be disallowed or reduced, claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the claim filing issue is $1,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated February 12, 1998 is affirmed in part and reversed in part. That portion of the order assessing a penalty is reversed. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the SAIF Corporation.

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[2] The ALJ did not make a finding concerning Shuler's credibility. We do not address this issue because, whether or not Shuler is credible, we conclude that claimant proved he informed the employer of the accident. That is, even assuming Shuler is credible, we find that claimant's testimony, along with Baird's testimony that claimant intended to tell Shuler about the accident, constitute a preponderance of evidence that the employer had knowledge of the injury shortly after the accident.

[3] In this regard, we disagree with the dissent's position concerning SAIF's conduct. Up to and throughout the hearing, the employer disputed claimant's assertion that he reported the injury to Ron Shuler. Thus, whatever investigatory actions were taken by SAIF, based on Shuler's testimony that claimant did not report the incident, it had a legitimate doubt that claimant timely filed his claim.

Board Member Hall dissenting in part.

I disagree with the majority that claimant is not entitled to a penalty based on an unreasonable investigation. The Form 801 has the same date as SAIF's letter denying the claim, showing that SAIF conducted *no* investigation concerning the claim. If SAIF had performed even a cursory investigation, it would have learned that claimant reported to his treating physician that, while working for the employer, he slipped and fell while working in a freezer. (Ex. 3). Confirmation that claimant's work for the employer was in a freezer, along with the identification of claimant's coworker, Sidney Baird, also was readily available from the employer. Because SAIF did not perform even these simple acts to investigate, instead simply issuing a denial in response to the Form 801, I would find that SAIF's conduct was unreasonable and it is liable for a penalty.

July 10, 1998 Cite as 50 Van Natta 1387 (1998)

In the Matter of the Compensation of
BRENDA DODSON, Claimant
WCB Case No. 95-09444
ORDER ON REVIEW
Willner & Associates, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Biehl, Bock and Haynes.

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

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

At hearing, claimant argued that her exposure to the polluted air at Taylor Hall was the major contributing cause of her fibromyalgia condition. The ALJ found that less than 50 percent of the time claimant spent at Taylor Hall involved activities as an employee and the rest of the time was spent as a student or in the performance of duties for outside sources. The ALJ reasoned that, assuming claimant has fibromyalgia and her exposure at Taylor Hall was 100 percent of the cause of the fibromyalgia, her job-related exposure was not sufficient to meet her burden of proof.

Claimant contends that even if she was working half of the time as a student and half of the time as an employee, Taylor Hall's polluted air caused her to contract an occupational disease, *i.e.*, fibromyalgia. She relies on Dr. Gillette's opinion that her exposure at Taylor Hall was the major contributing cause of her fibromyalgia condition. Claimant argues that Dr. Gillette did not distinguish between "full-time" and "part-time" employee-patients in discussing the etiology of fibromyalgia and, therefore, there is no basis for concluding that claimant's role at Taylor Hall should affect the outcome of the case. We disagree.

An occupational disease is "any disease or infection *arising out of and in the course of employment* caused by substances or activities to which an employee is not ordinarily subjected or exposed *other than during a period of regular actual employment.*" ORS 656.802(1)(a) (emphasis added). Under ORS 656.802(2)(a), claimant must prove that employment conditions were the major contributing cause of the disease. Claimant has the burden of proving that the occupational disease is compensable and of proving the nature and extent of disability. ORS 656.266.

We agree with the ALJ's conclusion that claimant has not established that the majority of her exposure at Taylor Hall was work-related and she did not establish compensability of her occupational disease claim. We therefore affirm the ALJ's order.

ORDER

The ALJ's order dated December 26, 1997 is affirmed.

Board Member Haynes specially concurring.

Although I agree with the lead opinion's conclusion, I write separately to indicate that I would also affirm on the basis that the medical evidence is insufficient to establish compensability.

Even if I assume, without deciding, that claimant does indeed have fibromyalgia and all of her exposure at Taylor Hall was work-related, the medical evidence does not establish that those conditions were the major contributing cause of her fibromyalgia condition. For the following reasons, I am not persuaded by Dr. Gillette's opinion. Dr. Gillette testified that "something" at Taylor Hall triggered an immunological response that resulted in claimant's fibromyalgia. (Tr. 50). He could not explain the precise mechanism or explain what the "something" was. (Tr. 51, 84, 86). Dr. Gillette testified that the immunological response was "theoretical" and he was not sure what actually triggers fibromyalgia. (Tr. 82). Nevertheless, he felt in claimant's case that it was "probable" that something in Taylor Hall had triggered her fibromyalgia. (*Id.*) He relied on the temporal relationship between claimant's time spent at Taylor Hall and her reported symptoms. (Tr. 86, 87).

Dr. Gillette's opinion is not persuasive because it is speculative and not based on medical probability. He was unable to identify a causal agent for claimant's fibromyalgia and he relied on the temporal relationship between the development of claimant's symptoms and her activities at Taylor Hall. Furthermore, Dr. Gillette acknowledged that none of the specific substances found in the air at Taylor Hall had been proven to cause fibromyalgia. (Tr. 82-83). Dr. Gillette's opinion is not well-reasoned and is insufficient to establish compensability.

None of the other medical opinions support compensability of claimant's fibromyalgia. Dr. Burton, Associate Director, Occupational and Environmental Toxicology at OHSU, found no evidence of a toxic exposure, toxicologic illness or building-related illness in claimant's case. (Ex. 7-13). Dr. Burton diagnosed depression associated with multiple somatic complaints and opined that the major contributing cause of claimant's symptoms was her underlying depression, which was unaffected by an occupational exposure. (Ex. 7-13, -15). He testified that there was no scientific literature to support any toxicologic or allergic cause of fibromyalgia. (Ex. 10-10). Furthermore, Dr. Burton concluded that there were not any organic, physical things in the building that could have resulted in claimant's symptoms. (Ex. 10-22).

Dr. Ochoa, neurologist, reported that claimant's complaints fit a somatoform pseudoneurological disorder. (Ex. 8a-35). He felt that her psychological condition accounted for most, if not all, of her complaints. (Ex. 8a-38).

Dr. Bardana, who is board certified in allergy and immunology, reported that there was no evidence that claimant's symptoms were caused or aggravated by any exposure to indoor pollutants while at work or studying at Taylor Hall. (Ex. 8c-23). He opined that the scientific literature had failed to associate fibromyalgia with any specific causation and he was unaware of any convincing or consistent medical studies that had associated fibromyalgia with indoor pollution of any kind. (Ex. 8c-24).

Dr. Klecan, psychiatrist, concluded that the preponderance of evidence indicated that claimant had no physical illness or disorder. (Ex. 9-6). He concluded that dependent, somatizing, hypochondriacal and suggestible personality traits were present within probability. (Ex. 9-7).

For the foregoing reasons, I would also conclude that claimant has not established that her employment conditions were the major contributing cause of her fibromyalgia condition.

In the Matter of the Compensation of
JOHN J. DRONKERS, Claimant
WCB Case No. 97-05107
SECOND ORDER ON RECONSIDERATION
Starr & Vinson, Claimant Attorneys
William J. Blitz, Defense Attorney

On May 20, 1998, we affirmed an Administrative Law Judge's (ALJ's) order that: (1) decreased claimant's scheduled permanent partial disability (PPD) award for loss of use or function of the right upper extremity from 25 percent (48 degrees) of the right arm, as granted by an Order on Reconsideration, to 27 percent (40.5 degrees) of the right forearm; and (2) decreased claimant's scheduled PPD award for loss of use or function of the left upper extremity from 25 percent (48 degrees) of the left arm, as granted by an Order on Reconsideration, to 25 percent (37.5 degrees) of the left forearm. The self-insured employer sought reconsideration of our May 20, 1998 order, reiterating its previously asserted position that the Director lacked authority to refer the claim to a medical arbiter under ORS 656.268(7)(a). On June 19, 1998, we issued an Order on Reconsideration adhering to and republishing our May 20, 1998 order.

We have now received claimant's separate motion for reconsideration of our May 20, 1998 order. On reconsideration, claimant seeks an impairment value for decreased elbow pronation and an out-of-compensation attorney fee.

As a preliminary matter, we note that the introductory paragraphs of our May 20, 1998 Order on Review and our June 19, 1998 Order on Reconsideration incorrectly identified the amount of scheduled PPD granted by the Department's reconsideration order. In addition, although the ALJ decreased the Department's award, the introductory paragraphs of these orders incorrectly stated that the ALJ increased the award. These errors have been corrected in the introductory paragraph of this order.[1]

We turn to claimant's contention that the ALJ and the Board erred in not awarding an impairment value for claimant's reduced elbow pronation. Where a medical arbiter is used, impairment is determined by the arbiter except where a preponderance of medical opinion, from the attending physician or other physicians with whom the attending physician concurs, establishes a different level of impairment. ORS 656.245(2)(b)(B) and 656.268(7); OAR 436-035-0007(13); *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, 670 (1994). Here, the ALJ concluded that a preponderance of the medical opinion indicated that claimant's diminished ranges of motion were not due to his compensable carpal tunnel syndrome (CTS). The ALJ relied on the treating physician's concurrence with Dr. Donahoo's opinion that "[t]he decreased range of motion in the shoulders, elbow, wrists and intrinsic joints of the hands is a combination of [claimant's] age, tendinous makeup, and his underlying arthritic condition [and the] carpal tunnel syndrome [and] truck driving on the trip to Idaho did not produce this constellation of symptoms." The ALJ also noted that the medical arbiter "did not opine about the causes of that impairment."

On reconsideration, claimant contends that the objective medical evidence establishes that the upper extremity osteoarthritis is limited to his hands and finger joints, and does not affect his elbows. Claimant also challenges the ALJ's conclusion that the arbiter did not address the cause of his reduced elbow pronation. Specifically, claimant contends that the arbiter's opinion supports a causal relationship between the CTS and the reduced elbow pronation because the arbiter did not attribute the loss of pronation to arthritis in the elbows. Claimant relies on the following language in the arbiter's opinion:

> "Osteoarthritis is causing some limitation of finger ROM and may be contributing to some of [claimant's] wrist pain and weakness. I do not have an objective basis to proportion the relative contribution of these two conditions, but would clinically estimate that carpal tunnel was responsible for 50-75% of [the] hand weakness and pain, and 100% of the sensory loss."

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[1] Whereas the Order on Reconsideration made an award for the right and left arms, the ALJ's award was made for the right and left forearm. That change resulted in a reduced award. *See* ORS 656.214(2)(a) and (b).

We do not agree that the objective medical evidence establishes that claimant has no arthritis in his elbows. The only medical evidence addressing this issue is Dr. Donahoo's opinion that the reduced elbow pronation is attributable to age, tendinous makeup, and arthritis, rather than the compensable CTS. The remaining medical record, including the arbiter's opinion, does not address the etiology of claimant's reduced elbow pronation. Claimant urges us to impute a causal relationship from the fact that the arbiter identified the reduced elbow pronation and did not expressly attribute it to a cause other than the compensable CTS. Medical evidence rating an impairment and describing it as consistent with a compensable injury does support a finding that the impairment is due to the compensable injury when the record discloses no other possible source of impairment. *See SAIF v. Danboise*, 147 Or App 550, 553, *rev den* 325 Or 438 (1997). Here, however, the treating physician concurred with Dr. Donahoo's identification of other possible sources of impairment, i.e., claimant's age, tendinous makeup and arthritis. On this record, we conclude that the preponderance of the evidence does not establish that the reduced elbow pronation is due to the compensable CTS.

We turn to the issue of attorney fees. Claimant's counsel contends that he is entitled to an attorney fee for his counsel's services at hearing, in the amount of 25 percent of the difference between the ALJ's award of PPD and the lesser award at closure. We disagree. The Department's reconsideration order awarded claimant's attorney an out-of-compensation fee equal to 10 percent of any increase in PPD beyond the amount awarded at claim closure. Claimant's attorney is not entitled to a separate 25 percent out-of-compensation fee for his services at hearing. Such a fee is authorized only when the ALJ increases the amount of PPD awarded under a Department reconsideration order. ORS 656.386(2); OAR 438-015-0040(1). Here, the ALJ reduced the PPD awarded under the Department's reconsideration order.

In summary, we continue to hold that claimant is not entitled to an impairment value for reduced elbow pronation. We further conclude that claimant's attorney is not entitled to an out-of-compensation fee for his services at hearing. Accordingly, we withdraw our June 19, 1998 Order on Reconsideration and our May 20, 1998 Order on Review. On further reconsideration, we adhere to and republish our May 20, 1998 Order on Review and our June 19, 1998 Order on Reconsideration, as supplemented herein. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
GEORGE D. HIXON, Claimant
WCB Case Nos. 97-07984 & 96-03728
ORDER ON REVIEW
Hilda Galaviz, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) upheld Liberty Northwest Insurance Corporation's partial denial of claimant's "new injury" claim for a cervical condition (C5-6 herniated disc); (2) upheld the SAIF Corporation's partial denial of claimant's "new injury" claim for the same condition; and (3) declined to assess penalties for Liberty's alleged discovery violation and allegedly unreasonable denial. On review, the issues are compensability, responsibility, and penalties. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact which we summarize as follows. In August 1988, claimant suffered a compensable injury to his neck at a SAIF-insured employer not a party to this claim. Claimant was diagnosed with a herniated disc at C6-7 for which three surgeries were performed. (Exs. 5, 17, 27). Diagnostic studies revealed a small central disc bulge at C5-6. (Exs. 8, 9, 12, 28). In October 1993, claimant suffered a compensable injury to his neck at a different employer, insured by Liberty,

also not a party to this claim. Claimant was diagnosed with a herniated disc at C7-T1 on the right, for which surgery was performed. (Ex. 61). Diagnostic studies showed mild, diffuse annular bulging at C5-6. (Ex. 58).

Beginning in about the summer of 1994 to August 1995, claimant worked for Liberty's insured. In April 1995, he sought treatment from Dr. Brett for assessment of his ongoing neck and low back pain with bilateral arm and leg dysesthesia. Claimant reported no work incidents to Dr. Brett at this time. After imaging studies, Dr. Brett noted some central bulging at C5-6, no other significant pathology, and no evidence of neural impingement, spinal canal compromise or spinal cord compression. Dr. Brett opined that claimant's current symptoms were related to the 1993 injury and surgery, and that claimant remained medically stationary. (Exs. 73 through 76). On December 5, 1995, Dr. Brett again evaluated claimant for neck and referred right scapular and shoulder pain. Brett found no radicular pain or any objective neurologic deficit, but did find ongoing moderate paracervical muscle spasm and reduced cervical range of motion, which he related to claimant's continued work in heavy construction. He found that claimant remained medically stationary. He also noted claimant's disc protrusion at C5-6. (Ex. 78).

On January 10, 1996, claimant filed a claim with Liberty for neck and low back injuries sustained during his employment with Liberty's insured in 1994 and 1995. (Ex. 77).

In March 1996, claimant was examined for Liberty by Drs. Smith and Hamby. They diagnosed a cervical strain and a lumbar strain, by history, as a result of the four reported injuries of 1994 and 1995. They opined that those injuries were the major contributing cause of claimant's need for treatment in April and December 1995, but that claimant's reduced range of motion in the cervical spine was due to his injuries occurring in 1993 and earlier. (Ex. 82). On April 4, 1996, Liberty denied claimant's C5-6 disc protrusion and lumbar strain conditions. (Ex. 83).

In January 1997, claimant returned to Dr. Brett for evaluation of his continuing neck and bilateral arm complaints. Subsequent to imaging studies, Dr. Brett concluded that claimant's complaints were arising from the C5-6 level and recommended anterior cervical discectomy and fusion at C5-6. (Ex. 87). Also in January 1997, Dr. Hamby reviewed his earlier written report for Liberty. (Ex. 86).

On June 5, 1997, claimant compensably injured his low back, head and neck while working for SAIF's insured. (Ex. 89). On July 3, 1997, as amended September 29, 1997, SAIF accepted disabling "low back contusion/strain, occipital contusion and neck strain." (Ex. 102).

On July 1, 1997, Dr. Brett opined that claimant's C5-6 disc herniation was a direct result of the multiple work injuries sustained while employed at Liberty's insured. (Ex. 103). On July 3, 1997, Dr. Brett found that claimant was continuing to experience neck and right scapular pain, but no radicular pain or clear-cut radicular symptoms into either upper extremity or long tract findings to suggest myelopathy. He noted that a repeat MRI showed a central disc protrusion persisting at C5-6 and slightly worse with some posterior displacement of the spinal cord and spinal stenosis. (Ex. 99). On August 1, 1997, subsequent to additional studies, Dr. Brett opined that claimant's pain into the right arm was due to chronic C7 and C8 radiculopathy. He also opined that claimant had a worsening disc protrusion centrally at C5-6, which he (Brett) thought to be the source of claimant's ongoing neck discomfort and referred interscapular and right scapular pain. (Exs. 110, 111).

On September 2, 1997, Dr. Bergquist evaluated claimant's C5-6 disc condition for SAIF. (Ex. 113).

On September 25, 1997, and again on October 13, 1997, claimant requested copies of his timecards while working at Liberty's insured. (Exs. 115A, 118A).

On September 26, 1997, as amended December 19, 1997, SAIF partially denied claimant's C5-6 disc herniation, on the ground that the June 5, 1997 injury at SAIF's insured was not the major contributing cause of that condition. (Ex. 115).

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant had failed to establish that his need for treatment and disability for his C5-6 disc condition were caused in major part by his employment at either Liberty's or SAIF's insured. We agree.

Here, the uncontroverted evidence indicates that claimant's C5-6 disc condition preexisted his employments at each employer. Therefore, he must prove that either the 1994/1995 work injuries at Liberty's insured or the June 1997 injury at SAIF's insured was the major contributing cause of the need for treatment and disability of the C5-6 herniated disc. 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), *aff'd mem* 153 Or App 125 (1998).

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 disc bulge at C5-6 and the two distinct work injuries in 1994-5 and 1997, 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).

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). After our *de novo* review of the record, we agree with the ALJ that there are persuasive reasons not to defer to Dr. Brett's opinions regarding the cause of claimant's C5-6 disc condition.

First, as discussed by the ALJ, Dr. Brett failed to explain the change in his opinion regarding the cause of claimant's C5-6 disc condition. In April and again in December 1995, Brett opined that claimant had no significant new pathology at C5-6. Yet, in July 1997, he opined that claimant's C5-6 disc herniation was a direct result of the multiple work injuries he sustained while employed at Liberty's insured. (*Compare* Exs. 74, 103). Then, on August 1, 1997, Brett opined, again without explanation, that "pathologic worsening [of the C5-6 disc protrusion] did occur with his new injuries of April 19, 1995 (sic) and again on June 5, 1997" and that the new injury of June 5, 1997 was the major contributing factor to claimant's need for surgery at C5-6. (Ex. 110). Finally, Brett stated that he felt that claimant's April 19, 1995 (sic) injury contributed "somewhat" to the pathology at C5-6, but, "were it not for his injury of [June 6, 1997], I do not feel that he would require operative intervention at this time." (Ex. 111).

Not only are Dr. Brett's changed opinions regarding causation unexplained, but they are undermined by his own findings in 1995 (during the period of claimant's work incidents with Liberty's insured) that claimant had no new pathology at C5-6. Moreover, as noted by the ALJ, Dr. Brett provided no explanation for his changed opinion regarding claimant's need for surgery. In January 1997, five months prior to the injury at SAIF's insured, Brett opined that claimant required anterior cervical diskectomy at C5-6. Subsequent to that injury, Brett opined that claimant would not need surgery at C5-6 absent the June 5, 1997 injury.

Finally, because Dr. Brett provided no evaluation of the relative contributions to claimant's C5-6 disc by his diagnosed degenerative disc disease, prior neck injuries and surgeries, as required by *Deitz* and *Noble*, we find additional reason not to find his opinion persuasive.

After reviewing claimant's cervical studies back to 1988, Dr. Bergquist opined that there had not been any pathological worsening of claimant's C5-6 disc bulge since that time. He attributed claimant's ongoing complaints of neck pain to the degenerative disc disease present since at least 1988, and opined that the preexisting degenerative condition was the major contributing cause of claimant's need for treatment. (Ex. 113).

Dr. Hamby initially opined, based on the medical history he obtained from claimant, that the major contributing cause of claimant's need for treatment in April and December of 1995 were the four separate job injuries sustained at Liberty's insured. (Ex. 82-12). However, subsequent to further review of claimant's history and Dr. Brett's April and December 1995 chart notes, Dr. Hamby concluded that claimant's soft tissue strains had combined with his preexisting cervical and lumbar conditions to cause or prolong his disability, and that the preexisting conditions were the major contributing cause of claimant's need for treatment in April and December 1995. Like Dr. Bergquist, Dr. Hamby also opined that claimant's C5-6 disc, which had been present since 1988, was a mild bulge, not a herniation, and

that it was not caused in major part by the work incidents at Liberty's insured. Finally, based on EMG studies of July 1997, Dr. Hamby concluded that the bulge at C5-6 was not causing claimant's current symptoms, and that claimant's work restrictions were due to his earlier injuries and surgeries to his spine. (Ex. 121A-22).

We find both Dr. Bergquist's and Dr. Hamby's opinions more persuasive than the unexplained changes of opinion provided by Dr. Brett. Therefore, we conclude that claimant has failed to prove that his C5-6 disc and need for treatment or disability are compensably related to his employment.

Because claimant's C5-6 disc condition is not compensable, we need not address the issue of responsibility.

Penalties

We adopt and affirm that portion of the ALJ's opinion that Liberty's failure to provide discovery was not unreasonable.

In addition, because there were no amounts due at the time of Liberty's allegedly unreasonable denial, there is no basis for a penalty. ORS 656.262(11)(a); *Wacker Siltronic v. Satcher*, 103 Or App 513 (1990). Moreover, claimant is not entitled to an assessed attorney fee under ORS 656.382(1) because the insurer did not unreasonably resist the payment of compensation. *SAIF v. Condon*, 119 Or App 194 (1993).

ORDER

The ALJ's order dated March 12, 1998 is affirmed.

In the Matter of the Compensation of
JAN M. HULKE, Claimant
WCB Case No. 97-08431
ORDER ON REVIEW
Charles L. Lisle, Claimant Attorney
Ronald W. Atwood, Defense Attorney

Reviewed by Board Members Hall and Moller.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Michael V. Johnson's order that affirmed an Order on Reconsideration that awarded 5 percent (16 degrees) unscheduled permanent disability for a right shoulder condition. On review, the issue is extent of unscheduled permanent disability.

We adopt and affirm that portion of the ALJ's order regarding claimant's non-impairment factors, with the following supplementation to address claimant's arguments regarding impairment.

In September 1995, claimant experienced the progressive onset of pain and limitations in the use of her right arm and shoulder. On October 9, 1996, Dr. Weiner performed surgery, which he identified as "right anterior shoulder modified Bankart reconstruction and capsular shift procedure." (Exs. R22, R23, R33-2). On April 3, 1997, Dr. Weiner declared claimant medically stationary and released her to regular work. (Exs. R27, R29). The claim was closed by a May 21, 1997 Determination Order that awarded 1 percent unscheduled permanent disability for reduced range of motion in the right shoulder. (Ex. R30).

Claimant requested reconsideration and, among other issues, requested promulgation of a temporary rule for her "right anterior shoulder modified Bankart reconstruction and capsular shift procedure," on the basis that OAR 436-035-0330(13) provided no impairment value for that surgery. The request for a temporary rule was denied. An arbiter panel was appointed and, based on their impairment findings, the October 3, 1997 Order on Reconsideration awarded a total of 5 percent unscheduled permanent disability for the right shoulder. (Ex. R34). Claimant requested a hearing.

At hearing, claimant argued that she should be awarded additional unscheduled permanent disability under OAR 436-035-0330(13) for a "total shoulder arthroplasty," and for non-impairment factors. The ALJ found that claimant had not sustained a "total shoulder arthroplasty" and that she had been released to regular work. Therefore, the ALJ concluded that claimant was not entitled to additional unscheduled permanent disability.

On review, claimant continues to seek additional unscheduled permanent disability based on a "total shoulder arthroplasty" pursuant to OAR 436-035-0330(13)[1], or, alternatively, a temporary rule for her "right anterior shoulder modified Bankart reconstruction and capsular shift procedure" under ORS 656.726(3)(f)(C). We reject both requests.

Claimant refers to no medical evidence in support of her contention, relying instead on definitions of "arthroplasty" as provided in medical dictionaries. Dr. Weiner, claimant's attending physician, reported the surgery he performed as "right anterior shoulder modified Bankhart reconstruction and capsular shift procedure," which he also identified as "anterior shoulder reconstruction surgery." (Exs. R22, R23, R25, R27). There is no medical evidence that the surgery performed on claimant's right shoulder was a "total shoulder arthroplasty." (Exs. R22, R24, R26, R32). Thus, because there are no medical findings in the record to establish that claimant underwent a "total shoulder arthroplasty," she has not established an impairment ratable under ORS 436-035-0330(13).

Finally, we need not address claimant's alternative argument regarding a temporary rule, as she withdrew that argument at hearing. (Claimant's Opening Argument at 4).

ORDER

The ALJ's order dated April 6, 1998 is affirmed.

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[1] OAR 436-035-0330(13) provides in relevant part:

"Shoulder surgery is rated as follows:

"* * * * *

"Total shoulder arthroplasty 30%"

In the Matter of the Compensation of
FLOYD L. SHELTON, Claimant
WCB Case No. 97-07211
ORDER ON REVIEW
Schneider & Hooton, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Livesley's order which determined that claimant's claim was prematurely closed. On review, the issue is premature claim closure.

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

Claimant sustained a compensable injury on November 18, 1996 that the insurer accepted as a lumbosacral strain. In March 1997, Dr. Blome became claimant's attending physician and diagnosed depression. (Ex. 9). On May 5, 1997, the insurer closed the claim by Notice of Closure, which found that claimant was medically stationary on March 19, 1997, based on the medical report of an examining physician, Dr. Hills. After claim closure, Dr. Blome was asked if he concurred with the Hills report, but indicated that he did not. (Ex. 16).

Claimant requested reconsideration of the closure notice, raising several issues, including premature claim closure. A September 4, 1997 Order on Reconsideration affirmed the Notice of Closure, finding that the closure was not premature. Claimant requested a hearing.

The ALJ found that the claim was prematurely closed. In reaching this conclusion, the ALJ reasoned that, because there was no showing that claimant's depression condition was medically stationary prior to claim closure, claimant was not medically stationary with respect to all injury-related conditions as required by *Rogers v. Tri-Met*, 75 Or App 470 (1985). Therefore, the closure was improper. The ALJ also determined that the accepted back condition could be expected to improve with additional treatment, based on Dr. Blome's opinion that a combination of physical medicine and psychological treatment would improve claimant's back pain.

Citing *James L. Mack*, 50 Van Natta 338 (1998), the insurer contends on review that the focus should be on accepted conditions at the time of claim closure in determining whether a claim is prematurely closed. *See also Julio C. Garcia-Caro*, 50 Van Natta 160 (1998) (in the absence of evidence that 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). Inasmuch as claimant's depression condition was not an accepted condition, the insurer asserts that the ALJ incorrectly considered that condition in finding that the claim was prematurely closed.

Following closure of the claimant's injury claim for a number of accepted physical conditions, the carrier in *Mack* accepted several other conditions, including reactive depression. Although the carrier reopened the claim for the processing of these "post-closure" accepted conditions, the claimant contended that the initial closure was premature because the record did not establish that his psychological condition was medically stationary when the claim was closed. Relying on *Utera v. Dept. of General Services*, 89 Or App 114, 116 (1987), the claimant contended that his injury-related psychological condition should have been considered at claim closure and, because it had not, the closure must be set aside as premature.

We disagreed with the claimant's contention. Citing the 1997 amendments to ORS 656.262(7)(c), we noted that "if a condition has been found compensable after claim closure, the [carrier] shall reopen the claim for processing regarding that condition." In light of that statutory amendment, we concluded that a determination of whether a claim has been prematurely closed must focus only on those conditions accepted at the time of closure. We found further support for our conclusion in other provisions of the aforementioned statutory amendment that require a carrier to issue an "updated notice of acceptance that specifies which conditions are compensable" and state that any objection to the updated notice "shall not delay claim closure pursuant to ORS 656.268." In addition, we considered our reasoning consistent with the rationale expressed in *Anthony J. Telesmanich*, 49 Van Natta 49, 51 (1997), *on recon* 49 Van Natta 166 (1997), and *Bernard G. Hunt*, 49 Van Natta 223 (1997), that only conditions that were accepted at claim closure were ratable and that "post-closure" accepted conditions must be remanded to the carrier for further processing.

Here, like *Mack*, there were pre-closure references to an injury-related, unaccepted psychological condition. However, unlike *Mack*, there has been no "post-closure" acceptance of claimant's psychological condition. Therefore, there is an issue of whether the *Mack* rationale applies to cases such as this. However, we need not determine that issue because we agree with the ALJ's reasoning and conclusion that Dr. Blome's opinion establishes that claimant's accepted back condition could be expected to improve with additional medical treatment consisting of physical medicine and psychological treatment. Therefore, considering claimant's accepted back condition, we agree with the ALJ that the claim was prematurely closed.

Claimant's attorney is entitled to an assessed fee for services on review concerning the premature claim closure issue. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the premature closure issue is $750 payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated March 24, 1998 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $750, to be paid by the insurer.

In the Matter of the Compensation of
MICHAEL C. REDDIN, Claimant
WCB Case Nos. 97-05669 & 97-00730
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Moller and Hall.

AIG Claim Services requests review of Administrative Law Judge (ALJ) McWilliams' order that: (1) set aside its partial denial, issued on behalf of ADIA Services, of claimant's current left shoulder condition; and (2) upheld the SAIF Corporation's partial denial, issued on behalf of Battery X-Change & Repair (Battery), of the same condition. In the event that its denial is upheld, AIG/ADIA contends that this matter should be remanded to the ALJ to resolve its cross-appeal of the temporary disability and permanent disability awarded by an Order on Reconsideration. In his respondent's brief, claimant contends that, if we affirm the ALJ's decision setting aside AIG/ADIA's denial, the Order on Reconsideration must be modified to set aside as premature the Determination Order that closed his 1994 injury claim with AIG/ADIA. In addition, claimant has submitted with his respondent's brief a one-page document for admission into evidence. We treat claimant's submission as a motion for remand. *See Judy A. Britton*, 37 Van Natta 1262 (1985). On review, the issues are compensability, responsibility, remand, premature claim closure, temporary disability, and extent of unscheduled permanent disability. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

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

Based on the opinion of claimant's treating orthopedist, Dr. Macha, the ALJ concluded that claimant had proved that his current left shoulder condition, diagnosed as unidirectional (anterior) instability superimposed on multidirectional instability and involving the biceps labral complex and the inferior labrum, was related in major part to his prior accepted 1991 injury with SAIF/Battery and his accepted 1994 injury with AIG/ADIA.[1]

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[1] The ALJ did not identify the statute that was applied to determine that claimant's current condition is compensable, but it appears that she applied ORS 656.005(7)(a)(A), which provides that "[n]o 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." Because the statutory language refers to the consequence of *a* compensable *injury*, it is questionable whether the statute applies to cases such as this one, where the medical evidence indicates that the major cause of the consequential condition is the combination of *multiple* accepted injuries. However, we need not address that question in this case because the parties do not challenge the ALJ's application of the statute. In any event, if such a challenge had been raised, we would conclude that the last injurious exposure rule (called "last injury rule" in the successive injury context, *see Hensel Phelps Const. v. Mirich*, 81 Or App 290, 293-94 (1986)), specifically the rule of proof, relieved claimant of the burden of proving medical causation as to a particular claim or employer and that it was sufficient for him to prove that his current condition is, in major part, a consequence of prior work-related injuries. *See Boise Cascade Corp. v. Starbuck*, 296 Or 238, 242-43 (1984) (quoting *Bracke v. Baza'r*, 293 Or 239, 246 (1982)).

On review, AIG contends that claimant's current left shoulder condition claim is barred by *res judicata*. AIG argues that the current left shoulder condition is the same condition that it denied by letter dated June 28, 1996. Although claimant requested a hearing from that denial, he subsequently withdrew his hearing request and the denial became final. The June 28, 1996 denial letter stated in part:

> "*We are in receipt of a claim* filed on your behalf by [your attorney] *for a condition of a rotator cuff tear of the left shoulder.*
>
> "After careful review of your file, we find that there is insufficient medical evidence to support that your 03-24-96 work injury caused a left shoulder rotator cuff tear *or caused an objective worsening of a pre-existing left shoulder condition.*
>
> "Therefore, without waiving further issues of compensability or responsibility, *we hereby issue this partial denial of a left shoulder rotator cuff tear condition.*" (Ex. 101, italics added).

AIG points to the above-emphasized language in the second paragraph of the denial letter as stating an intent to deny the same left shoulder condition that is the subject of claimant's current claim. However, based on our reading of the denial letter as a whole, we conclude that the denial was of a left shoulder rotator cuff tear condition only. We base our interpretation on the above-emphasized language in the first and third paragraphs, which specifically refer to a claim for, and denial of, a rotator cuff tear condition. When the second paragraph is read in the context of the denial letter as a whole, we find that AIG's intent was to deny a rotator cuff tear, as either a new condition or a worsening of a preexisting condition. Although AIG cites to extrinsic evidence to support a broader interpretation of its denial, it is bound by the express language of its denial. *See Tattoo v. Barrett Business Service*, 118 Or App 348, 351-52 (1993); *Gregg Muldrow*, 49 Van Natta 1866, 1867 (1997). Based on our interpretation of the express language of the denial as a whole, we conclude that claimant's current left shoulder condition claim was not barred by *res judicata*.

Furthermore, to the extent that the June 28, 1996 denial letter could be interpreted to deny *any* alleged worsening of a left shoulder condition (aside from a rotator cuff tear), we would find that claimant did not make a claim for his current left shoulder condition (*i.e.*, unidirectional instability superimposed on multidirectional instability and involving the biceps labral complex and the inferior labrum) prior to issuance of the denial, nor did he seek treatment for the condition prior to the denial. The record shows that claimant first sought treatment for his current left shoulder condition on July 25, 1996, (Ex. 102), and that the current diagnosis (*i.e.*, anterior/unidirectional instability) was not made by Dr. Macha until October 1996. (Exs. 117, 119). Because the current left shoulder condition was neither diagnosed nor treated prior to the June 28, 1996 denial, we conclude that it could not have been the subject of the denial. For these reasons, claimant was not precluded by the prior denial from asserting the current left shoulder condition claim.

Responsibility

The ALJ applied ORS 656.308(1)[2] to find that claimant's current left shoulder condition is materially related to-and involved the same condition that was processed under-the accepted 1994 injury claim with AIG/ADIA. The ALJ therefore assigned responsibility for the current condition to AIG/ADIA. On review, AIG/ADIA contends that the ALJ erroneously applied ORS 656.308(1) to assign responsibility for the current left shoulder condition to its 1994 injury claim. In particular, AIG argues that the current left shoulder condition does not involve the "same condition" that was processed as part of the 1994 injury claim with AIG/ADIA. We modify the ALJ's conclusions and opinion regarding this issue.

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[2] ORS 656.308(1) provides:

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

Subsequent to the ALJ's order, the Court of Appeals held in *Conner v. B & S Logging*, 153 Or App 354 (1998), that ORS 656.308(1) does not apply to an initial claim for a previously unaccepted condition caused by earlier work-related injuries. *See SAIF v. Yokum*, 132 Or App 18, 22-23 (1994). In this case, it is not disposition whether the current left shoulder condition was "processed as part of" both the 1991 and 1994 claims. Rather, as the court stated in *Conner*, the proper inquiry is to determine whether the current condition claim is for a condition that was previously "accepted." After reviewing the record, we are not persuaded that the current left shoulder condition (*i.e.*, anterior/unidirectional instability) was accepted either by SAIF/Battery as part of the 1991 claim or by AIG/ADIA as part of the 1994 claim. In fact, the current condition was first treated and diagnosed after the 1991 and 1994 claims had been closed. Because claimant's current condition was not previously "accepted," ORS 656.308(1) does not apply to this claim. *See Conner*, 153 Or App at 358 n 2.

In *Conner*, after holding that ORS 656.308(1) did not apply to the current condition claim, the court concluded, based on medical evidence indicating that the current condition was caused by one of the prior accepted injuries, that ORS 656.005(7)(a)(A) provided the proper analysis. *Id.* Finding substantial evidence to support the finding that one of the prior accepted injuries was the major cause of the current condition, the court concluded that the carrier responsible for that accepted injury was responsible for the current consequential condition as well. *Id.*

In this case, treating orthopedist Dr. Macha opined that the two prior accepted injuries "in combination" were the cause of the current condition. (Exs. 132, 134). We agree with the ALJ's conclusion that Dr. Macha's opinion is persuasive and establishes that the two prior accepted injuries were the major contributing cause of the current condition. Because the medical evidence attributes the current condition to prior accepted injuries, it would appear that ORS 656.005(7)(a)(A) provides the proper analysis in this case as well.[3] However, unlike the medical evidence in *Conner*, Dr. Macha's opinion does not establish that either one of the accepted injuries alone was the major contributing cause of the current condition. Therefore, the responsibility issue cannot be resolved by application of ORS 656.005(7)(a)(A) alone, as it was in *Conner*.

Under these particular circumstances, we hold that the responsibility issue must be resolved by application of the last injury rule and the rebuttable presumption in *Industrial Indemnity Co. v. Kearns*, 70 Or App 583 (1984). The last injury rule, specifically the rule of assignment of liability, and the *Kearns* presumption provide that, in cases involving multiple accepted injuries involving the same body part as the current condition, there is a rebuttable presumption that the last injury independently contributed to the current condition. *See, e.g., Raymond H. Timmel*, 47 Van Natta 31 (1995). The last accepted injury to claimant's left shoulder was in 1994 with AIG/ADIA. Furthermore, based on Dr. Macha's persuasive opinion, we conclude that AIG/ADIA has failed to prove that there is no causal connection between the 1994 injury and the current condition. To the contrary, Dr. Macha's opinion affirmatively establishes that the 1994 injury independently contributed to the current condition. Having failed to rebut the *Kearns* presumption, AIG/ADIA must be held responsible for the current left shoulder condition.[4]

Claimant's attorney is entitled to an assessed fee for successfully defending against AIG/ADIA's appeal. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee regarding the denial issues is $1,400, to be paid by AIG/ADIA. 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 a fee for services regarding the premature closure, temporary disability and permanent disability issues.

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[3] There is also medical evidence supporting the application of ORS 656.005(7)(a)(B) to this claim. However, even if we were to apply that provision, we would reach the same outcome.

[4] Because we conclude that claimant has prevailed on the merits of the compensability and responsibility issues based on the existing record, we need not address his motion to remand this case to the ALJ for further supplementation of the record regarding those issues (with the one-page document submitted on review).

Premature Closure

After setting aside AIG's denial, the ALJ stated that the issues relating to the Order on Reconsideration dated August 4, 1997, which closed the accepted 1994 injury claim with AIG, were "mooted by the imposition of responsibility upon [AIG] which will result in further processing and a new claim closure." (O&O, p. 9). Among the issues raised was whether the 1994 injury claim was prematurely closed by the Determination Order dated April 25, 1997.

On review, claimant contends that, if we affirm the ALJ's decision setting aside AIG's denial of his current condition, then the 1994 injury claim must be deemed prematurely closed. We disagree with claimant's contention, but modify the ALJ's order to address the premature closure issue.

Subsequent to the ALJ's order, we held in *James L. Mack*, 50 Van Natta 338 (1998), that under the current statutory scheme, as amended in 1997, a determination of whether a claim has been prematurely closed (because the worker was not medically stationary) must focus only on those conditions that were *accepted* at the time of claim closure. We further held that an evaluation of condition(s) accepted after claim closure must await the reopening and processing of the claim for the new condition(s). *Id.* In reaching those conclusions, we relied primarily on *amended* ORS 656.262(7)(c), which went into effect on July 25, 1997 and was made fully retroactive. That provision states, in part, 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., §§ 1, 2 (July 25, 1997).

In this case, claimant's current left shoulder condition was not an accepted condition when the 1994 injury claim was closed on April 25, 1997. Therefore, the issue of whether the current condition was medically stationary at the time of claim closure is not relevant to a determination of whether the claim was prematurely closed. *See id.* For this reason, we reject claimant's contention that the setting aside of AIG's denial should automatically result in a determination that claim closure was premature. We also reject the notion that the premature closure issue was mooted by the setting aside of AIG's denial. Instead, we conclude that the premature closure issue remained ripe for adjudication, but only as to those conditions that were accepted at the time of claim closure.

We turn to the merits of the premature closure issue. At the time of claim closure, the following conditions were in accepted status: Low back and neck strain, left shoulder strain, and left biceps tendinitis. (Ex. 106A). In order to establish that his claim was prematurely closed, claimant must carry the burden of proving by a preponderance of the evidence that the above-listed conditions were not medically stationary on April 25, 1997, the date of claim closure. *See Berliner v. Weyerhaeuser Co.*, 54 Or App 624, 628 (1981). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment, or the passage of time. ORS 656.005(17). We conclude that claimant has not carried his burden of proof.

On December 5, 1996, Dr. Strum, orthopedist, examined claimant at AIG's request. Dr. Strum opined that claimant's left shoulder strain and left biceps tendinitis were medically stationary on that date. (Ex. 123-7). On March 19, 1997. claimant was also examined by Dr. Gripekoven, orthopedist, at AIG's request. Dr. Gripekoven declared that claimant's left shoulder sprain and biceps tendinitis and lumbar sprain were medically stationary. (Ex. 131A-6).

Dr. Macha, treating orthopedist, wrote a letter on March 20, 1997 stating that claimant required further treatment for his *current* left shoulder condition. (Exs. 132). In addition, Dr. Macha opined, by check-the-box response dated May 2, 1997, that he "d[id] not concur that [claimant's] condition in relation to his injury of March 25, 1994 [was] medically stationary." (Ex. 135-2). Subsequently, Drs. Strum and Gripekoven adhered to their earlier opinions that claimant's left shoulder condition was medically stationary, with Dr. Gripekoven adding that the 1994 injury "can be considered medically stationary." (Exs. 138-1, 139-2).

After reviewing the medical opinions in the record, we conclude that claimant has not carried his burden to prove that the conditions in accepted status at the time of claim closure were not medically stationary at that time. Although Dr. Macha's "medically stationary" opinion ordinarily would be entitled to deference because of his status as claimant's treating physician, *see Weiland v. SAIF*, 64 Or App 810, 814 (1983), his opinion must be discounted because it was based on consideration of claimant's

current left shoulder condition, which was in denied status at the time of claim closure. As we held in *Mack*, the medically stationary status of non-accepted conditions is irrelevant to the premature closure determination. Because claimant has not carried his burden of proving his claim was prematurely closed, we conclude that the Determination Order properly closed the claim on April 25, 1997. We modify the ALJ's order accordingly.

Temporary Disability

Having found that claim closure was proper, we turn to AIG/ADIA's cross-appeal of the temporary disability awarded by the Order on Reconsideration. AIG contends that, upon redetermination of the claim following the conclusion of vocational training, the Department erroneously awarded temporary disability for periods when claimant was not actively engaged in vocational training. We agree, and modify the ALJ's order regarding this issue.

The parties stipulated at hearing that the 1994 injury claim was reopened for an authorized training program and that claimant was involved in the program on June 15, 1996, and from September 3, 1996 through November 1, 1996. (Tr. 3, 11-12). Furthermore, contrary to the finding by the Department's Appellate Reviewer at reconsideration, we find no evidence that claimant filed an aggravation claim with AIG/ADIA or that the 1994 injury claim with AIG/ADIA was reopened for an aggravation.[5] Under these circumstances, claimant's substantive entitlement to temporary disability for the period of claim reopening is governed by ORS 656.268(9), which provides that "the worker shall receive temporary disability compensation while the worker is enrolled and actively engaged in the [vocational] training."

Based on the parties' stipulation, we find that claimant was "enrolled and actively engaged" in vocational training on June 15, 1996 and from September 3, 1996 through November 1, 1996. Therefore, under ORS 656.268(9), claimant was entitled to temporary disability compensation for the periods of June 15, 1996[6] and from September 3, 1996 through November 1, 1996. Accordingly, the Order on Reconsideration shall be modified to award temporary disability, less any time worked, for the day of June 15, 1996, in addition to the Determination Order's award of temporary disability for the period from September 3, 1996 through November 1, 1996.

Permanent Disability

AIG also cross-appealed the 14 percent (44.8 degrees) unscheduled permanent disability awarded by the Order on Reconsideration.[7] The Department's Appellate Reviewer based the award on the impairment findings made by the examining orthopedist, Dr. Gripekoven. (Exs. 131A, 137 pp. 3-4). There is no evidence that Dr. Macha, the attending physician, concurred with those impairment findings. (Ex. 135).

When rating impairment due to a compensable injury, only the opinions of the attending physician and the medical arbiter(s), if any, may be considered. *See Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666 (1994); *Roseburg Forest Products v. Owen*, 129 Or App 442 (1994). The impairment findings of an independent (insurer-requested) medical examiner may be used only when the attending physician has ratified those findings. *Owen*, 129 Or App at 445; *Raymond D. Lindley*, 44 Van Natta 1217 (1992).

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[5] It appears that the Appellate Reviewer may have misinterpreted the aggravation claim that claimant filed with SAIF/Battery, (Ex. 133A), as an aggravation claim filed with AIG/ADIA.

[6] AIG argues that claimant appeared to have waived his entitlement to temporary disability for the day of June 15, 1996 by entering the "Proposed and Final Letter of Agreement" dated August 14, 1996. (Ex. 106). Based on our reading, however, the Letter of Agreement merely provided for a *new* start date for vocational training; it does not preclude a finding that claimant was enrolled and actively engaged in training prior to the date of the agreement, nor does it purport to resolve any issue regarding claimant's entitlement to temporary disability.

[7] Although claimant also raised the permanent disability issue in his hearing request from the Order on Reconsideration, he subsequently withdrew that issue at hearing. (Tr. 3-4).

Because Dr. Gripekoven examined claimant at AIG's request, and Dr. Macha did not ratify Dr. Gripekoven's impairment findings, those findings may not be considered in rating permanent disability. Furthermore, no medical arbiter was appointed after completion of vocational training, and Dr. Macha did not make any ratable findings regarding claimant's permanent impairment following completion of training. Under these circumstances, the record contains no probative evidence on which to base a redetermination of claimant's permanent disability. Absent measurable impairment, claimant is not entitled to an unscheduled permanent disability award. *See* OAR 436-035-0320(3). For this reason, the Order on Reconsideration shall be modified to award no additional unscheduled permanent disability for the 1994 injury.[8] The ALJ's order is modified accordingly.

Because AIG/ADIA has prevailed on the merits of the temporary disability and permanent disability issues based on the existing record, we need not address its motion to remand this case to the ALJ for further supplementation of the record regarding those issues.

ORDER

The ALJ's order dated November 5, 1997 is modified in part and affirmed in part. The portion of the ALJ's order that concluded that the issues regarding the Order on Reconsideration (*i.e.*, premature closure, temporary disability and permanent disability) were moot, is modified. The Order on Reconsideration dated August 4, 1997 is modified to award temporary disability, less any time worked, for the periods of June 15, 1996 and from September 3, 1996 through November 1, 1996, and to award no additional unscheduled permanent disability for the 1994 left shoulder injury. The ALJ's order is otherwise affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,400, payable by AIG/ADIA.

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[8] With the "post-closure" acceptance of claimant's current left shoulder condition (as a result of this order affirming the ALJ's decision on the compensability/responsibility issue), AIG/ADIA is required to "reopen the claim for processing regarding that condition." *See* ORS 656.262(7)(c).

In the Matter of the Compensation of
CAROL J. INGRAM, Claimant
WCB Case No. 97-06351
ORDER OF ABATEMENT
Swanson, Thomas & Coon, Claimant Attorneys
Reinisch, McKenzie, et al, Defense Attorneys

Claimant requests reconsideration of that portion of our June 15, 1998 Order on Review that reversed an Administrative Law Judge's (ALJ's) order that set aside the insurer's denial of claimant's right radial tunnel syndrome claim. On reconsideration, claimant submits two reports from her treating physician. Claimant contends that the reports were not available at the time of hearing. Consequently, claimant seeks admission of the reports on review or, alternatively, seeks remand to the ALJ for purposes of reopening the record and admission and consideration of the new exhibits.

We have also received the employer's response to claimant's motion. The employer opposes claimant's motion and contends that claimant must show that the evidence was unobtainable (as opposed to being unavailable) with due diligence at the time of hearing. *See William R. Wallace*, 49 Van Natta 1078 (1997). The employer also argues that the evidence must be likely to affect the outcome of the case, and in this case, the additional reports of Dr. Puziss are cumulative and will not affect the outcome. *See Randy Baker*, 50 Van Natta 316 (1998); *Emery E. Grim, Jr.*, 50 Van Natta 101 (1998).

In order to further consider claimant's motion and memorandum in support and the employer's response, we withdraw our June 15, 1998 order. Furthermore, in light of the cases raised by the employer's response, we implement the following supplemental briefing schedule. Claimant is permitted to submit further argument on the remand issue. Claimant's response is due within 14 days of the date of our order. The employer's response, if any, is due within 10 days of the date of

claimant's supplemental response. The parties' supplemental arguments should address the cases cited above and any other relevant cases on the remand issue. Following our receipt of the parties' supplemental arguments, we will take this matter under advisement.

IT IS SO ORDERED.

July 13, 1998 Cite as 50 Van Natta 1402 (1998)

In the Matter of the Compensation of
JOSEPH E. YATES, Claimant
WCB Case No. C8-00560
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Stephen A. Moen, Claimant Attorney
Kenneth W. Stodd, Defense Attorney

Reviewed by Board Member Biehl and Haynes.

On June 29, 1998, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for his compensable injury. We approve the proposed disposition.

On May 20, 1998, we disapproved the parties' previous CDA. *Joseph E. Yates*, 50 Van Natta 970 (1998). As originally submitted, the proposed CDA provided that the consideration was the insurer's reduction of its third party lien by the amount of $1,250. However, the CDA did not provide the full amount of the insurer's lien or the amount of the settlement.

In our order disapproving the parties' previous CDA, we indicated that without the third party settlement amount and the full amount of the carrier's lien, we were unable to determine the value of the consideration flowing to claimant under the CDA. *See Michael Salber*, 48 Van Natta 757 (1996) (Board generally disapproves CDAs in which the consideration consists of a carrier's reduction of a lien, but the CDA contains no information concerning the amount of the third party settlement or judgment). Thus, the prior CDA was disapproved as unreasonable as a matter of law. *See* ORS 656.236(1)(a)(A).

On June 29, 1998, we received the parties' "Second Addendum to Claim Disposition Agreement," which addresses the issue of concern in our disapproval order. Specifically, the current CDA now provides the amount of claimant's third party settlement ($18,252.77) and the full amount of the insurer's third party lien ($4,757.77). With this additional information, we are now able to ascertain the "value" of the consideration flowing to claimant as a result of the third party settlement. Thus, the current CDA is not unreasonable as a matter of law.[1]

Because the agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board, the parties' claim disposition agreement is approved. *See* ORS 656.236(1).

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] In reaching this conclusion, we have considered claimant's "current" CDA to encompass the originally submitted CDA, as well as all of the subsequently filed addendums.

In the Matter of the Compensation of
DEMOND L. CLARK, Claimant
WCB Case No. 94-15330
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Brazeau's order that set aside its denial of claimant's right hand injury claim. On review, the issue is whether the injury is within the course and scope of employment.

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

For an injury to be compensable, it must arise out of and in the course of employment. ORS 656.005(7)(a). In *Redman Industries, Inc. v. Lang*, 326 Or 32 (1997), the Supreme Court explained that, in evaluating whether the injury "arises out of" the employment, we must look to whether the risk of injury resulted from the nature of the work or whether the work environment exposed the worker to the risk of his injury. Unless the motivation for the workplace assault is an event or circumstance pertaining to the employee separate and apart from the workplace and the assault was not fueled, in part, by any workplace event, the *Lang* court has determined that injuries sustained in workplace assaults are generally considered to arise out of employment. 326 Or at 41. Here, we agree with the ALJ's reasoning and conclusion that claimant's injury "arose out of" his employment and we adopt that portion of his order.

The *Lang* court also discussed the effect of ORS 656.005(7)(b)(A)[1] and, in particular, held that, based on the Board's finding that the claimant was not an "active participant" in the assault that injured him, the statutory exclusion was not applicable and the claim was compensable. 326 Or 41-42. Because we agree with the ALJ that claimant was not an "active participant," and because the *Lang* court has ruled that all elements of the statutory exclusion must be satisfied, we concur with the ALJ's conclusion that ORS 656.005(7)(b)(A) is not applicable. Consequently, we find the claim compensable. ORS 656.005(7)(a).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,800, 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 February 10, 1998 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,800, to be paid by the self-insured employer.

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[1] ORS 656.005(7)(b)(A) provides: "'Compensable injury' does not include * * * [i]njury to any active participant in assaults or combats which are not connected to the job assignment and which amount to a deviation from customary duties[.]"

In the Matter of the Compensation of
ALBERT L. CRAWFORD, Claimant
WCB Case No. 95-11714
ORDER OF DISMISSAL
Heiling, Dodge & Associates, Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

On June 24, 1998, we received claimant's request for review of Administrative Law Judge (ALJ) Menashe's May 30, 1996 order. We have reviewed the request to determine whether we have jurisdiction to consider the matter. Because the record does not establish that the Board received a timely request for review within 30 days of the ALJ's order, we dismiss.

FINDINGS OF FACT

On May 30, 1996, the ALJ issued an Opinion and Order upholding the SAIF Corporation's denials of claimant's accidental injury and occupational disease claims. Copies of that order were mailed to claimant, claimant's attorney, the employer, SAIF, and its counsel. The order contained a statement explaining the parties' rights of appeal, including a notice that a request for Board review must be mailed to the Board and to the other parties to the proceeding within the 30-day appeal period.

On June 24, 1998, the Board received a letter from claimant's attorney stating that he had appealed the ALJ's order on June 5, 1996, and requesting that the Board advise counsel of the status of the case. Attached to the letter was a letter dated June 5, 1996 from claimant's attorney to the Board stating that "[c]laimant appeals the Opinion and Order in this claim." There is no indication that the June 5, 1996 letter was mailed by means of certified mail.

On July 2, 1998, the Board mailed its computer-generated letter to all parties acknowledging its receipt of claimant's June 24, 1998 request for review.

CONCLUSIONS OF LAW AND OPINION

An ALJ's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. *See* ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the ALJ. ORS 656.295(5). Compliance with ORS 656.295 requires that statutory notice of the request be mailed or actual notice be received within the statutory period. *Argonaut Insurance Co. v. King*, 63 Or App 847, 852 (1983).

Filing means the physical delivery of a thing to any permanently staffed office of the Board, or the date of mailing. OAR 438-005-0046(1)(a). If filing of a request for Board review of an ALJ's order is accomplished by mailing, it shall be presumed that the request was mailed on the date shown on a receipt for registered or certified mail bearing the stamp of the United States Postal Service showing the date of mailing. OAR 438-005-0046(1)(b). If the request is actually received by the Board after the date of filing, it shall be presumed that the mailing was untimely unless the party filing establishes that the mailing was timely. *Id.*

Here, the 30th day after the ALJ's May 30, 1996 order was Saturday, June 29, 1996. Thus, the final day to perfect a timely appeal of the ALJ's order was Monday, July 1, 1996. *See Anita L. Clifton*, 43 Van Natta 1921 (1991). Although claimant contends that he filed his request for review on June 5, 1996, the record fails to show that the Board received such request. For instance, there is no receipt for registered or certified mail showing the date of mailing; nor is there any correspondence from the Board prior to July 2, 1998 acknowledging a request for review. Consequently, we find that claimant did not prove that he filed a request for review on June 5, 1996 or at any time prior to the expiration of the statutory appeal period.[1]

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[1] Claimant may submit information for our consideration showing that he mailed a request for review within 30 days of the ALJ's order, and provided copies of the request to the other parties. Because our authority to reconsider this order expires within 30 days after the date of this order, claimant must file any written submission as soon as possible.

Considering claimant's June 22, 1998, correspondence as a request for review, claimant's filing is untimely. Therefore, because claimant did not prove that he filed a request for review on June 5, 1996 and the June 22, 1998 request for review is not timely, we lack jurisdiction to review the ALJ's order. *See* ORS 656.289(3). Accordingly, claimant's request for Board review is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
SHERLIE A. DIAL, Claimant
WCB Case No. 97-08725
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Hall and Bock.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Herman's order that awarded an attorney fee of $4,000. SAIF also moves to remand to the ALJ. In her brief, claimant moves for sanctions and requests an assessed attorney fee for services on review. On review, the issues are attorney fees, remand, and sanctions.

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

The ALJ set aside SAIF's denial of claimant's occupational disease claim and awarded an assessed attorney fee of $4,000 pursuant to ORS 656.386(1). The ALJ awarded the assessed attorney fee "[a]fter considering the factors contained in OAR 438-15-010(4)."

SAIF contends that the ALJ's reasoning underlying the attorney fee award is inadequate because the ALJ did not make findings of fact concerning the factors contained in OAR 438-015-0010(4).[1] Relying on *Schoch v. Leupold & Stevens*, 325 Or 112 (1997), SAIF argues that we should remand the case to the ALJ to make such findings of fact. Additionally, SAIF asserts that, if we deny the motion to remand, we should decrease the ALJ's attorney fee award.

The record contains no specific attorney fee request, such as a 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. Under such circumstances, the ALJ is not obligated to make specific findings regarding the rule-based factors in order to have a reviewable order. *Russell L. Martin*, 50 Van Natta 313 (1998) (the absence of a fee request or argument based on the rule-based factors distinguished the case from *Schoch v. Leupold & Stevens*, 325 Or 112, *on remand* 49 Van Natta 788 (1997), which required a "sufficient explanation" of how the rule-based factors were weighed in deciding that a

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[1] OAR 438-015-0010(4) provides that "[i]n any case where an Administrative Law Judge or the Board is required to determine a reasonable attorney fee, the following factors shall be considered:

"(a) The time devoted to the case;

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

"(c) The value of the interest involved;

"(d) The skill of the attorneys;

"(e) The nature of the proceedings;

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

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

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

"reasonable" fee was substantially less than the amount requested). *See also McCarthy v. Oregon Freeze Dry Inc.*, 327 Or 84, *on recon* 327 Or 185 (1998) (findings regarding an attorney fee award must describe the relevant facts and legal criteria in terms sufficiently clear to permit meaningful appellate review). Thus, because the ALJ's order states that the factors recited in OAR 438-015-0010(4) were considered, we find sufficient the ALJ's order concerning the amount of the attorney fee.

In any event, we do not find the record to be improperly, incompletely or otherwise insufficiently developed. *See* ORS 656.295(5). In other words, because we are authorized to modify or supplement the ALJ's findings and conclusions under ORS 656.295(6), it would be unnecessary to remand this case to the ALJ for the supplementation of findings regarding claimant's attorney fee award. Consequently, we deny SAIF's motion to remand.

On review, SAIF submits specific arguments regarding the factors provided by OAR 438-015-0010(4), arguing 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. *Russell L. Martin*, 50 Van Natta at 315.

As indicated above, claimant's attorney did not submit a statement of services showing the time devoted to the case. A hearing convened that lasted 30 minutes; claimant was the only witness to testify. The record consists of approximately 19 exhibits, seven of which were submitted by claimant's attorney. Claimant's attorney generated two reports.

Based on compensability disputes generally litigated before this forum, we find the compensability issue was of average complexity; the value of the interest and benefit secured also were average. Claimant's attorney skillfully conducted the litigation. No frivolous issues or defenses were raised. Moreover, considering claimant's underlying condition, claimant's attorney assumed a moderate risk that he might go uncompensated for his services in attempting to establish the compensability of claimant's occupational disease claim.

Based on our consideration of the factors in OAR 438-015-0010(4), particularly the aforementioned factors of time devoted to the issue (as represented by the record), value, benefit, and risk, we conclude that $4,000 is a reasonable attorney fee for claimant's services at hearing for prevailing over SAIF's denial. We accordingly affirm the ALJ's award.

Claimant requests sanctions against SAIF on the basis that its appeal is "frivolous." Pursuant to ORS 656.390(1), the Board may impose an appropriate sanction if the request for review was frivolous or was filed in bad faith or for the purpose of harassment. "Frivolous" means the matter is not supported by substantial evidence or is initiated without reasonable prospect of prevailing. SAIF, especially with regard to the amount of the attorney fee, presented a colorable argument on review that was sufficiently developed so as to create a reasonable prospect of prevailing on the merits. Although SAIF on review did not ultimately prevail, we cannot say it is "frivolous." Accordingly, we deny claimant's request for sanctions.

Finally, claimant contends that he is entitled to an assessed attorney fee for services on review. In particular, claimant contends that, because SAIF's request for review generally appealed the ALJ's order, it included the issue of compensability, even though its brief on review challenged only the attorney fee award. Thus, according to claimant, because our order does not disallow or reduce compensation, he is entitled to a fee under ORS 656.382(2).[2]

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[2] ORS 656.382(2) provides:

"If a request * * * for review * * * is initiated by an employer or insurer, and the * * * board * * * 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 * * * board * * * for legal representation by an attorney for the claimant at and prior to the * * * review * * *."

Whether or not SAIF's request for review "initiated" review of the compensability issue, because claimant did not address or discuss the compensability issue in his brief on review, we find that his attorney did not perform any legal services in defending the compensation award. Consequently, we conclude that claimant is not entitled to an attorney fee under ORS 656.382(2). *See Strazi v. SAIF*, 109 Or App 105, 107-08 (1991) (the claimant must prove three things in order to be entitled to an attorney fee under ORS 656.382(2), including the fact that the claimant's attorney performed legal services in defending the compensation award). Finally, claimant is not entitled to an attorney fee for services in defending the ALJ's attorney fee award. *Saxton v. SAIF*, 80 Or App 631 (1986).

ORDER

The ALJ's order dated February 12, 1998 is affirmed.

In the Matter of the Compensation of
ESTON JONES, Claimant
WCB Case No. 97-07515
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Stephen D. Brown's order that assessed a 25 percent penalty for allegedly unreasonable claim processing. Claimant cross-requests review of that portion of the ALJ's order that awarded an assessed fee of $3,600, contending that the fee should be increased. On review, the issues are penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" with the following correction. In lieu of the first sentence of paragraph (1), we substitute the following: claimant filed a claim in June 1995 for a neck and shoulder injury that occurred on May 29, 1985. We now supplement the ALJ's findings of fact with the following findings regarding the penalty issue.

As result of the compensable May 1985 injury, claimant has multiple accepted conditions, including TMJ. In 1994, the parties entered into a claim disposition agreement (CDA), which settled claims for compensation and payments of any kind due or claimed for all past, present, and future conditions, except compensable medical services. (Ex. 19-3).

On October 27, 1996, claimant fell from a roof of a shed at home, fracturing his right ankle. In a letter dated December 2, 1996, claimant's wife wrote the following to SAIF's claims adjuster:

> "This is to inform you that Eston broke his right foot, ankle and leg on October 27, 1996. He got dizzy, blacked out and fell. This happened due to his TMJ being out of alignment and also Dr. Shonerd had taken him off his hydroxzine 25, which is for dizziness.
>
> "When the jaw is out it pinches nerves in the head & neck, which causes the jaw to squeak, noises and ringing in the ears and dizziness. His TMJ has been out for sometime. We haven't been able to find a Dentist that will treat TMJ and bill SAIF, since we no longer can go to 7th Street Dental due to your refusal to past expenses. Dr. Jack Wilson will bill SAIF but needs money up front for a night guard. I've submitted that bill and a bill, for reimbursement on my Visa, for $46.95 for Osbon Medical Systems in early October.
>
> "This accident can be connected to his TMJ problem which is caused from the 1985 accident. I am enclosing bills received to this date and am requesting reimbursement for prescriptions. Copies also enclosed." (Ex. 39).

A date stamp at the bottom of the letter indicates that the letter was received on February 11, 1997. Claimant's wife wrote a second letter to SAIF that was dated February 10, 1997:

> "Received your letter dated February 3, 1997. Not sure why you said you just received a billing from Rogue Valley Medical Center. I sent you a letter in December telling you about the fall and how it is related to his claim. I also enclosed several billings and prescriptions for reimbursement.
>
> "Eston doesn't do roofing work and hasn't done any work since the accident in 1985. We were putting a blue tarp on our roof as it was leaking. As I wrote before this wouldn't have happened if he was getting the proper treatment for the TMJ and on the medication for dizziness.
>
> "Enclosed are copies of the billings and prescriptions that were sent in December. Also am enclosing ones to date.
>
> "We will be consulting with an attorney if these aren't taken care of and going to the Workers Compensation Board.
>
> "We have never had trouble getting bills paid and being reimbursed before. So for the best interest of us all we are requesting another claims adjuster at this time. You have been insulting, refused to pay for medication and haven't reimbursed us for the medications we paid for." (Ex. 43).

The date stamp shows that SAIF received the letter on February 11, 1997. On February 12, 1997, SAIF wrote claimant's wife and informed her that medical bills related to the fall would not be paid on the ground that claimant's dizziness was not related to his compensable TMJ condition. (Ex. 45). Claimant requested a hearing raising the issue of unreasonable claims processing and denial of medical benefits.

A prior ALJ granted SAIF's motion to dismiss the hearing request on the ground that the Hearings Division lacked jurisdiction over the medical services dispute. After claimant requested review, we vacated the ALJ's order and remanded the claim for further proceedings. We concluded that the ALJ had inappropriately decided the merits of the parties' dispute without conducting a hearing and taking evidence. *Eston Jones*, 49 Van Natta 1841 (1997).

On September 9, 1997, SAIF denied the compensability of claimant's right ankle fracture. (Ex. 54). Claimant requested a hearing, appealing the denial and requesting penalties and attorney fees for allegedly unreasonable resistance to the payment of compensation as a result of SAIF's delay in formally denying the claim for medical services.

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside SAIF's denial, finding that the compensable 1985 injury was the major contributing cause of claimant's ankle fracture. The ALJ also determined that claimant's wife's December 2, 1996 letter "substantially complied" with the "new medical condition" claim requirements of ORS 656.262(7)(a).[1] Thus, the ALJ also assessed a 25 percent penalty based on SAIF's failure to deny

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[1] 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."

the new medical condition claim within 90 days of the claim as required by the statute. Finally, the ALJ awarded an assessed fee of $3,600 for claimant's counsel's services with respect to the compensability issue.

On review, SAIF does not contest compensability. Instead, it asserts that the ALJ incorrectly assessed a penalty. SAIF contends that it did not act unreasonably in waiting until September 9, 1997 to deny the fractured ankle because claimant's wife's letters did not constitute a "new medical condition" claim under ORS 656.262(7)(a). We now proceed with our analysis of the penalty issue.

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). Pursuant to ORS 656.262(7)(a), a carrier has 90 days in which to accept or deny a "new medical condition" claim after receiving written notice of such a claim. However, to make a "new medical condition" claim pursuant to ORS 656.262(7)(a), claimant must have clearly requested formal written acceptance of the condition. *See Diane S. Hill*, 48 Van Natta 2351, 2352-53 (1996), *aff'd mem Hill v. Stuart Andersons*, 149 Or App 496 (1997) (a claimant must clearly request formal written acceptance of the new medical condition before a carrier is obligated to issue a written acceptance or denial).

Here, we conclude that claimant made no clear request that his right ankle condition be accepted, assuming, but not deciding, that a spouse can make a valid new medical condition claim on behalf of a claimant. Claimant's wife informed SAIF of claimant's right ankle injury resulting from the October 1997 accident and stated that claimant's October 1997 accident "can be connected to his TMJ problem caused from the 1985 accident," However, much of claimant's correspondence concerned reimbursement of medical expenses. As previously noted, ORS 656.262(7)(a) requires that a claimant "clearly request formal written acceptance of the [new medical] condition." Based on our review of the December 1996 and February 1997 letters, we cannot say that there was a clear request for formal written acceptance of claimant's ankle condition. Thus, we conclude that the statutory requirements of ORS 656.262(7)(a) were not satisfied.

Moreover, even if we assumed that a "new medical condition" claim had been perfected, we would still conclude that SAIF's claim processing was not unreasonable given the ambiguity in the above letters. Accordingly, we conclude that SAIF did not unreasonably delay acceptance or denial of a new medical condition claim.[2] Thus, we reverse the ALJ's penalty assessment.

We now address the attorney fee issue. The ALJ awarded a $3,600 attorney fee pursuant to ORS 656.386(1).[3] Claimant contends that it should be increased. We disagree.

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

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[2] In light of our finding that a new medical condition claim was not perfected, SAIF's denial may have been premature. However, because the parties litigated the merits of the denial without a procedural objection to the claim, we do not address that issue. *See Diane S. Hill*, 48 Van Natta at 2356 n. 2, citing *EBI Companies v. Thomas*, 66 Or App 105 (1983) (parties in a workers' compensation may agree to litigate issues not properly raised); *cf. Ralph L. Morris*, 50 Van Natta 69, 71 (1998) (carrier's denial found premature when no "new medical condition" claim was perfected and the carrier objected to litigating issues not properly raised).

[3] We note that, in making his attorney fee award, the ALJ did not reference OAR 438-015-0010(4) or indicate that he considered the factors listed in that rule. The ALJ is reminded that, in determining a reasonable attorney fee, the criteria in the administrative rule must be considered and, further, that there should be an indication in the order that the appropriate factors were considered.

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).[4]

Our review of the record reveals the following information. The issue in dispute was the compensability of claimant's fractured ankle condition. Approximately 60 exhibits were received into evidence. The hearing lasted approximately one and one-half hours and the transcript consists of approximately 35 pages. There was one deposition of a treating physician (Dr. Shonerd) lasting approximately 45 minutes (35 pages of transcript). Two witnesses, including claimant, testified. Considering the "consequential" nature of claimant's current right ankle claim to his compensable TMJ condition, the compensability issue presented factual and medical questions of a complexity somewhat greater than those generally submitted for Board consideration. Because of the prior CDA, the claim's value and the benefits are limited to medical services for the ankle fracture. 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, considering the conflicting medical evidence, 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 $3,600 attorney fee is reasonable. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.[5]

ORDER

The ALJ's order dated February 25, 1998 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.

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[4] In *Russell L. Martin*, 50 Van Natta 313 (1998), we distinguished *Schoch* and held that an ALJ was not obligated to make specific findings regarding the factors in OAR 438-015-0010(4) when no specific attorney fee was requested and the parties did not submit argument as to how the rule-based factors should be weighed in determining a reasonable fee. However, because the carrier advanced arguments on review regarding application of the rule-based factors, and because further appellate review would be subject to the "range of discretion" criteria discussed in *Schoch*, we provided a discussion of the factors mentioned in OAR 438-015-0010(4) in determining the appropriate attorney fee. 50 Van Natta at 315. In this case, claimant has requested an increase in the ALJ's attorney fee award, and the parties have submitted arguments regarding the factors in the administrative rule. Therefore, in accordance with our decision in *Martin*, we address the rule-based factors in determining a reasonable attorney fee. Our approach is consistent with the Supreme Court's decisions in both *Schoch* and *McCarthy v. Oregon Freeze Dry Inc.*, 327 Or 84, *on recon* 327 Or 185 (1998), in which the Court held that findings regarding an attorney fee award must describe the relevant facts and legal criteria in terms sufficiently clear to permit meaningful appellate review.

[5] Claimant's attorney is not entitled to an attorney fee for services on review concerning the attorney fee and penalty issues. *See Saxton v. SAIF*, 80 Or App 631, *rev den* 302 Or 159 (1986); *Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986); *Amador Mendez*, 44 Van Natta 736 (1994) (no attorney fee for counsel's services in seeking an attorney fee award).

Board Member Haynes specially concurring.

Although I agree that SAIF's claim processing does not warrant assessment of a penalty, I am still troubled by the fact that an unrepresented claimant had such difficulty filing a "new medical condition" claim. I agree with the ALJ that the letters from claimant's wife "substantially complied" with the requirements of ORS 656.262(7)(a), but I am also forced to conclude that more than substantial compliance is necessary in order to satisfy the statutory requirements, *i.e.*, a claimant "must clearly request formal written acceptance" of the new medical condition. *See Diane S. Hill*, 48 Van Natta 2351, 2352-53 (1996), *aff'd mem Hill v. Stuart Andersons*, 149 Or App 496 (1997). Because the rather stringent requirements of ORS 656.262(7)(a) were not met in this case, I conclude that SAIF did not unreasonably delay its denial. However, I would encourage carriers in the future to clarify in close cases whether a claimant desires to file a new medical condition claim. Had such clarification occurred in this case, expensive litigation regarding the penalty issue may have been avoided.

In the Matter of the Compensation of
VICTORIA A. BROKENSHIRE, Claimant
WCB Case No. TP-98005
THIRD PARTY DISTRIBUTION ORDER
Huegli & Jones, Claimant Attorneys
Peggy J. Millican (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant has petitioned the Board for the allowance of an extraordinary attorney fee for services rendered in connection with a third party judgment. Specifically, claimant seeks approval of an attorney fee equal to 45 percent of the third party judgment. The SAIF Corporation, as the paying agent, does not oppose the petition. We find that extraordinary circumstances exist to justify the requested fee.

FINDINGS OF FACT

While working at a bakery on January 11, 1993, claimant slipped and fell on a recently installed floor and, as a result, seriously injured her back. Subsequently, claimant engaged legal counsel to bring a strict product liability claim against the company that had sold and installed the floor.

Over a five and a half year period, claimant's counsel and his office expended approximately 2,500 hours in handling this case at all levels; almost 500 hours of that time was spent on appellate matters. To help represent claimant at the appellate levels, claimant's counsel retained co-counsel, whose fees totaled $30,471. Those fees were paid by claimant's counsel's office; are not included in the contingent fee agreement; and, will not be charged to claimant as costs.

All investigation, discovery, trial preparation, and trial of the matter was handled by the attorneys and staff of claimant's attorney's office. Claimant prevailed at trial before a jury and obtained a judgment of $729,967.76. The defendant appealed the matter to the Court of Appeals, which affirmed the trial court. *Brokenshire v. Rivas and Rivas, Ltd.*, 142 Or App 555 (1996). Thereafter, the defendant filed a petition for review with the Supreme Court, which initially granted review. *Brokenshire v. Rivas and Rivas, Ltd.*, 324 Or 487 (1996). However, after briefing from the parties, the Court dismissed the petition for review as improvidently allowed. *Brokenshire v. Rivas and Rivas, Ltd.*, 327 Or 119 (1998).

Claimant and her counsel entered into a contingent fee agreement for varying levels of attorney fees, depending on when recovery was made during the litigation process. The fee arrangement ranged from 25 percent of any amount recovered before the complaint was filed to 45 percent of any amount recovered on an appeal of claimant's case to the Court of Appeals or Supreme Court. In addition, claimant signed an "Agreement for Approval of Attorney Fees" in which she asked that the Board approve a fee of 45 percent of the gross recovery in this case. This agreement also stated that costs incurred by her counsel would be deducted out of her portion of the settlement, although those costs would not include the costs incurred in hiring co-counsel.

The case proceeded to appeal at the Court of Appeals and the Supreme Court, although the Supreme Court ultimately dismissed the defendant's petition for review after briefing. Thus, pursuant to the contingent fee agreement, claimant agrees to a fee of 45 percent of the gross moneys received.

SAIF will be fully reimbursed its lien of $123,237.78 and does not oppose claimant's attorney's request for an extraordinary attorney fee of 45 percent.

CONCLUSIONS OF LAW AND OPINION

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

We have authorized extraordinary attorney fees in the past. *See Pamela J. Jennings*, 49 Van Natta 12 (1997) (a 40 percent share of a $280,000 judgment was allowed where the case involved a complex

medical negligence issue, extensive motion practice and court memorandum were necessitated due to the defendants failure to follow the usual voluntary methods of obtaining discovery, and litigation extended over almost ten years and involved several appeals; in addition, the paying agent did not object to the fee); *Gerald G. Sampson*, 42 Van Natta 1098 (1990) (a 40 percent share of a $275,000 settlement was allowed where the case involved a complex legal issue which initially resulted in a summary judgment against claimant, and settlement was reached only after successful appeal to the Ninth Circuit Court of Appeals, certification of a legal question to the Oregon Supreme Court, and withdrawal of the certification question following a favorable Court of Appeals decision; in addition, the paying agent did not object to the fee); *John P. Christensen*, 38 Van Natta 613 (1986) (claimant's counsel was awarded 50 percent of proceeds where the case had been litigated over a 10-year period, including two appearances before the Oregon Supreme Court and the paying agency did not object to the fee); *John Galanopoulos*, 35 Van Natta 548 (1983) (an extraordinary fee of 40 percent was allowed where claimant's attorney expended nearly three full months in trial preparation for a five day trial and achieved an extremely favorable result); *Leonard F. Kisor*, 35 Van Natta 282 (1983) (a 40 percent share of the proceeds was allowed where the third party litigation involved a complex asbestosis issue and the paying agency did not object to the fee).

We find the circumstances of the present case very similar to those in cases where we have authorized extraordinary attorney fees. Specifically, here, the issues in this strict product liability case were complex, requiring extensive case preparation. Furthermore, the litigation extended over a period of five and a half years and involved two appeals, one to the Court of Appeals and one to the Oregon Supreme Court. While the Supreme Court ultimately dismissed the defendant's petition for review as improvidently allowed, this dismissal did not take place until after briefs had been submitted. In addition, in dismissing the petition for review, the Court agreed with claimant's argument that the defendant first raised its argument on review at the Court of Appeals, without preserving that argument at the trial court. *Brokenshire v. Rivas and Rivas, Ltd.*, 327 Or at 121. Therefore, the Court relied on claimant's brief in determining that review should not have been allowed. *Id.*

Moreover, claimant's counsel achieved a favorable result, with a judgment of $729,967.76. In addition, claimant and her counsel agree to an attorney fee of 45 percent, as represented by the retainer agreement and the "Agreement for Approval of Attorney Fees." Finally, SAIF does not object to claimant's counsel's request of a fee of 45 percent of the proceeds.

Under these circumstances, we are persuaded that claimant's counsel is entitled to an attorney fee in excess of one-third of the third party settlement. Accordingly, for the reasons expressed herein, we find that this case constitutes extraordinary circumstances justifying the allowance of an extraordinary attorney fee. Commensurate with the request from claimant's counsel and the agreement between claimant and her counsel, we further hold that the extraordinary attorney fee shall equal 45 percent of the third party judgment proceeds.[1] Consequently, claimant's counsel is directed to retain the aforementioned extraordinary attorney fee from the judgment proceeds.

IT IS SO ORDERED.

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[1] Inasmuch as the court's "Money Judgment" provided for the inclusion of "post-judgment interest" at the statutory rate, we presume that this interest is a component of the judgment proceeds.

In the Matter of the Compensation of
SHARON A. ELMORE, Claimant
WCB Case No. 97-06268
ORDER ON REVIEW
Gatti, Gatti, 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) Howell's order that declined to award claimant an assessed fee for her counsel's efforts in obtaining the SAIF Corporation's pre-hearing amendment of its acceptance of a "resolved" low back and left shoulder strain. On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

Claimant has a preexisting low back condition, including a herniated L4-5 disc which was surgically repaired. On January 11, 1997, claimant injured her left shoulder and low back while working as an LPN II in the employer's hospital. The initial diagnosis was left shoulder strain and low back strain, but a subsequent MRI demonstrated a recurrent L4-5 disc herniation. On March 17, 1997, SAIF issued a Notice of Acceptance of a "left shoulder strain resolved and low back strain resolved." The following day, SAIF issued a denial of the recurrent disc herniation. Claimant's former counsel filed a request for hearing from the denial of the disc herniation, and the matter was assigned WCB Case No. 97-02682.

Claimant retained her current attorney on April 16, 1997. SAIF issued an amended, pre-hearing acceptance of the recurrent disc herniation on May 16, 1997. WCB Case No. 97-02682 then proceeded to hearing on the issue of attorney fees. In a July 7, 1997 Opinion and Order, ALJ Michael Johnson awarded claimant's current attorney a $2,200 assessed fee for obtaining SAIF's pre-hearing rescission of its denial of the recurrent disc herniation. *See Sharon A. Elmore*, 49 Van Natta 1975 (1997). The ALJ's order was not appealed and became final as a matter of law.

Meanwhile, on August 5, 1997, claimant's current attorney filed a request for hearing from SAIF's "[i]mproper prospective denial (see Notice of Acceptance * * * indicating left shoulder strain & low back strain resolved)." This matter was assigned WCB Case No. 97-06268. On October 22, 1997, SAIF issued a modified Notice of Acceptance of "shoulder strain, low back strain and re-current disc herniation L4-5." WCB Case No. 97-06268 then proceeded to hearing on the attorney fee issue which is presently before us.

The parties stipulated that SAIF has paid claimant all compensation to which she is entitled for the accepted shoulder and low back strains.

CONCLUSIONS OF LAW AND OPINION

Claimant seeks review of the ALJ's decision not to award attorney fees under ORS 656.386(1). That statute mandates the award of a reasonable carrier-paid fee when an attorney is instrumental in obtaining a rescission of a "denied claim" prior to a decision by an ALJ. The statute defines "denied claim" as a claim for compensation which a carrier "refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation[.]"

In declining to award a carrier-paid fee under ORS 656.386(1), the ALJ reasoned that SAIF's acceptance of "resolved" left shoulder and low back strains was only an implied denial of future responsibility for those conditions. The ALJ further reasoned that such an implication that future responsibility might be denied is not a "denied claim" within the meaning of ORS 656.386(1) because it "is neither expressed, nor a refusal to pay, nor an assertion 'that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation.'"

In reaching that decision, the ALJ relied on our analysis in *Michael J. Galbraith*, 48 Van Natta 351 (1996). The claimant in *Galbraith* requested a hearing from the carrier's *de facto* denial of a consequential condition, and the carrier filed a response which stated that the claimant was "entitled to no relief." We

held in *Galbraith* that there was no "denied claim" under ORS 656.386(1) because the carrier paid all benefits for the claimed condition and did not expressly challenge the causal relationship between the condition and the compensable injury.

Subsequent to the ALJ's order in this case, the court reversed our decision in *Galbraith* based on its conclusion that the carrier's responsive pleading was an express denial within the meaning of ORS 656.386(1). *Galbraith v. L.A. Pottsratz Construction*, 152 Or App 790. The *Galbraith* court reasoned that the carrier's responsive pleading "carried with it an *implicit* refusal to pay compensation in the future." (Emphasis supplied). The *Galbraith* court also noted that, while the claimant's medical bills had been paid when the carrier accepted the claim, the "relief" requested included acceptance of the claim and not merely the payment of accrued expenses. In so ruling, the *Galbraith* court relied on its prior decision in *Kimberly Quality Care v. Bowman*, 148 Or App 292 (1997). In *Bowman*, the court concluded that a check-the-box responsive pleading that the claimant had not sustained a work-related injury or disease was an "express denial" under ORS 656.386(1) because it carried with it an *implicit* refusal to pay compensation in the future and unequivocally expressed the employer's denial of compensability.

We applied the court's ruling in *Galbraith* and *Bowman* in our recent decision in *Joni M. Varah*, 50 Van Natta 1124 (1998), *on recon* 50 Van Natta 1360 (1998). In *Varah*, the carrier issued a Notice of Acceptance of a claim as a "thoracolumbar muscular back strain, resolved," and the claimant filed a hearing request, raising the issue of an improper "prospective denial." In response, the carrier issued a modified acceptance notice, eliminating the word "resolved" and accepting the compensable condition as a "thoracolumbar muscular strain." The claimant then filed a supplemental hearing request, requesting an attorney fee under ORS 656.386(1) for obtaining rescission of a denial prior to an ALJ's decision.

We concluded in *Varah* that, consistent with the *Galbraith* and *Bowman* holdings, the carrier's written acceptance of a "resolved" condition constituted an express denial of the claim on the basis that the condition would not give rise to an entitlement to any compensation. In reaching that decision, we relied on well-settled Board case law that a carrier's acceptance of a "resolved" condition is a denial of future benefits for that condition. *See Charles L. Wallace*, 49 Van Natta 472 (1997) (denial of low back strain as resolved and subsequent unequivocal acceptance of that condition was an implied denial of future responsibility for the low back strain); *Gary L. Best*, 46 Van Natta 1691 (1994) (acceptance of a "resolved" osteomyelitis was an implied denial of responsibility for future benefits for that condition). Thus, we ultimately concluded in *Varah* that the claimant's counsel became entitled to an assessed fee under ORS 656.386(1) when the carrier rescinded its denial after the claimant's hearing request.

We conclude that the facts in *Varah* are indistinguishable from those in the case before us. As in *Varah*, the present claimant is requesting an assessed fee under ORS 656.386(1) for a pre-hearing, unequivocal written acceptance of a condition that was initially accepted in writing as a resolved condition. Accordingly, consistent with our decision in *Varah*, other prior Board case law, and the court's analysis in *Galbraith* and *Bowman*, we conclude that SAIF's claims processing in the present case was an express refusal to pay compensation on the ground that the accepted conditions had "resolved" and, thus, do not give rise to an entitlement to any future compensation. Because such an expression is a "denied claim" within the meaning of ORS 656.386(1), claimant is entitled to a reasonable carrier-paid attorney fee for his counsel's efforts in obtaining the pre-hearing amendment of its acceptance.[1]

We now turn to the determination of that fee. After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's pre-hearing services in obtaining rescission of SAIF's denial is $1,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated. We further note that claimant is not entitled to an assessed fee for her counsel's services subsequent to SAIF's pre-hearing modification of its acceptance. *See Amador Mendez*, 44 Van Natta 736 (1992).

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[1] Board Member Haynes notes that, under the doctrine of *stare decisis*, she is obligated to follow the majority's holding in *Joni M. Varah*. Nevertheless, she directs the parties' attention to the dissent in *Varah*, in which she agrees that the *implied* denial at issue in that case does not give rise to an assessed attorney fee under ORS 656.386(1) because the carrier has not refused to pay the claim "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).

ORDER

The ALJ's order dated November 14, 1997 is reversed. Claimant's counsel is awarded a $1,000 assessed fee, payable by the SAIF Corporation.

In the Matter of the Compensation of
SANDRA L. KAY, Claimant
WCB Case No. 97-05932
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that: (1) redetermined claimant's unscheduled permanent disability to award an additional 6 percent (19.2 degrees) unscheduled permanent disability; (2) found that claimant was not entitled to a scheduled permanent disability award; (3) found claimant had not established entitlement to permanent total disability benefits; and (4) declined to award additional temporary disability. In its brief, the insurer argues that the ALJ erred in increasing claimant's unscheduled permanent disability award on the ground that her condition had permanently worsened since the last arrangement of compensation. On review, the issues are permanent total disability, temporary disability and extent of scheduled and unscheduled permanent disability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, which we summarize below.

Claimant was compensably injured on July 29, 1992 after moving a box of paper at work. The claim was accepted for a lumbosacral strain. Claimant underwent surgery for a large herniated disc at L5-S1 on December 1, 1992. On March 23, 1993, claimant underwent another surgery at L5-S1.

By May 1993, claimant was doing better and had returned to part-time work. In May 1994, her attending physician, Dr. White, released her to a 27-hour work week.

On August 12, 1994, the insurer issued a Notice of Closure awarding 20 percent unscheduled permanent disability.

In July 1995, claimant had a severe exacerbation of her low back and leg symptoms during a period when she was participating in a pain center program. On July 21, 1995, an MRI revealed "chronic epidural scarring encasing the right S1 nerve root * * * with no new right-sided abnormality." On October 11, 1995, Dr. White restricted claimant to a 17.5-hour work week.

The insurer issued an aggravation denial on October 13, 1995. Claimant requested a hearing from the denial and a March 6, 1996 Opinion and Order found that the condition had pathologically worsened and set aside the aggravation denial. The insurer appealed and the Board affirmed and adopted the ALJ's order. The Board's order became final by operation of law.

In approximately December 1996, Dr. White restricted claimant to a 16-hour work week.

On February 26, 1997, a Determination Order issued closing the claim with an award of temporary disability and a 5 percent increase in claimant's award of unscheduled permanent disability for a total unscheduled award of 25 percent. Both claimant and the insurer requested reconsideration of the Determination Order. As of April 1997, claimant was working a 15 hour a week schedule for the employer although she sometimes left work early due to pain. On July 18, 1997, an Order on Reconsideration issued, which reduced claimant's unscheduled award to 20 percent on the ground that her condition had not permanently worsened since the last closure.

CONCLUSIONS OF LAW AND OPINION

Permanent Worsening

Applying OAR 436-035-0007(8)(b), the ALJ found that claimant had sustained an "actual worsening" of her compensable condition because her condition had not changed since the March 6, 1996 Opinion and Order finding that she had established a compensable aggravation claim. On the basis of this reasoning, the ALJ found that claimant had established that her condition had permanently worsened such that she was entitled to a redetermination of her permanent disability.

OAR 436-035-0007(8)(b) and (c) (now renumbered OAR 436-035-0007(9)) provide:

> "(b) When an actual worsening of the worker's compensable condition occurs, the extent of permanent disability shall be redetermined. When an actual worsening of the worker's compensable condition does not occur, the extent of disability shall not be redetermined, but shall remain unchanged.
>
> "(c) * * * There shall be no redetermination for those conditions which are either unchanged or improved. * * *"

The Supreme Court has stated:

> "The threshold requirement to recover increased PPD [permanent partial disability] or PTD [permanent total disability] is a greater permanent injury than formerly existed * * * . On a worsening claim for additional PPD or PTD, the referee [now ALJ], Evaluation Division and Board should first compare the claimant's present medical condition with the condition at the time of the earlier award or arrangement of compensation. If that condition is unchanged or improved, no further inquiry is necessary, for there has been no worsening." *Stepp v. SAIF*, 304 Or 375, 381 (1987).

We discussed the application of *Stepp* in *Kelly R. Holifield-Taylor*, 50 Van Natta 286 (1998). In *Holifield-Taylor*, the employer relied on *SAIF v. Walker*, 145 Or App 294 (1996), to argue that the claimant was required to show a "pathological worsening" of her compensable condition in order to trigger redetermination of disability upon closure of the aggravation claim. We noted that 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 under ORS 656.273(1). We further stated that the *Walker* court did not address the meaning of "worsening" in the context of a worker's entitlement to redetermination of disability upon closure of an aggravation claim.

Consistent with this observation, we noted that in *Stepp*, the Supreme Court indicated 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, we concluded in *Holifield-Taylor* that the requirement that a claimant establish a permanently worsened condition to prove entitlement to a redetermination of permanent disability on closure of an aggravation claim was a court-made doctrine intended to limit increased awards to those situations where injury-related conditions have permanently worsened.

Here, whether claimant has established a compensable aggravation claim by showing an "actual worsening" is a different question than whether claimant's condition has permanently worsened under the Court's analysis in *Stepp*. Thus, we disagree with the ALJ's decision insofar as it relies on the fact that claimant has established an actual pathological worsening of her compensable condition. Rather, the issue in this case is whether, comparing claimant's condition at the time of the current claim closure with her condition at the last arrangement of compensation, she has sustained a permanent worsening.

Thus, although the administrative rule refers to an "actual" worsening, the primary focus of the rule and of the *Stepp* analysis is whether claimant's low back condition has worsened since the prior 20 percent permanent disability award. *See Clay R. Herring*, 49 Van Natta 1898 (1997); *Peter Gevers*, 49 Van Natta 1228 (1997). If the "permanent worsening" threshold is not satisfied, claimant's permanent disability is not redetermined under the standards. *See Gayle S. Johnson*, 48 Van Natta 381, *aff'd mem* 143 Or App 629 (1996).[1]

Here, the medical arbiter panel compared claimant's condition at the time of its examination with claimant's condition at the time of the last arrangement of compensation. The arbiters also compared range of motion findings that were taken in May 1997 and January 1996. The arbiter panel indicated that there was some fluctuation in claimant's range of motion findings, which likely reflected waxing and waning of a stable condition as opposed to a specific worsening over time. Comparing claimant's condition to her closing evaluation in June 1994, the arbiter panel concluded that claimant's limitations "appear to be pretty much the same now as they were then." (Ex. 20B-3). There is no medical opinion to the contrary.

Based on the arbiter panel's unrebutted report, we conclude that claimant's condition has not permanently worsened. Under such circumstances, we are unable to find that claimant's claim qualifies for a redetermination of permanent disability.[2] Accordingly, we reverse the ALJ's award of additional permanent disability benefits. Because claimant's claim does not qualify for redetermination, we do not address the issues of permanent partial disability or permanent total disability.

Temporary Disability

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

ORDER

The ALJ's order dated December 18, 1997 is reversed in part and affirmed in part. That portion of the ALJ's order which modifies the Order on Reconsideration to award unscheduled permanent disability and awards an "out-of-compensation" attorney fee is reversed. The Order on Reconsideration is affirmed. The remainder of the ALJ's order is affirmed.

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[1] To the extent that OAR 436-035-0007(8)(b) can be interpreted to permit a redetermination of a worker's permanent disability award in the absence of a permanent worsening of the condition, we find the rule to be inconsistent with the *Stepp* Court's interpretation of the statutory scheme and conclude that the rule should not be given effect. *See Cook v. Workers' Compensation Department*, 306 Or 134, 138 (1988) (an agency may not alter, amend enlarge or limit the terms of a statute by rule). After examining several workers' compensation statutes including ORS 656.206(1), 656.214(5), 656.273(1) and (2), the *Stepp* Court concluded that the threshold requirement to recovery of a permanent partial or permanent total disability award is a greater permanent injury than formerly existed. Authoritative court interpretations of a statute become a part of that statute as if written into it at the time of enactment. *SAIF v. Allen*, 320 Or 192, 204 (1994) *Walther v. SAIF*, 312 Or 147, 149 (1991); *Adam J. Delfel*, 50 Van Natta 1041 (1998). Thus, we find that the *Stepp* Court's interpretation has become part of ORS 656.273(1) and that in order to obtain an award for permanent disability on closure of an aggravation claim, the worsened condition must be permanent. We note that in *Holifield-Taylor*, we applied the holding of *Stepp* to the current versions of the aggravation and permanent disability statutes. To the extent that OAR 436-035-0007(8)(b) allows redetermination of permanent disability in the absence of a permanent worsening, we find it inconsistent with the *Stepp* rationale and the statutory scheme.

[2] In reaching the conclusion that claimant's condition has not permanently worsened, we distinguish *SAIF v. Frank*, 153 Or App 514 (1998). In *Frank*, the court held that a claimant whose initial claim had been accepted as nondisabling and who consequently did not have a prior permanent disability award did not have to establish a "permanent worsening" of his condition in order to be entitled to an award of permanent disability on closure of his subsequent aggravation claim. Here, in contrast to *Frank*, claimant had received an award of permanent disability on closure of his initial injury claim. Thus, we find *Frank* to be distinguishable.

Board Member Hall dissenting.

I do not disagree with the majority's legal conclusion that the establishment of a compensable aggravation claim, *i.e.*, proof of an "actual worsening," does not per se equate with the establishment of a "permanent worsening." However, I disagree with the majority's conclusion that this record does not factually establish a permanent worsening of the compensable condition. Because the aggravation claim

has been reopened, it is evident that the statutory requirement of an "actual worsening" under ORS 656.273 has been met. Thus, it is clear that there has been a worsening of the *condition*. The question now is whether the worsening has become permanent so that claimant may receive a redetermination of her permanent disability.

Based on the evidence in this record, I am in agreement with the ALJ that, factually, claimant has shown that the actual worsening has not improved and that the worsening has now become "permanent." Accordingly, I would find that a permanent worsening of the condition has been established and that claimant has shown an entitlement to a redetermination of her permanent disability.

Finally, I disagree with the majority's reliance on the medical arbiter report to conclude that the condition has not permanently worsened since the last arrangement of compensation. The arbiter's report represents the very redetermination which the majority concludes claimant is not entitled to. That a claimant does not sustain greater ratable impairment upon redetermination does not defeat a factual finding of a permanent worsening which would entitle one to a redetermination. After all, the issue in this case is not the results of the redetermination, but claimant's entitlement to a redetermination.

In the Matter of the Compensation of
ROBERT D. MOORE, Claimant
Own Motion No. 98-0130M
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 claimant's compensable L3-4 disc herniation. Claimant's aggravation rights on that claim 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. SAIF contended that claimant's surgery for L3-4 hardware removal was both causally related to his compensable injury and that SAIF was responsible for the hardware removal.

However, on March 26, 1998, we postponed action because there was litigation pending regarding the responsibility for claimant's current low back condition.[1] We took that action because that litigation would necessarily address the issue of whether claimant's need for surgery was causally related to the 1989 injury or to a subsequent injury.

By Opinion and Order dated June 1, 1998, Administrative Law Judge (ALJ) Podnar approved SIMS' February 18, 1998 responsibility denial finding that the August 5, 1997 injury was not the major contributing cause of his "need for the treatment in the nature of the removal of the hardware from his lumbar spine." That order was not appealed, and has become final by operation of law.

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

On January 8, 1998, claimant underwent hardware removal at L3-4 level. Thus, we conclude that claimant's compensable injury has worsened requiring surgery.

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[1] Claimant had an August 5, 1997 accepted lower thoracic and lumbar strains claim through SIMS, which had issued a February 18, 1998 responsibility denial regarding the L3-4 hardware removal. Claimant appealed that denial. (WCB Case No. 98-01619).

Accordingly, we authorize the reopening of claimant's 1989 injury claim to provide temporary disability compensation beginning January 8, 1998, 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.[2]

IT IS SO ORDERED.

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[2] Claimant may have been receiving timeloss in the SIMS claim at the time of his January 8, 1998 surgery. Therefore, we note that an injured worker is not entitled to receive any more than the statutory sum of benefits for single period of temporary disability resulting from multiple disabling injuries. *See Fischer v. SAIF*, 76 Or App 656, 661 (1985); *Petshow v. Portland Bottling Co.*, 62 Or App 614 (1983), *rev den* 296 Or 350 (1984). If any concurrent temporary disability compensation is due claimant as a result of this order, SAIF and SIMS may petition the Workers' Compensation Division of the Department of Consumer and Business Services for a pro rata distribution of payments. OAR 436-060-0020(8) and (9); *Michael C. Johnstone*, 48 Van Natta 761 (1996); *William L. Halbrook*, 46 Van Natta 79 (1994).

In the Matter of the Compensation of
CARL C. GEIER, Claimant
Own Motion No. 98-150M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable fracture tip of right lateral malleolus. Claimant's aggravation rights expired on August 29, 1996. SAIF opposes authorization of temporary disability compensation, contending that claimant has withdrawn from the work force.

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

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

SAIF contends that claimant was not in the work force at the time his compensable condition worsened requiring surgery. Claimant replied to SAIF's contentions and submitted several chart notes and a paystub in support of his position.

Claimant is a commercial fisherman. The paystub he submitted demonstrates that he last worked in August of 1996. On September 5, 1996, he sought treatment for instability in his right ankle. The physician assistant who treated claimant on that date noted that the current instability may be related to his 1991 initial fracture and commented that a reconstruction procedure had been recommended and may need to be carried out in the future. He placed claimant in a fixed ankle hinge brace for three weeks.

On February 16, 1998, claimant sought treatment with Dr. Hayhurst, for continuing right ankle pain. Dr. Hayhurst noted that claimant injured his right ankle in 1991 and sustained a fracture of the distal fibula. Claimant eventually became asymptomatic and returned to work. In 1996, claimant re-injured his ankle in the same place while he was working and has had pain ever since. Claimant told the doctor that he had been unable to work since the "re-injury" due to pain and swelling. Dr. Hayhurst ordered a diagnostic bone scan.

On February 23, 1998, claimant was examined by Dr. Wisdom, at Dr. Hayhurst's request. Dr. Wisdom also noted claimant's history of re-injury in 1996 and inability to work since that time. The bone scan showed a bone fragment at the tip of the lateral malleolus which Dr. Wisdom opined could be the source of claimant's discomfort. Dr. Wisdom diagnosed a painful nonunion fracture on the tip of the lateral malleolus of the right ankle. He recommended excising the bone fragment and re-attaching any ligament tissue that was present.

Dr. Wisdom saw claimant again on May 6, 1998 for continuing pain complaints in the right ankle. He agreed with claimant that, for the last two years, he "could not work effectively on a shrimp or crab boat, with his repeated pain on physical stress on the foot, not knowing if it would suddenly cause pain, often swelling and be useless for several days."

In order to satisfy the third *Dawkins* criterion, claimant must demonstrate that he was willing work but was unable to do so due to the compensable condition and that it would have been futile for him to seek work. Claimant submitted a letter wherein he states that he has worked as a commercial fisherman. He states that he is unable to work a modified "desk job" because of his "lurning [sic] disability and poor grades in school." He further contends that because of his initial injury and subsequent re-injury in 1996, he has been unable to work. Despite his inability to work due to his compensable condition, claimant asserts that he sought work on other people's boats but that "they are afraid I will get hurt worse and they will get stuck with the liability of my injury." Finally, claimant maintains that he needs to get back to work so "I can suport [sic] my family in a way they can be proud of." Based on claimant's statements, we find that he has demonstrated his willingness to work.

Additionally, as discussed above, Dr. Wisdom opined that claimant could not work as a commercial fisherman and has been unable to do so since his re-injury in 1996. Thus, we find that Dr. Wisdom's unrebutted opinion sufficient to meet claimant's burden of proof regarding the futility standard of the third *Dawkins* criterion.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
ROYCE G. LUTHER, Claimant
WCB Case No. C8-01401
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Lundeen, et al, Defense Attorneys

Reviewed by Board Member Biehl and Haynes.

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

Parties may dispose of all matters concerning a claim, except for medical services, with a CDA "subject to such terms and conditions as the Workers' Compensation Board may prescribe." ORS 656.236(1). The worker, insurer or self-insured employer may request disapproval of the disposition within 30 days of its submission to the Board. ORS 656.236(1)(a)(C). Notwithstanding this provision, however, the CDA may provide for waiver of the 30 day period if the worker was represented by an attorney at the time the worker signed the disposition. ORS 656.236(1)(b). This rule requires that the first page of the CDA contain a "statement indicating whether or not the parties are waiving the "30-day" approval period of ORS 656.236(1)(a)(C) as permitted by ORS 656.236(1)(b)."

The first page of the agreement includes the required statement indicating that the parties do not wish to waive the "30-day" cooling off period. However, the body of the document on page 4, number 19, provides that the parties request a waiver of the 30-day statutory period. Nonetheless, because claimant is unrepresented, the Board is without statutory authority to waive the "30-day" cooling off period. *See Kathleen McKay*, 49 Van Natta 2062 (1997). Thus, consistent with the first page of the document, we conclude that the "waiver" language was left in the body of the agreement inadvertently. Thus, we do not interpret the agreement as attempting to waive the 30 day period.

We conclude the agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved.

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

IT IS SO ORDERED.

July 20, 1998 Cite as 50 Van Natta 1421 (1998)

In the Matter of the Compensation of
BRIAN LUTZ, Claimant
Own Motion No. 94-0392M
OWN MOTION ORDER
Martin J. McKeown, Claimant Attorney
Liberty NW Ins. Corp., Insurance Carrier

Claimant requests Own Motion relief, contending that the insurer has failed to comply with our August 11, 1994 Own Motion Order. Specifically, claimant seeks an order: (1) directing the insurer to commence the payment of temporary disability benefits until claimant's current medical status becomes stationary; and (2) establishing a time limit for insurer to decide the propriety of the proposed treatment at the Lichtenstein Institute. Having received the parties' respective positions, we proceed with our review.

Entitlement to Temporary Disability Benefits

On August 11, 1994, we issued an order that authorized the payment temporary disability compensation to begin May 6, 1994, the date claimant was hospitalized for surgery. Thereafter, the insurer paid temporary disability benefits from May 6, 1994 to June 24, 1994, the date claimant was released to modified duty. Nearly three years later, on May 6, 1997, the insurer issued a Notice of Closure, which provided for no temporary disability award. By an order dated November 18, 1997, we set aside the May 6, 1997 closure as premature. That order was not appealed.

In his current request for Own Motion relief, claimant requests reinstatement of his temporary disability compensation beginning from June 24, 1994, the date such benefits were terminated. In response to claimant's request, the insurer reports that it re-commenced claimant's temporary disability compensation effective April 22, 1998, the date claimant was once again hospitalized.

After consideration of this matter, we reinstate claimant's temporary disability award effective June 24, 1994. We reach this conclusion based on the following reasoning.

For claims in own motion status, temporary disability compensation shall be paid beginning the date the claimant is hospitalized for surgery or other treatment requiring hospitalization until claimant is declared medically stationary. ORS 656.278(2). However, a carrier may terminate temporary disability compensation if one of the following should occur: (1) the claim is closed pursuant to OAR 438-012-0055; (2) a claim disposition agreement is submitted to the Board pursuant to ORS 656.236(1); or (3) termination of such benefits is authorized by the terms of ORS 656.268(3)(a) through (c). OAR 438-012-0035(4).

ORS 656.268 provides that payment of temporary total disability (TTD) shall continue until whichever of the following events first occurs: (a) the worker returns to regular or modified employment; (b) the attending physician gives the worker a written release to return to regular employment; or (c) the attending physician gives the worker a written release to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment.

Here, claimant returned to work for the employer at injury in a modified capacity in June of 1994. He continued to work in that position through April of 1997, when his employer informed him that the modified job would no longer be available and did not offer claimant an alternate modified job. Claimant has never been released to full duty.

The insurer appropriately terminated TTD when claimant returned to a modified job in June of 1994. However, on this record, we find that claimant was temporarily partially disabled from June 24, 1994 through April of 1997. Because we have found that claimant's disability was partial, claimant is entitled to temporary partial disability (TPD) benefits during the period in question. ORS 656.212; *David L. Gooding*, 47 Van Natta 1468 (1995); *Ricardo Morales*, 47 Van Natta 1394 (1995). The rate of TPD must be based on a comparison of his wages at modified duty with his at-injury wage. ORS 656.212; *Lonnie L. Dysinger*, 47 Van Natta 2282 (1995). A comparison of claimant's wages at modified duty and the wage used to calculate temporary disability pursuant to ORS 656.210 may very well be computed as zero. In any event, that is a matter to be eventually be resolved by the parties once the insurer completes its calculation of claimant's temporary partial disability rate.[1]

Further, we hold that the insurer was obligated to reinstate his TTD when his modified job was withdrawn. OAR 436-060-0030(8) provides that TTD shall begin when a modified job no longer exists or the job offer is withdrawn by the employer. Here, in April of 1997, claimant's modified, permanent job no longer existed when his employer informed him that due to extensive refurbishing his light duty job was no longer available to him and that it did not foresee having any work for an extended period of time that fell within his limitations. Accordingly, claimant was entitled to TTD benefits as of the date his job was eliminated in April of 1997.

The insurer argues that our November 18, 1997 Own Motion Order Reviewing Carrier Closure did not direct it to immediately commence temporary disability benefits. We acknowledge that, in setting aside the insurer's notice of closure, we stated that "this order does not require the insurer to immediately commence payment of temporary disability benefits. * * * If claimant is hospitalized while this claim remains open, payment of temporary disability benefits is authorized from the date of the hospitalization/surgery to continue until such benefits can be lawfully terminated." Nonetheless, the primary issue for resolution in our November 18, 1997 order was the propriety of the insurer's claim closure. Inasmuch as the closure was set aside and the claim reopened, the insurer was required to process the claim in accordance with all applicable laws, including the conversion of TPD into TTD when appropriate. Additionally, based on the record before us, it is now apparent that, contrary to the implication in our prior order, claimant had, in fact, undergone surgery on May 6, 1994. In other words, the condition precedent for commencement of claimant's temporary disability benefits as set forth in our original August 11, 1994 Own Motion Order that reopened the claim (i.e. claimant's hospitalization for surgery) had occurred.

In conclusion, our November 18, 1997 order set aside the insurer's Notice of Closure, which necessarily reinstated the insurer's obligation as set forth in our August 11, 1994 order that reopened the claim.[2] Consequently, claimant is entitled to temporary disability benefits beginning June 24, 1994, the date the insurer stopped paying such benefits. As previously noted, in light of claimant's modified job

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[1] The record does not establish claimant's wages at his modified work. As previously noted, if his "modified" wages either met or exceeded his "at-injury" wages, claimant's temporary partial disability benefits would be zero. However, resolution of that question is not ripe for these proceedings. Any future dispute regarding the insurer's calculation of claimant's temporary disability benefits during the period of June 24, 1994 through April of 1997 may be presented for review should claimant subsequently disagree with the insurer's calculation.

[2] Although the statements contained in our November 18, 1997 order may have provided a basis for the insurer's legitimate doubt regarding its responsibility for the payment of temporary disability compensation, it does not absolve the insurer from its ultimate obligation to provide such benefits in accordance with statutory and administrative requirements.

for several years, it is possible that claimant's TPD during this period will equal zero. However, whenever the job no longer existed, the insurer became obligated to provide TTD and to continue such benefits until lawfully terminated.

Attorney Fee

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.

Medical Treatment at the Lichtenstein Institute

Claimant requests that we provide a time frame in which the insurer must make the necessary evaluations and determinations regarding medical treatment at the Lichtenstein Institute. Inasmuch as this matter pertains to the propriety of proposed medical services, authority to address the issue rests with the Director. *See* ORS 656.245(6), ORS 656.327(1); *Liberty Northwest Insurance Corporation v. Yon*, 137 Or App 413 (1995); *Newell v. SAIF*, 136 Or App 280 (1995), and *SAIF v. Bowen*, 136 Or App 222 (1995). Thus, we are without authority to consider claimant's request regarding treatment at the Lichtenstein Institute.

IT IS SO ORDERED.

In the Matter of the Compensation of
AUDREY L. McDANIEL, Claimant
WCB Case No. 97-09297
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Livesley's order which modified an Order on Reconsideration to reclassify claimant's nondisabling injury claim as disabling. On review, the issue is claim reclassification. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact but not his findings of ultimate fact. We summarize the factual findings as follows.

Claimant compensably injured her right wrist while performing her janitorial job for the employer on September 13, 1996. She did not report the injury to the employer until September 17, 1996. She received conservative treatment and was released for modified work on September 17, 1996, with restrictions on the use of her right hand. That same day, she returned to a modified job with the employer at her regular, at-injury wage and continued modified employment at her regular wage until September 19, 1996.

Claimant's injury claim was accepted for a nondisabling tenosynovitis of the right wrist. Claimant, who was on probationary status as a new employee, was terminated by the employer on September 19, 1996 for violation of company rules requiring prompt reporting of work injuries.

Claimant challenged the "nondisabling" classification of her claim. By Determination Order dated July 30, 1997, the Department affirmed the "nondisabling" classification. That determination was later affirmed by Order on Reconsideration dated October 16, 1997.

CONCLUSIONS OF LAW AND OPINION

The ALJ disapproved the Order on Reconsideration and Determination Order, concluding that claimant's injury claim must be classified as disabling because she suffered "diminished earning 1424 capacity" due to the compensable injury. In reaching his conclusion, the ALJ relied on pre-1995 case law

(*i.e., Bono v. SAIF*, 298 Or 405 (1984), *Safeway Stores v. Owsley*, 91 Or App 475 (1988), and *RSG Forest Products v. Jensen*, 127 Or App 247 (1994)) for the proposition that proof of "diminished earning power" is sufficient to establish entitlement to temporary disability benefits. The ALJ also found that the employer did not comply with the requirements of ORS 656.325(5)(b).

On review, the employer argues that claimant must prove actual loss of wages to establish entitlement to temporary disability under the current, post-1995 law and that the provisions of ORS 656.325(5)(b) do not apply to the facts of this case. The employer argues that claimant has not proven a loss of wages and that her claim should therefore remain classified as nondisabling. We agree and reverse.

This case is governed by ORS 656.005(7)(c), which provides:

> "A 'disabling compensable injury' is an injury which entitles the worker to compensation for disability or death. *An injury is not disabling if no temporary benefits are due and payable,* unless there is a reasonable expectation that permanent disability will result from the injury." (Italics added).

Because the record does not support a reasonable expectation that permanent disability will result from the compensable injury, claimant's challenge to the "nondisabling" claim classification rests entirely on her contention that "temporary [disability] benefits are due and payable" for the injury. The ALJ concluded, based on ORS 656.325(5)(b), that temporary disability benefits were due and payable for the period beginning September 19, 1996, the date that claimant's employment was terminated for violation of company rules.

ORS 656.325(5)(b) provides:

> "If a 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 [the temporary total disability (TTD) statute] and commence payments pursuant to ORS 656.212 [the temporary partial disability (TPD) statute] 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."

We previously interpreted and applied this statutory provision in *Ricardo Chavez*, 50 Van Natta 90 (1998). In *Chavez*, we stated that this provision applies only if the worker who has been terminated was entitled to receive TTD benefits under ORS 656.210. *Id.* at 91.

In this case, we conclude that claimant was not entitled to received TTD benefits. Prior to claimant's termination, she was working at a modified job for the employer and receiving her regular, at-injury wage. Because she was receiving her regular wage, claimant had sustained no actual loss of wages due to the injury, and she therefore was entitled to TPD benefits at the rate of zero.[1] *See* ORS 656.212(2); *former* OAR 436-060-0030(2) (WCD Admin. Order 96-053); *Nenita Stockie*, 48 Van Natta 299 (1996); *Lonnie L. Dysinger*, 47 Van Natta 2282 (1995). Absent entitlement to TTD benefits, the provisions of ORS 656.325(5)(b) do not apply to the facts of this case.

Furthermore, the record shows that claimant was terminated for violating company rules regarding reporting of injuries. Because she was not terminated for reasons related to her compensable injury, she was not entitled to the payment of TTD following her termination. *See Patricia K. Stodola*, 48

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[1] Notwithstanding the absence of actual wage loss, the ALJ found evidence of "diminished earning capacity" and, relying on pre-1995 case law, concluded that such evidence supported claimant's continued entitlement to TPD benefits. However, the concept of "diminished earning capacity" is no longer relevant to the calculation of TPD benefits. Whereas the pre-1995 version of ORS 656.212 provided that TPD was to be based on the worker's "loss of earning power at any kind of work," *see Stone v. Whittier Wood Products*, 124 Or App 117 (1993), the current version of ORS 656.212 provides that TPD must be based on a comparison between the wage earned at modified work and the at-injury wage. *See Lonnie L. Dysinger*, 47 Van Natta 2282, 2283 (1995). Therefore, it is the actual wage loss, not diminished earning capacity, that determines claimant's rate of TPD. To the extent that prior case law held otherwise, those cases have been legislatively overruled.

Van Natta 613, 614 (1996).[2] Rather, she was entitled to continued receipt of TPD at the same rate (zero) that she was receiving during her modified employment. Accordingly, claimant has not proven that temporary disability benefits were "due and payable," and her injury claim therefore must remain classified as nondisabling.

ORDER

The ALJ's order dated March 13, 1998 is reversed. The Order on Reconsideration is affirmed in its entirety.

[2] The ALJ distinguished *Stodola* on the basis that, whereas the Board in *Stodola* concluded there was no evidence that the claimant suffered diminished earning capacity as a result of her compensable injury, there is evidence in this case that claimant suffered diminished earning capacity due to her injury. We note, however, that the dispositive finding in *Stodola* was that the claimant did not prove any loss of actual wages due to the injury. Therefore, any comment made about the claimant's earning capacity in *Stodola* was gratuitous and unnecessary to our ultimate conclusion that the claimant was not entitled to temporary disability benefits after termination from her modified job.

In the Matter of the Compensation of
STEVE L. PAUL, Claimant
WCB Case No. 97-09986
ORDER DENYING RECONSIDERATION
Reinisch, McKenzie, et al, Defense Attorneys

On June 5, 1998, we issued an Order on Review affirming an Administrative Law Judge's (ALJ's) order that dismissed claimant's request for hearing. On July 7, 1998, we received claimant's letter (dated June 29, 1998), which states: "I [claimant] want an appeal."[1] We interpret the letter as a motion for reconsideration of our June 5, 1998 order. Since our June 5, 1998 order has become final, we deny claimant's motion for reconsideration of our 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 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).

Here, the 30th day following our June 5, 1998 order was Monday, July 6, 1998. Therefore, the final day for us to reconsider our decision was July 6, 1998. Claimant's request for reconsideration was mailed to the Board on July 2, 1998, within the 30-day appeal period. Nevertheless, by the time the reconsideration request was received by the Board (July 7, 1998) and brought to our attention, the 30-day period of ORS 656.295(8) had expired.

Inasmuch as our June 5, 1998 order has neither been stayed, withdrawn, modified, nor appealed by July 6, 1998, we are without authority to alter our prior decision. See ORS 656.295(8); *International Paper Co. v. Wright; Fischer v. SAIF.*

Accordingly, claimant's motion for reconsideration is denied.

IT IS SO ORDERED.

[1] Inasmuch as it is unclear whether the self-insured employer has received a copy of claimant's letter, we have included a copy with its attorney's copy of this order.

In the Matter of the Compensation of
JACK B. ROY, Claimant
WCB Case No. 97-00659
ORDER OF DISMISSAL
Schneider, et al, Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney

Claimant requested Board review of Administrative Law Judge (ALJ) Podnar's June 3, 1998 order. We have reviewed the request to determine whether we have jurisdiction to consider the matter. Because the record does not establish that the Board received a timely request for review within 30 days of the ALJ's order, we dismiss.

FINDINGS OF FACT

On April 16, 1998, the ALJ issued an Opinion and Order that upheld the SAIF Corporation's denial of a right knee condition. After subsequently abating the order, on June 3, 1998, the ALJ issued an Order on Reconsideration republishing the original order.

On July 8, 1998, the Board received claimant's request for review. The request was mailed by certified mail showing the date of mailing on July 6, 1998. On July 10, 1998, the Board mailed a computer-generated acknowledgment of claimant's request for review.

CONCLUSIONS OF LAW AND OPINION

An ALJ's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. *See* ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the ALJ. ORS 656.295(5). Compliance with ORS 656.295 requires that statutory notice of the request be mailed or actual notice be received within the statutory period. *Argonaut Insurance Co. v. King*, 63 Or App 847, 852 (1983).

Filing means the physical delivery of a thing to any permanently staffed office of the Board, or the date of mailing. OAR 438-005-0046(1)(a). If filing of a request for Board review of an ALJ's order is accomplished by mailing, it shall be presumed that the request was mailed on the date shown on a receipt for registered or certified mail bearing the stamp of the United States Postal Service showing the date of mailing. OAR 438-005-0046(1)(b). If the request is actually received by the Board after the date of filing, it shall be presumed that the mailing was untimely unless the party filing establishes that the mailing was timely. *Id.*

Here, the 30th day after the ALJ's June 3, 1998 order was Friday, July 3, 1998. As the receipt for certified mail shows, however, claimant did not mail the request for board review until July 6, 1998. The Board did not receive the request for review until July 8, 1998. Consequently, we lack jurisdiction to review the ALJ's order. *See* ORS 656.289(3). Accordingly, claimant's request for Board review is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID C. KINGSLEY, Claimant
WCB Case No. 97-04887
ORDER ON REVIEW
John C. DeWenter, Claimant Attorney
John M. Pitcher, Defense Attorney

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) McWilliams' order that: (1) found that claimant had timely filed his right direct inquinal hernia injury claim; and (2) set aside the employer's denial of that claim. On review, the issues are timeliness and compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following exceptions, supplementation, and summary. We do not adopt the ultimate findings of fact or the last sentence of the second paragraph of the findings of fact.

We replace the first sentence of the sixth paragraph with the following: "After his observations at surgery, Dr. Schauer told claimant that his hernia was 'possibly' or 'conceivably' work-related." (Tr. 19, Ex. 6).

Some time between Halloween and Thanksgiving of 1996, claimant was lifting a 50-pound box of chains at work and felt pain in his low back, which he attributed to having aggravated a prior back injury. Claimant did not seek medical treatment for this back pain. Following this lifting incident, claimant first sought treatment on February 10, 1997, at which time he saw Dr. Jones, his family physician. Claimant reported increased swelling with intermittent tenderness in the right groin area over the last several weeks. (Ex. A-5). Claimant did not report any work injury at the time of this initial exam. (*Id.*). Dr. Jones diagnosed a right inguinal hernia and referred claimant to Dr. Schauer, M.D., for further treatment.

On April 4, 1997, Dr. Schauer surgically repaired the right hernia. After his observations at surgery, Dr. Schauer told claimant that his hernia was "possibly" or "conceivably" work-related. (Tr. 19, Ex. 6). Dr. Schauer testified that lifting is not the only mechanism that can cause a direct hernia, it can also be caused by straining such as Valsalva or acute cough or a variety of other ways. (Ex. 11-28). Dr. Schauer also explained that a direct hernia would not necessarily have immediate symptoms, and a person could have such a hernia without being aware of it at the time. (Exs. 11-8-10).

CONCLUSIONS OF LAW AND OPINION

Preliminary Matter

As a preliminary matter, we note that Exhibits 8, 9, and 10[1] were admitted at hearing but not included in the hearings record. To resolve this problem, the Board's staff notified the parties about these missing exhibits and requested that the parties submit authenticated copies. Claimant's attorney sent the Board copies of Exhibits 8, 9, and 10 and indicated that he was sending copies to the employer's attorney, who would inform the Board whether he agreed the enclosures were the exhibits admitted into the record at hearing. Having received no indication from the employer's attorney that the copies submitted are other than authenticate copies of Exhibits 8, 9, and 10, we assume that the employer's attorney has no objection to those copies and proceed with our review.

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[1] Exhibit 8 is an August 20, 1997 letter from claimant's attorney to Dr. Jones, claimant's family physician, requesting Dr. Jones' causation opinion and Dr. Jones' September 8, 1997 letter in response. Exhibit 9 is an August 20, 1997 letter from claimant's attorney to Dr. Schauer, claimant's treating surgeon, requesting Dr. Schauer's causation opinion and a September 9, 1997 phone conversation summary in which Dr. Schauer agrees to claimant's attorney's summary of their conversation occurring on that date. Exhibit 10 is a "near miss" accident form.

Timeliness

The ALJ found that claimant timely reported the November 1996 lifting incident to the employer. We adopt the ALJ's reasoning and conclusions regarding this issue.

Compensability

The ALJ found that, because there is no evidence that claimant had any preexisting hernia condition, he need only establish that the lifting incident was a material cause of the right direct inguinal hernia. The ALJ concluded that the claim is compensable, based on Dr. Schauer's opinion. We disagree.

We note that only Dr. Jones, family physician, and Dr. Schauer, treating surgeon, provide opinions regarding the cause of claimant's hernia condition. We also note that the inquiries made of these physicians regarding causation were phrased in terms of whether the lifting incident was the major contributing cause of claimant's hernia condition. Nevertheless, whether claimant's burden of proof is material or major contributing cause, for the following reasons, we find that claimant failed to meet that burden. ORS 656.266.

His surgical findings led Dr. Schauer to diagnose a moderate right direct inguinal hernia. (Ex. 3). Dr. Schauer explained that a direct inguinal hernia is caused by a tear in the transversalis fascia, which is a very thin membrane beneath the floor of the groin. (Ex. 11-9, -18). A direct hernia is a hernia that protrudes through this torn transversalis fascia. (*Id.*). This is in contrast to an indirect hernia, which usually is related to a congenital problem. Dr. Schauer explained that, because the transversalis fascia has no sensation, a direct hernia would not necessarily cause any symptoms at the time it occurred. (Ex. 11-8-10). The hernia would not necessarily be painful until it resulted in stretching or irritation of the peritoneum. (Ex. 9). Thus, a person could have a direct hernia and not be aware of it at the time it occurred. (Ex. 11-10). Dr. Schauer also testified that lifting is not the only mechanism that can cause a direct hernia, it can also be caused by straining such as Valsalva or acute cough or a variety of other ways. (Ex. 11-28).

Considering the number of potential causes identified for claimant's direct hernia condition, the fact that a person would not necessarily have any symptoms or be aware that he had a hernia at the time it occurred, and the passage of time between the work incident and the date claimant sought medical treatment, 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.

In his May 27, 1997 chart note, Dr. Schauer noted that he and claimant discussed the type of hernia claimant had and the issues regarding workers' compensation. (Ex. 6). Dr. Schauer stated that the type of hernia claimant had "where the transversalis fascia is in fact torn is a hernia consistent with traumatic etiology." (*Id.*) He added, "[i]t is conceivable that this was the result of a lifting episode at work to which he alluded to on his initial visit."[2]

In a September 9, 1997 conversation summary prepared by claimant's attorney, Dr. Schauer agreed that, if the facts as stated in the attorney's earlier letter to him were true, "the November 14, 1996 lifting incident at [the employer] is the cause of [claimant's] right direct inguinal hernia which necessitated [his] surgery on April 4, 1997." (Ex. 9-1). Dr. Schauer also added a handwritten note that "the lifting incident which [claimant] alludes to as described by [claimant's attorney's] letter is highly likely to be the direct cause of this hernia in the absence of any other similar event." (*Id.*)

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[2] Dr. Schauer later testified that claimant first told him about a lifting incident at work during claimant's April 15, 1997 post-surgical examination and he did not have anything in his records or recall any specifics about claimant discussing a work injury at his initial exam on March 12, 1997. (Ex. 11-17-18). In fact, Dr. Schauer testified that claimant did not relate his hernia to any work injury during the initial exam because, if claimant had implicated a work injury during that visit, Dr. Schauer would have referred claimant to one of his associates since he does not handle workers' compensation injuries. (Ex. 11-16-17, -22-23, -26-28).

Subsequently, Dr. Schauer was deposed and explained what he meant by his prior opinions in his May 27, 1997 chart note and the September 9, 1997 letter. (Ex. 11). Dr. Schauer testified that, if there is no immediate pain, bulge, or other symptoms caused by the hernia, he identifies the inciting incident by the temporal relationship. (Ex. 11-8-9). In this case, Dr. Schauer explained that two things lead to his opinion that the lifting incident at work was a "direct cause" of the hernia: (1) the type of hernia encountered in surgery; and (2) the work incident being about six months prior, which corresponded to claimant's history. (Ex. 11-21). However, Dr. Schauer also explained that by "direct cause" he meant "[t]hat conceivably that supposed incident, if it did, in fact, happen, could have been the cause of the hernia." (Ex. 11-19-20). In fact, Dr. Schauer repeatedly explained his opinion regarding the work relationship in terms of it being conceivable that the work incident caused claimant's hernia. (Ex. 11-15, -20, -23-24).

Thus, Dr. Schauer's opinions, read as a whole, only indicate the possibility of the work incident causing claimant's hernia. However, a possible causal relationship is not sufficient to prove a compensable injury. *See Gormley v. SAIF*, 52 Or App 1055 (1981) (probability, not possibility, is the requisite standard of proof). In addition, because Dr. Schauer apparently based his causation opinion primarily on the timing of the work incident and the subsequent appearance of symptoms, 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); *Devin D. Cole*, 50 Van Natta 191 (1998); *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).

Dr. Jones provides the only other medical opinion addressing causation. However, Dr. Jones's opinion presents the same problem as Dr. Schauer's opinion. Specifically, Dr. Jones also indicates only a possibility of a causal connection between the lifting incident and claimant's hernia. (Ex. 8).

Accordingly, in the absence of persuasive medical evidence supporting the claim, we uphold the employer's denial.

ORDER

The ALJ's order dated March 2, 1998 is reversed. The self-insured employer's April 18, 1997 denial of claimant's right direct inguinal hernia injury claim is upheld.

In the Matter of the Compensation of
MARLA J. KRISMAN, Claimant
WCB Case No. 97-04725
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's current degenerative spondylolisthesis at L4-5. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

Claimant, age 45 at the time of hearing, has worked for the employer, an airline company, as a customer service representative for more than 10 years. Her job duties include issuing tickets, checking in passengers and moving baggage (weighing up to 100 pounds) onto the conveyer belt. Passenger bags generally weigh between 40 to 70 pounds, and claimant has, on occasion, handled up to 100 bags per day.

On December 13, 1994, claimant experienced a sudden onset of low back pain while lifting a bag weighing approximately 40 pounds and twisting to place the bag on the conveyer belt. She sought treatment and Dr. Pliska diagnosed a lumbar strain. On April 11, 1995, the employer accepted her lumbar strain claim.

Claimant received treatment for a few months, and her symptoms gradually improved. In November 1995, however, she experienced a flare up and returned for further treatment, including physical therapy. She experienced further exacerbations of low back pain in March and May 1996. Dr. Pliska placed claimant on light duty. Her low back symptoms continued despite conservative treatment.

In January 1997, Dr. Pliska referred claimant to Dr. Gambee, an orthopedist. X-rays of claimant's lumbar spine showed degenerative disk disease from T12 to L2, significant degenerative disease at L4-5 with facet arthrosis and degenerative spondylolisthesis. Degenerative spondylolisthesis at L5-S1 was also noted. Dr. Gambee diagnosed degenerative disk disease of the lumbar spine and suggested a return to physical therapy. In a follow-up report, Dr. Gambee put claimant on a permanent lifting restriction.

In March 1997, Dr. Pliska referred claimant to Dr. Laycoe, who diagnosed mechanical low back pain secondary to degenerative spondylolisthesis at L4-5. He reported that claimant had grade I spondylolisthesis with some sclerosis in the pars, suggesting that her condition was an acquired degenerative condition.

On April 10, 1997, the employer denied claimant's current condition and need for treatment, asserting that her grade 1 spondylolisthesis at L4-5 and degenerative disc disease was unrelated to her accepted lumbar strain. On April 21, 1997, Dr. Pliska reported that claimant was, in his opinion, medically stationary. He advised claimant that her current problem was her preexisting spondylolisthesis and degenerative disc disease.

On August 21, 1997, claimant was examined by Dr. Thompson at the employer's request. He diagnosed chronic intermittent low back pain secondary to degenerative spondylolisthesis L4-5 and degenerative disc disease T12 to L2. Dr. Thompson concluded that claimant's current condition was not caused by her December 1994 injury.

On December 11, 1997, claimant was examined by Dr. Gritzka. He diagnosed L4-5 degenerative spondylolisthesis, grade 1, with superimposed lumbosacral sprain. He concluded that claimant's work activities, including her accepted injury, were the major contributing cause of her current disability and need for treatment.

CONCLUSIONS OF LAW AND OPINION

Relying on the opinion of Dr. Gritzka and applying an occupational disease analysis, the ALJ concluded that claimant's work activities for the employer were the major contributing cause of her current condition and her current need for treatment. On review, the employer contends that the compensability of claimant's current condition should be analyzed under ORS 656.005(7)(a)(B) rather than ORS 656.802(2). In addition, the insurer asserts that the persuasive medical evidence fails to support the compensability of claimant's current condition under either statute. For the reasons set forth below, we agree with the employer.

Pursuant to ORS 656.005(24), a preexisting condition includes any injury or disease "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." Here, the expert medical evidence establishes that claimant's degenerative disc disease and degenerative spondylolisthesis at L4-5 preexisted her December 13, 1994 compensable injury. (*See, e.g.*, Exs. 8a, 10-5, 11-7, 12). The record also establishes that, insofar as claimant did not experience any low back symptoms until her December 13, 1994 compensable lumbar strain (an acute event, which generated the sudden onset of low back pain), her compensable injury combined with her preexisting asymptomatic condition to prolong her disability and need for treatment.[1] (*See, e.g.*, Exs. 7, 10, 11).

[1] For example, Dr. Thompson reported that the incident of December 13, 1994 caused "a lumbar strain superimposed on the degenerative spondylolisthesis" which probably caused the onset of her ongoing symptoms. (Ex. 10-5).

Where an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or need for treatment, the applicable statute is ORS 656.005(7)(a)(B). Under that section, "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."

With the exception of Dr. Gritzka, all of the physicians who treated or examined claimant (*i.e.*, Drs. Pliska, Gambee, Laycoe and Thompson) have opined that the major contributing cause of her disability and need for treatment in 1997 is her preexisting, underlying degenerative spondylolisthesis at L4-5. (Exs. 4, 7, 8a, 10, 12). Drs. Laycoe and Thompson both expressly indicated that claimant's current disability is unrelated to her December 1994 lumbar strain. (Exs. 10-5, 12). Although Dr. Gritzka opined that claimant's work activities, including her injury of December 1994, are the major cause of her current disability, we find his opinion insufficient to outweigh the significant evidence to the contrary.

Indeed, because Dr. Gritzka is not claimant's attending physician and he only saw claimant on one occasion in December 1997 (three years after her compensable injury), his opinion is not entitled to any special deference. Further, although Dr. Gritzka recited the magic words, it appears his opinion is based on the fact that claimant's 1994 strain precipitated symptoms in her previously asymptomatic (but admittedly compromised) low back.[2] It is well established that an injury that precipitates symptoms in an asymptomatic condition is not necessarily the major contributing cause. *See Dietz v. Ramuda*, 130 Or App 397, *rev dismissed* 321 Or 416 (1995); *see also Robinson v. SAIF*, 147 Or App 157 (1997). Major causation requires that the work injury or exposure contribute more to the claimed condition that all other causes or exposures combined. *Id.* Although Dr. Gritzka characterizes claimant's December 1994 injury as "activating" her symptoms, he does not opine that the injury caused her degenerative disc disease and spondylolisthesis at L4-5, nor does he explain how the 1994 strain injury continues to affect claimant's symptomatology in December 1997.

Consequently, on this record, we are not persuaded by a preponderance of the evidence that claimant's December 1994 compensable injury is the major contributing cause of her current disability or need for treatment. Furthermore, even if we were to analyze the compensability of claimant's current condition as an occupational disease under ORS 656.802(2), we would find the medical evidence insufficient to establish that claimant's work activity in general was the major contributing cause of her degenerative disc disease and spondylolisthesis at L4-5, or a pathological worsening thereof.

Again, with the exception of Dr. Gritzka, none of the treating or examining physicians related claimant's current condition to her work activities for the employer. Dr. Laycoe found evidence suggesting claimant had "acquired degenerative spondylolisthesis" and did not indicate that her work activity was a contributing factor. (Ex. 7). Dr. Thompson related claimant's condition to a developmental or genetic type of abnormality in the formation of claimant's L4-5 disc rather than her work activity. (Ex. 10-5). Although Dr. Gritzka opined that claimant's work activities were of the type that could be stressful to the lumbar spine, his opinion does not persuasively establish that claimant's work was the major contributing cause of her underlying degenerative disease process.

ORDER

The ALJ's order dated March 6, 1998 is reversed. The employer's April 10, 1997 partial denial is reinstated and affirmed. The ALJ's attorney fee award is also reversed.

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[2] Dr. Gritzka reported that claimant had a certain preexisting anatomical arrangement, a deep-seated L5-S1 intervertebral disc, which caused most of the flexion and extension of her lumbar spine to take place through the L4-5 level, which eventually results in degenerative changes and degenerative spondylolisthesis at that level. He noted that "[t]his condition is usually asymptomatic unless [] something happens to destabilize the situation." He further reported that claimant's injury "activated her condition causing it to become symptomatic and in that way is the major contributing cause of her current disability and need for treatment." (Ex. 11-7).

In the Matter of the Compensation of
JESSE W. MEYER, Claimant
WCB Case No. 97-07926
ORDER ON REVIEW
Woodard & Gerstenfeld, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Bock and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that upheld the insurer's denial of his upper back, bilateral shoulder, and bilateral arm injury claim. In addition, with his brief, claimant submits copies of several documents[1] and requests that we remand the case to the ALJ to supplement the record and allow argument regarding the insurer's alleged failure to comply with claimant's discovery request. On review, the issues are compensability and remand.

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

At hearing, the sole issue was compensability of claimant's upper back, bilateral shoulder, and bilateral arm injury claim. (Tr. 2-3). On review, claimant raises the issue of an alleged discovery violation and requests that we remand the case to the ALJ for further development of the record. In response, the insurer argues that claimant should not be permitted to raise this discovery issue for the first time on review.[2] For the following reasons, we deny claimant's motion to remand.

In the first place, claimant did not raise this alleged discovery violation issue at hearing. To the extent that claimant raises a new issue on review, we are not inclined to address it. *Fred Meyer, Inc. v. Hofstetter*, 151 Or App 21 (1997) (Board did not abuse its discretion in refusing to consider an issue first raised on Board review).

Second, even if we considered claimant's request to remand, we would find that it did not satisfy the requirements to remand. Our review is limited to the record developed at hearing, and we have no authority to consider evidence not admitted in the record at hearing. ORS 656.295(5); *Brown v. SAIF*, 51 Or App 389, 393 (1981). However, 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). 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); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

On review, claimant argues that an issue developed at hearing as to whether Mr. Finley, a co-worker of claimant and a witness for the insurer, was with claimant at the time of the alleged injury. Claimant also argues that the insurer failed to provide documents requested prior to hearing pursuant to a December 3, 1997 Request for Production of Documents, which would have resolved this issue. Claimant further argues that time records and work schedules in the employer's personnel file would answer the question as to the location of Mr. Finley on the day of the work incident. Furthermore, claimant argues, if those time records showed that Mr. Finley was not within "yelling distance" of claimant on the date of the incident, as Mr. Finley testified, other portions of Mr. Finley's testimony would be undermined, including his testimony that he saw claimant performing heavy work with no indication of any problems after the alleged work injury.

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[1] These documents are identified as "Exhibits" A through J. "Exhibit A" consists of copies of: (1) claimant's "Motion/Order to Supplement the Record," which was sent to the Board after the ALJ's order was issued; (2) an affidavit from claimant's attorney; (3) a "Request for Production of Documents" addressed to the attention of the insurer's attorney; and (4) a letter from the Board's staff informing the parties that claimant's motion to "supplement the record" would be addressed at the time of the Board's review of this case. "Exhibit B" is a copy of the ALJ's January 7, 1998 Order and Opinion. "Exhibits C through J" were admitted into the record as Exhibits 1, 2A, 5, 8, 9, 6, 12, and 7, respectively.

[2] In the alternative, the insurer's attorney addressed the merits of claimant's discovery arguments and submitted an affidavit regarding his conversations with claimant's attorney about production of documents in this case.

Reviewing the December 3, 1997 Request for Production of Documents solely for purposes of the remand issue, we note that it requested only documents related to claimant, including copies of claimant's personnel file and payroll ledgers. The documents requested would not provide any information regarding Mr. Finley's time records. In addition, Mr. Frabel, the general manager, also testified that he worked with claimant and witnessed him performing heavy work without problems after the alleged work injury. Therefore, we conclude that, even if the records requested were not timely produced, claimant has failed to prove that those records are material evidence, or that the record was incompletely developed without them. In addition, if claimant was surprised by new evidence at hearing, the remedy was to request a continuance. Accordingly, we are unable to find that a compelling basis exists for remanding this matter to the ALJ. Claimant's motion for remand is, therefore, denied.

ORDER

The ALJ's order dated January 7, 1998 is affirmed.

In the Matter of the Compensation of
JOEY D. SMALLING, Claimant
WCB Case Nos. 96-06633 & 96-10890
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Lane, Powell, Spears & Lubersky, Defense Attorneys

Reviewed by Board Members Bock and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Brazeau's order that upheld the self-insured employer's partial denial of claimant's right ankle instability condition. On review, the issues are propriety of the denial, and, if proper, compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact. We summarize the pertinent findings of fact as follows.

Claimant sustained three right ankle injuries prior to his compensable July 22, 1995 right ankle injury, which the employer accepted as a disabling "right ankle sprain." The first injury occurred off the job in October 1994, when claimant missed his step on a camp trailer. He was diagnosed with a right ankle strain and recovered in about a week. In January 1995, he experienced a compensable Grade I-II right ankle sprain when he turned his ankle going down stairs at work. He returned to work a week later wearing an air splint. The employer accepted a nondisabling "right ankle sprain." The third injury occurred off the job, when claimant caught his right heel in the wheel of an ATV he was unloading from a truck by backing down a ramp. The vehicle fell on him and he sought emergency room treatment for pain from his right hip to his right ankle, which was lacerated. Dr. Dodson noted that claimant had experienced a "significant ankle sprain" and that he was unable to walk. Dr. Dodson also noted that claimant complained of considerable tenderness in all the joints of his right leg. Claimant was taken off work for a week.

On July 22, 1995, claimant inverted his right ankle when he stepped on an uneven surface while working. Two days later, Dr. Williams noted bruising over the medial aspect of claimant's forefoot and heel and reported pain from the distal third of the right tibia to the metatarsal phalangeal joint, both malleoli, and the anterior talofibular ligament. The employer accepted the claim as a disabling right ankle sprain. Subsequent to this injury, claimant continued to experience right ankle problems. In November 1995, considerable ankle laxity was noted after claimant tripped over an electrical cord at work. Claimant's condition improved, and he was released to regular work on December 1, 1995.

In April 1996, claimant reported to his attending physician, Dr. Matheson, that his ankle felt weak and unstable. Matheson found no gross instability of the anterior talofibular ligament and requested a disability determination. Later the same month, claimant experienced another inversion injury to his right ankle. Matheson noted that claimant's ankle problem had become chronic.

In May 1996, Dr. Fuller, orthopedist, conducted a closing examination for the employer. The examination revealed severe subtalar and calcaneofibular ligament laxity on the right, resulting in substantial right ankle instability, and a widening of the syndesmosis and changes on the lateral tibia indicative of an interosseous membrane tear, with a widening of the ankle mortise. Dr. Fuller opined that the right ankle instability preexisted claimant's July 1995 ankle sprain, and that the effects of that sprain had resolved. Fuller declared claimant medically stationary with regard to the accepted July 1995 right ankle sprain injury, and opined that claimant's continuing ankle problem was due to the underlying, preexisting instability. Dr. Matheson concurred.

On June 19, 1996, the employer issued a Notice of Closure closing the accepted July 1995 right ankle sprain claim and awarding only temporary disability. On the same date, the employer issued a partial denial, which provided:

> "We have accepted your sprained right ankle injury. Due to recent medical evidence we are doing a partial denial to read that your July 22, 1995 accepted workers' compensation claim is not the major contributing factor to your right ankle instability secondary to rupture anterior talofibular and calcanofibular ligaments with probable full or partial tear of the tibiofibular syndesmosis and interosseous membrane.
>
> "This is a partial denial of the above mentioned conditions and does not affect the accepted portion of your July 22, 1995 workers' compensation claim." (Ex. 73A).

Claimant requested a hearing contesting the procedural and substantive validity of the employer's partial denial.

On June 28, 1996, claimant began treating with Dr. Holmboe. Dr. Holmboe diagnosed "chronic instability secondary to ligament injury, multiple injuries." On July 31, 1996, Dr. Holmboe operated on claimant's right ankle to repair the anterior talofibular and calcanofibular ligaments.

On July 19, 1996, claimant requested reconsideration of the Notice of Closure, raising the issue of premature claim closure, among other issues. (Ex. 76). An October 4, 1996 Order on Reconsideration affirmed the Notice of Closure in all respects. (Ex. 82).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's accepted July 22, 1995 right ankle sprain was no longer the major contributing cause of his current condition and need for treatment and upheld the employer's partial denial. On review, claimant contends that the employer's June 19, 1996 denial is an improper "back-up" denial or an improper preclosure denial. We disagree.

Claimant contends that the denial is an improper "back-up" denial because it purports to deny the accepted right ankle condition. After our review of the record, we adopt and affirm that portion of the ALJ's order which concluded that the accepted condition ("sprained right ankle") is different from the denied condition ("right ankle instability secondary to rupture anterior talofibular and calcanofibular ligaments with probable full or partial tear of the tibiofibular syndesmosis and interosseous membrane").[1] Consequently, the employer's June 19, 1996 denial is not an improper "back-up" denial of the accepted condition.

Claimant also challenges the employer's denial of his chronic right ankle instability condition as an invalid preclosure denial. The ALJ concluded that ORS 656.262(6)(c)[2] is inapplicable to this case, as the employer had not accepted a "combined" or "consequential" condition. We agree.

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[1] Henceforth, we will refer to the denied condition as "chronic right ankle instability."

[2] 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."

The employer accepted a "right ankle sprain" and not a combined condition involving claimant's preexisting right ankle instability. (Ex. 17). *See Richard L. Markum*, 48 Van Natta 2204 (1996) (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 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). Moreover, ORS 656.262(7)(b),[3] which permits a "pre-closure" denial when the denial is based on the combined condition no longer being compensable under ORS 656.005(7)(a)(B), is not applicable in this case for the same reason. *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).

Because neither ORS 656.262(6)(a) nor 656.262(7)(b) is applicable, 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 separate from the accepted condition,[4] the employer may not issue a pre-closure 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 accepted a disabling right ankle sprain. Claimant did not claim, and the insurer did not accept, a preexisting right ankle laxity condition or a combined condition. On June 19, 1996, the employer issued a denial denying claimant's right ankle instability condition, stating that the denial was a partial denial of that condition and did not affect the accepted sprained right ankle injury portion of the claim. The denial also stated that the accepted July 22, 1995 injury was not the major contributing cause of the instability condition.

At the time the employer issued the denial of claimant's right ankle instability condition, there was no evidence that the accepted right ankle sprain had combined with the right ankle instability condition. To the contrary, Dr. Fuller's discussion of the cause of the instability condition determined only that the syndesmotic changes and injury were present prior to the July 1995 work injury, and that claimant's current condition and need for treatment was due to the instability that occurred as a result of a prior accident that caused the changes in the syndesmotic and interosseous ligaments. (Ex. 70-9, -10).

Because the medical evidence at the time of claim closure unequivocally indicated that claimant's right ankle instability condition was not related to the previously accepted right ankle sprain, we conclude that the insurer's denial was a valid "pre-closure" denial. *See Zora A. Ransom*, 46 Van Natta 1287 (1994) (upholding "pre-closure" denial not based on ORS 656.005(7)(a)(B) where the claimant's current low back strain condition was not related to the accepted low back strain). Finally, because the employer accepted claimant's injury claim for a right ankle sprain (and it has not since denied the accepted condition), we find that the June 19, 1996 denial is properly characterized as a partial denial.

Compensability

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

ORDER

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

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[3] 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."

[4] *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).

In the Matter of the Compensation of
LYNN E. AMSTUTZ, Claimant
WCB Case No. 97-07966
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Reinisch, McKenzie, et al, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Michael Johnson's order that: (1) upheld the self-insured employer's denial of claimant's claim for medical services for a left shoulder impingement syndrome; and (2) declined to assess penalties or penalty-related attorney fees for the employer's allegedly unreasonable denial. In its brief on review, the employer contends that the claim for medical services and the request for penalties/attorney fees are barred by a prior Claim Disposition Agreement (CDA). On review, the issues are claim preclusion, scope of acceptance, compensability, and penalties/attorney fees.

We adopt and affirm the ALJ's order subject to the following alternative rationale on the claim preclusion, scope of acceptance and compensability issues.

Claimant contends that her claim for medical services for her impingement syndrome is compensably related to the accepted January 1994 injury. Accordingly, claimant contends that she is entitled to those medical services under ORS 656.245. The ALJ upheld the employer's denial of the medical services claim, concluding that claimant was barred from arguing that the impingement syndrome is compensably related to the accepted injury. We disagree.

The ALJ reasoned that the September 12, 1995 CDA "outlawed" all of claimant's left shoulder problems except left elbow and shoulder strains. We agree that a CDA that settles "all issues raised or raisable" can extinguish all right to further *non-medical benefits* for accepted conditions enumerated in the CDA, as well as other conditions that have been diagnosed, treated and related to the accepted injury prior to the execution of the CDA. *Trevitts v. Hoffman-Marmolejo*, 138 Or App 455 (1996). However, pursuant to the express terms of ORS 656.236(1) and OAR 438-009-0001(1), a CDA can have no effect on a claimant's right to future medical benefits for any condition compensably related to the accepted claim.

Specifically, ORS 656.236(1) permits parties, by agreement, to make such disposition "of any or all matters regarding a claim, *except for medical services*, as the parties consider reasonable," subject to the terms and conditions prescribed by the Board. (Emphasis supplied). OAR 438-009-0001(1) defines a "claim disposition agreement" as "a written agreement executed by all parties in which a claimant agrees to release rights, or agrees to release an insurer or self-insured employer from obligations, under ORS 656.001 to 656.794 *except for medical services*, in an accepted claim." (Emphasis supplied).

Accordingly, we disagree with the ALJ's conclusion that claimant's medical services claim is barred. *Accord John L. Partible*, 48 Van Natta 434 (1996) (notwithstanding CDA limiting accepted condition to a cervical strain and disc, claimant may seek medical benefits for thoracic strain under prior accepted claim).

Nevertheless, we affirm the ALJ's ultimate ruling based on the following alternative analysis. Claimant contends that the employer's acceptance encompassed her impingement syndrome. We are not persuaded by this argument for the same reasons the ALJ found that the impingement syndrome was not encompassed in the accepted condition identified in the September 1995 CDA. Nor are we persuaded by claimant's alternative argument that the record establishes the requisite causal relationship between her impingement syndrome and the January 1994 injury.

Claimant can establish compensability of her medical services claim by proving that the January 1994 injury directly and materially contributed to the impingement syndrome. *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992). Alternatively, if the impingement syndrome was an indirect consequence of the injury, claimant can establish compensability by proving that the injury was the major contributing cause of the impingement syndrome. ORS 656.005(7)(a)(A).

Claimant relies on her testimony that the symptoms Dr. Zirschky attributed to impingement syndrome are the same symptoms she has experienced since the January 1994 injury. However, we are unwilling to rely on claimant's subjective evaluation of her symptoms, given her documented history of functional overlay. Moreover, as the first diagnosis of an impingement syndrome did not occur until September 1994, eight months after the injury, we conclude that the causation issue in this case is a complex medical question. Accordingly, we conclude that claimant must present persuasive, supporting medical opinion to carry her burden of proof in this matter. *Uris. v. Compensation Department*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279, 283 (1993).

There is no medical evidence in the record to support a finding that the injury was the major contributing cause of claimant's impingement syndrome. Accordingly, claimant cannot establish causation as a consequential condition under ORS 656.005(7)(a)(A). She must, instead, establish a compensable medical services claim by proving a direct and material causal relationship between the injury and the impingement syndrome.

Claimant relies on the opinion of the Dr. Zirschky, the treating orthopedic surgeon. In his initial reports in March 1995 and July 1997, Dr. Zirschky related claimant's impingement syndrome to the January 1995 injury. However, he then opined in October 1997:

> "I can now respond in retrospect since the surgery has been done * * * that she did indeed have findings consistent with bursitis and impingement[.] The shoulder pain syndrome is clearly related to the work exposure and accident. *The impingement itself may be related to the injury.* However, there are additional factors such as weight, condition, age and activity that feed into this." (Emphasis supplied).

Dr. Zirschky's equivocal observation that "[t]he impingement itself *may* be related to the injury" does not satisfy claimant's burden of proving a material contribution by a preponderance of the evidence. Nor does Dr. Zirschky's subsequent ambiguous opinion in November 1997:

> "I believe the original injury, pulling the pallet and lifting, produced the *bursitis*. As I pointed out in the response to the insurance carrier, there are some additional factors that feed into the bursitis and pain syndrome of her left shoulder including weight, conditioning and activities that are not directly related to the job and I believe the *job and work exposure* is the precipitating event for her ongoing *impingement syndrome* problem." (Emphasis supplied).

While Dr. Zirschky relates the bursitis to the original injury, he attributes the impingement syndrome to *job and work exposure,* rather than the specific injury. We are unable to ascertain whether Dr. Zirschky was relating the impingement syndrome to the discrete injury or to claimant's ongoing work activity.

Moreover, even assuming that the injury materially contributed to the impingement syndrome, Dr. Zirschky's opinion does not expressly state that the impingement is the *direct* result of the injury. Nor is such a relationship implicit in his opinion. To the contrary, on September 8, 1997, Dr. Zirschky reported that "[claimant] has chronic refractory shoulder pain, mostly in the deltoid and AC areas related to an old injury and *now* chronic refractory bursitis and impingement." This language suggests that claimant's impingement syndrome arose sometime after the injury rather than immediately and directly from that traumatic event. Furthermore, Dr. Zirschky did not have the opportunity to personally observe the immediate effects of the injury, as he was not the initial treating physician. For these reasons, his opinion does not establish that the impingement syndrome is a direct result of the injury.

In summary, we conclude that Dr. Zirschky's opinion does not establish the January 1994 injury as a direct and material cause of claimant's impingement syndrome. There is no other medical opinion in the record which supports claimant's medical services claim. Accordingly, on this basis, we affirm the ALJ's ultimate decision upholding the employer's medical services denial.

ORDER

The ALJ's order dated April 3, 1998 is affirmed.

In the Matter of the Compensation of
DONALD M. FRANKE, Claimant
Own Motion No. 98-0246M
OWN MOTION ORDER ON RECONSIDERATION
Dale C. Johnson, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our June 30, 1998 Own Motion Order, in which we reopened claimant's claim for the payment of temporary disability benefits commencing April 25, 1998, the date claimant was hospitalized for problems following a myelogram. Claimant contends that he was not hospitalized but was rather treated and then released. Claimant asserts he was not admitted to the hospital until his exploratory surgery on May 15, 1998 and that temporary disability compensation should be authorized beginning May 15, 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 his request for reconsideration, claimant submits an addendum letter wherein he outlines the SAIF Corporation's position regarding his position on the start date of his temporary disability compensation. Claimant's attorney asserts: "I was able to stop issuance of the checks payable under your Own Motion Order of June 30, 1998. SAIF will await the amended order or Own Motion Order on Reconsideration. Claimant understands that payment will be delayed at his request." We interpret SAIF's agreement to withhold timeloss payments at claimant's request, as a concurrence with claimant that temporary disability compensation should be awarded to commence on May 15, 1998, the date he was hospitalized for surgery. Additionally, SAIF has not submitted a contrary position.

Inasmuch as the parties agree that temporary disability compensation should be awarded beginning the date claimant entered the hospital for his exploratory surgery or May 15, 1998, rather than the date he sought treatment following complications arising from his myelogram on April 25, 1998, we withdraw our previous finding regarding the commencement of claimant's temporary disability. Instead, on reconsideration, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning May 15, 1998, the date claimant was hospitalized for surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055. The parties' rights of appeal and reconsideration shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
APRIL HIGGINS, Claimant
WCB Case No. 97-09207
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Hall and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) set aside its denial of claimant's current right shoulder condition; and (2) awarded a $5,000 employer-paid attorney fee under ORS 656.386(1).[1] On review, the issues are compensability and attorney fees.

We adopt and affirm the ALJ's order, with the following modification of the ALJ's opinion regarding the attorney fee issue.

The ALJ awarded a $5,000 assessed attorney fee under ORS 656.386(1), considering the factors set forth in OAR 438-015-0010, particularly the time and effort devoted to the case, the value and nature of the results obtained, and the risk that claimant's attorney may go uncompensated. In considering the risk factor, the ALJ applied a factor of 2.5 as a multiplier.

The employer argues that the ALJ's fee assessment was excessive for several reasons. First, the employer notes that claimant's counsel already received a $3,000 attorney fee for services associated with obtaining acceptance of the initial right shoulder injury claim. Second, the employer contends that this is an uncomplicated matter which "boils down to a simple request" for arthroscopic surgery. (Employer's Brief, p. 13). Finally, because the hearing was relatively short, the only deposition was short, and claimant was the only witness at hearing, the employer argues that claimant's counsel "did nothing extraordinary to promote this claim." *(Id).*

Claimant responds that the prior fee award should not be considered partial payment for services related to this hearing. Considering her counsel's services devoted to overcoming this denial, his experience and expertise, the benefit obtained for claimant, and the risk that counsel might go uncompensated, claimant argues that the ALJ's fee should be affirmed.

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 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. We do not, however, apply a contingency factor or "multiplier" in a strict mathematical sense, as the ALJ did in this case. *E.g., Lois J. Schoch*, 49 Van Natta 788, 790, n.1 (1997); *Lois J. Schoch*, 49 Van Natta 170, 173, n.1 (1997). Rather, we consider the risk factor *in conjunction with the remaining factors*, particularly the time devoted to the case (as represented by the hearing record), the complexity of the issue(s), and the value of the interest involved.

Applying the factors to this case, we find that the time factor is limited. Approximately 32 exhibits were received into evidence, including a "post-hearing" deposition of 43 pages. The hearing transcript consists of approximately 30 pages, with claimant as the only witness who testified. Turning to the complexity factor, when comparing this case to others presented to the Hearings Division for resolution, we find that the issue in dispute (*i.e.*, compensability of claimant's current right shoulder condition) involved issues of average medical complexity, but also issues of slightly above average legal complexity.

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[1] The Board has approved the parties' stipulation resolving the penalty issue litigated at hearing. Accordingly, pursuant to our May 18, 1998 Interim Order of Dismissal, which is automatically incorporated herein, there is no longer a penalty issue on review.

The value factor is significant in this case. Because surgery is involved, the value of the claim and the benefits secured for claimant by his counsel are substantial. The parties' respective counsels presented their positions in a skillful and thorough manner. No frivolous issues or defenses were presented. Finally, considering the employer's vigorous defense and the doctors' diagnostic uncertainty, there was a risk that claimant's counsel's efforts might have gone uncompensated.

Based upon our application of each of the previously enumerated factors and considering the parties' arguments, we conclude that $5,000 is a reasonable and appropriate attorney fee for services at the hearings level in this case.[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 $1,800, 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. Claimant is not entitled to an attorney fee for services related to the attorney fee issue. *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated March 9, 1998 is affirmed. For services on review, claimant is awarded an assessed attorney fee of $1,800, payable by the self-insured employer.

[2] The fee award for claimant's counsel's services in this proceeding is *not* discounted based on the fee awarded for services at the prior hearing concerning claimant's initial injury claim.

In the Matter of the Compensation of
MARY C. AKERS, Claimant
WCB Case No. C8-01357
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

On June 12, 1998 the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We disapprove the proposed disposition.

A claim disposition agreement shall not be approved if, within 30 days of submitting the disposition to us, the worker, insurer or self-insured employer requests that we disapprove the disposition. ORS 656.236(1)(c).

Here, the disposition was submitted to us on June 12, 1998. The statutory 30th day following the submission is July 13, 1998. Claimant filed her request for disapproval of the disposition on July 9, 1998. Accordingly, we disapprove the disposition. *Id.*

It does not appear that the parties were provided with claimant's request for disapproval, we are now providing the parties with a copy.

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-060-0150(5)(k).

IT IS SO ORDERED.

In the Matter of the Compensation of
KIM P. NICHOLS, Claimant
WCB Case Nos. 97-05686 & 97-05611
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by the Board *en banc.*

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Brown's order that awarded claimant temporary total disability benefits from June 14, 1996 to September 3, 1996. On review, the issue is temporary disability.

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

SAIF challenges the ALJ's decision that it unlawfully terminated claimant's temporary total disability (TTD) benefits under ORS 656.325(5). This provision provides in pertinent part:

> "(b) 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*[.]
>
> "(c) If the worker is a person present in the United States in violation of federal immigration laws, 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 *whether or not such a job is available.*" (Emphases supplied).

Here, SAIF terminated claimant's TTD based on the attending physician's approval of a modified position as a "night watch person." The ALJ concluded that the approval of this position did not trigger the provision of ORS 656.325(5)(b) because, pursuant to *former* ORS 181.873, it required a license that claimant does not have. Thus, the ALJ reasoned that the employer had not complied with ORS 656.325(5)(b) because the proposed modified job did not lawfully exist. We agree.

Neither the Board nor the courts have had occasion to construe the term "available" as used in ORS 656.325(5) or elsewhere in Workers' Compensation Law. In defining that term in the present case, we rely on the text and context of the statute. ORS 174.20; *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610 (1993).

While ORS 656.325(5)(b) does not expressly require that the modified job be legally available to the claimant, that is the clear implication when that provision is read in the context of ORS 656.325(5)(c). Specifically, we rely on the inclusion of the phrase "whether or not such a job is available" in subsection (c), and the omission of that phrase from subsection (b). Moreover, we decline to construe ORS 656.325 to allow the employer to avoid its legal obligation to pay temporary disability by offering a job that claimant could not legally perform. *Compare Carillo v. Employment Div.*, 88 Or App 204 (1987) (undocumented alien seeking unemployment compensation was "available for work" where claim was filed prior to the effective date of legislation making it a criminal offense for an undocumented alien to perform work in this country, or for an employer to hire an undocumented alien).

Accordingly, we conclude that the dispositive factual issue in this case is whether the night watch position approved by the attending physician was legally available to claimant.

Under *former* ORS 181.873(1)(a) and 181.878, it is unlawful to work as a "private security officer" without a certificate from the Board of Public Safety Standards and Training. *Former* ORS 181.870(8)(a)(A) defines "private security officer" as an individual who "[p]erforms, as one of the individual's primary responsibilities, *security services* for consideration as an * * * *employee*, whether armed or unarmed, full-time or part-time or in uniform or plain clothes[.]" (Emphasis supplied). *Former*

ORS 181.870(11)(a) defines "security services" to include the "observation and reporting of any unlawful activity." Under *former* ORS 181.870(5), an "employee" is an individual who "renders personal services * * * to an *employer* who pays or agrees to pay the individual at a fixed rate, and includes an applicant for employment to perform security services." (Emphasis supplied). *Former* ORS 181.870(6) defines "employer" as "a *proprietory security manager* or a security contractor." (Emphasis supplied). Finally, *former* ORS 181.870(9) defines "proprietory security manager" as "an individual employed by a person or entity, other than a security contractor, whose responsibilities include implementing security services provided by a private security officer."

Here, the individual working for SAIF's insured who would have arranged the modified night watch position and/or trained claimant for that position is "an individual * * * whose responsibilities include implementing security services provided by a private security officer" within the meaning of *former* ORS 181.870(9). Thus, that individual is a "proprietory security manager" and, therefore, an "employer" within the meaning of *former* ORS 181.870(6). Claimant would have rendered personal services to this proprietory security manager and is, thus, an "employee" under *former* ORS 181.870(5). Finally, one of claimant's primary responsibilities in the night watch position would be "the observation and reporting of any unlawful activity" as provided under *former* ORS 181.870(8)(11)(a). Thus, the individual in the night watch position "[p]erforms, as one of the individual's primary responsibilities, security services for consideration as an . . . employee" within the meaning of *former* ORS 181.870(8)(a)(A). Consequently, an individual performing the night watch position is a "private security officer" within the meaning of *former* ORS 181.873(1)(a) and must be licensed.

Claimant did not have the requisite certificate from the Board of Public Safety Standards and Training. It therefore follows that the ALJ correctly concluded that the night watch position was not "available" modified employment within the meaning of ORS 656.325(5)(b). Accordingly, the ALJ was correct in ordering SAIF to reinstate payment of TTD benefits from June 14, 1996 to September 3, 1996.

Claimant's attorney is entitled to an assessed attorney fee for prevailing over SAIF's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $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 November 26, 1997, as amended and republished on December 23, 1997, is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by SAIF.

In the Matter of the Compensation of
SUSAN LAUGHLIN, Claimant
Own Motion No. 97-0536M
OWN MOTION ORDER OF ABATEMENT
Linerud Law Firm, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

The self-insured employer requests reconsideration of our June 24, 1998 Own Motion Order Reviewing Carrier Closure, in which we set aside the employer's April 14, 1998 Notice of Closure as premature.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
TANGELA E. PURDOM, Claimant
WCB Case No. 97-10187
ORDER ON REVIEW
Michael A. Bliven, Claimant Attorney
David J. Jorling, Defense Attorney

Reviewed by Board Members Moller and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Tenenbaum's order that found that, because claimant had withdrawn her claim prior to the employer's denial, the denial was null and void. In her brief, claimant contends that sanctions should be awarded for the employer's allegedly frivolous request for review. On review, the issues are whether the employer's denial was null and void, and sanctions. We affirm on the merits and deny claimant's request for sanctions.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Denial

We adopt and affirm the ALJ's "Opinion and Conclusions" on the issue of the employer's denial. *See William C. Becker*, 47 Van Natta 1933 (1995) (Board disagreed with the carrier's contention that a claim could not be withdrawn prior to the carrier's denial).

Sanctions

Claimant argues that sanctions should be assessed under ORS 656.390 for the employer's allegedly frivolous appeal. Specifically, claimant contends that the employer "agrees that the current state of the law is as outlined in [the ALJ's] Order." Appellant's Brief, pg. 1.

ORS 656.390(1) provides that if a party requests review by the Board of an ALJ's decision and the Board finds that the appeal was frivolous or was filed in bad faith or for the purpose of harassment, the Board may impose an appropriate sanction upon the attorney who filed the request for review. "Frivolous" means that the matter is not supported by substantial evidence or is initiated without reasonable prospect of prevailing. ORS 656.390(2); *see also Winters v. Woodburn Carcraft Co.*, 142 Or App 182 (1996).

We conclude that sanctions are not appropriate in this case. For the reasons expressed by the ALJ, we disagree with the employer's contention that ORS 656.236(8) provides authority for the proposition that claimant cannot withdraw her claim prior to issuance of the employer's denial. Nevertheless, based on the statutes and Court case law cited by the employer, we conclude that the employer has at least provided a colorable argument to support its request for review. Specifically, the employer raised cases and theories not discussed in *Becker* and its progeny. Accordingly, although we disagree with the employer's contention, we conclude that the appeal is not frivolous. Consequently, claimant's request for sanctions is denied.

ORDER

The ALJ's order dated February 11, 1998 is affirmed. Claimant's request for sanctions is denied.

In the Matter of the Compensation of
JEAN B. ROGERS, Claimant
WCB Case Nos. 93-14437 & 93-14436
ORDER ON REMAND
Schneider, et al, Claimant Attorneys
Hoffman, Hart, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. *Rogers v. Hewlett-Packard Company*, 153 Or App 436 (1998). The court has reversed our prior order, *Jean B. Rogers*, 48 Van Natta 1307 (1996), that held that the self-insured employer's acceptance of claimant's aggravation claim constituted a reclassification of claimant's nondisabling injury claim to disabling. Reasoning that the statutory scheme contemplates the possibility of a valid aggravation claim for a nondisabling injury, the court found no statutory prohibition against accepting an aggravation claim as "nondisabling." Determining that the employer did not unknowingly agree to reclassify claimant's claim from nondisabling to disabling, the court concluded that claimant's recourse was to convince the Board that the compensable injury had become disabling. Consequently, the court has remanded for resolution of this question of fact. In accordance with the court's mandate, we now proceed with our reconsideration.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We begin by briefly summarizing the factual and procedural background of the claim. In September 1991, claimant, a software engineer, developed bilateral upper extremity complaints, for which she filed a workers' compensation claim. The claim was accepted as a nondisabling bilateral wrist overuse condition. Claimant's worksite was modified, but claimant did not miss any work, nor was any permanent disability anticipated by claimant's then-attending physician, Dr. Stevens.

In May 1993, claimant was required to perform increased keyboarding. Claimant's bilateral wrist symptoms returned, worse on the left. Claimant came under the care of Dr. Haddeland and filed a new injury claim. (Ex. 17). The claim was accepted as a "nondisabling" aggravation claim and denied as a "new injury" claim. (Exs. 24, 26)

Requesting a hearing before the Board's Hearings Division, claimant sought to change the employer's acceptance of her aggravation claim from nondisabling to disabling. *See* ORS 656.277(2). The ALJ determined that, because the Hearings Division had jurisdiction over aggravation claims, it therefore had jurisdiction over the classification issue concerning the aggravation claim. Turning to the merits of the classification issue, the ALJ held that the employer's classification of the claim as nondisabling was proper.

In reaching this conclusion, the ALJ reasoned that, in order for an aggravation claim to be classified as "disabling," there either had to be temporary disability benefits due or a reasonable expectation of permanent disability. *See* ORS 656.005(7)(c). Inasmuch as no temporary disability was authorized and because there was no reasonable expectation of permanent disability, the ALJ concluded that claimant's claim should remain classified as "nondisabling." Given this conclusion, the ALJ declined claimant's request for penalties and attorney fees for the employer's allegedly unreasonable failure to properly classify the aggravation claim.

Claimant requested Board review, where she contended that, by accepting claimant's aggravation claim, the employer was necessarily required to classify it as "disabling." Moreover, claimant asserted that the employer's failure to properly classify claimant's aggravation claim was unreasonable, justifying an award of penalties under ORS 656.262(11) or an attorney fee under ORS 656.382(1). In its cross-request for review, the employer contended that the Board did not have jurisdiction to address the classification dispute.

We first determined that the Board had jurisdiction over the classification dispute because the Board has jurisdiction over aggravation claims pursuant to ORS 656.273. Proceeding to the merits of the classification dispute, we reversed that portion of the ALJ's order that declined to reclassify the claim to

disabling. We held that, by accepting an aggravation claim that sought to reclassify a nondisabling injury as disabling, the employer, as a matter of law, accepted the claim as disabling. *Rogers*, 48 Van Natta at 1309.

Claimant petitioned for court review of those portions of our order that declined to award penalties and that limited attorney fees to a portion of claimant's temporary disability. The employer cross-petitioned for court review of our decision regarding the classification issue.

The court reversed the portion of our order that reclassified claimant's aggravation claim as "disabling." Noting that an aggravation claim under ORS 656.273(1) is based on "worsened conditions arising from the original injury," the court found no reason that a worsening of a nondisabling condition cannot also be nondisabling. The court also found nothing in ORS 656.277(2) that limited the carrier to either accepting an aggravation claim as disabling or denying that there had been any worsening.

Finally, the court determined that the carrier was not precluded from accepting less than the entirety of the claim. In doing so, the court concluded that, in accepting claimant's aggravation claim, the carrier could reject her request to reclassify the nondisabling claim to disabling. The court reasoned that claimant's recourse was to request a hearing pursuant to ORS 656.283, challenging the carrier's refusal to reclassify the claim as disabling.

The court has now remanded to us to consider the factual question of whether claimant's claim should be reclassified to "disabling."[1] ORS 656.005(7)(c) provides: "A 'disabling compensable injury' is an injury which entitles the worker to compensation for disability or death. An injury is not disabling if no temporary benefits are due and payable, unless there is a reasonable expectation that permanent disability will result from the injury." In *Karren S. Maldonado*, 47 Van Natta 1535 (1995), we held that to establish a disabling injury under ORS 656.005(7)(c), it is not enough that a claimant be limited to modified work; there also must be entitlement to temporary disability benefits or a reasonable expectation of permanent disability.

Here, claimant lost no time from work and, therefore, is not entitled to temporary disability. Thus, claimant's claim is not disabling under ORS 656.005(7)(c) unless there is a reasonable expectation of permanent disability. Based on this record, we agree with the ALJ that there was no expectation of permanent disability. Dr. Haddeland, claimant's attending physician at the time of the 1993 "aggravation," did not predict that there would be permanent disability. (Ex. 32). Therefore, we conclude that, as a factual matter, claimant's claim was correctly classified as "nondisabling."

Accordingly, on reconsideration, the ALJ's order dated August 23, 1995 is affirmed.

IT IS SO ORDERED.

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[1] Although the employer did not contest our jurisdictional analysis before the court, we take this opportunity to supplement that portion of the ALJ's order that determined that the Hearings Division had jurisdiction over the classification issue. ORS 656.262(6) requires that a claimant be given notice of his or her right to challenge a decision by a carrier to classify a claim as "nondisabling." However, ORS 656.277(1) requires that claimant request reclassification within one year after the injury. In cases such as this, where over a year has passed since the date of injury, the reclassification request cannot be brought before the Director. Under such circumstances (and considering the court's opinion that a claimant has a right to request a hearing pursuant to ORS 656.283 to prove that, as a factual matter, a claim is disabling), we once again conclude that we have jurisdiction to decide the classification issue. *Cf. Degrauw v. Columbia Knit, Inc.*, 118 Or App 277, 281, *rev den* 316 Or 527 (1993) (the claimant must be notified of the classification of the claim, as well as the right to challenge that classification, within a sufficient time period that would allow the status of the claim to be challenged); *Donald R. Dodgin*, 45 Van Natta 1642 (1993) (where a claimant is precluded, through no fault of his own, from seeking reclassification by the Department because the claim was initially classified as nondisabling more than one year after the date of injury, the claimant may request a hearing on the matter pursuant to ORS 656.283(1)).

In the Matter of the Compensation of
SHARON A. SWEET, Claimant
WCB Case No. 97-05161
ORDER ON REVIEW
Cobb & Woodworth, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Myzak's order that: (1) determined that the Department properly considered the issue of whether claimant's claim was prematurely closed; and (2) affirmed an Order on Reconsideration that found that the claim was prematurely closed. On review, the issues are jurisdiction and premature closure.

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

The ALJ affirmed a June 5, 1997 Order on Reconsideration that found that claimant's right hip and head injury claim was prematurely closed. In doing so, the ALJ concluded that the Department's Appellate Unit had authority to review the medically stationary/premature claim closure issue, even though claimant checked the box marked "no" on her reconsideration request form when asked if she was contesting the medically stationary date or raising premature closure as an issue.

Noting that the reconsideration request form contained the comment "not stationary" in the portion of the form asking for the correct medically stationary date, the ALJ reasoned that this was sufficient to raise the premature claim closure issue before the Department. Moreover, based on an analysis of various statutory provisions, the ALJ further reasoned that the Appellate Unit could evaluate the propriety of the claim closure on its own motion. Finally, the ALJ determined that the Order on Reconsideration correctly rescinded the March 10, 1997 Notice of Closure, finding that the medical evidence supported the Department's conclusion that the claim was prematurely closed.

On review, SAIF contends that the Appellate Unit did not have authority to review the premature claim closure issue because the issue was not raised by the parties in the reconsideration proceeding. SAIF also asserts that, even if the issue was properly raised, the claim closure should be affirmed.

We need not determine whether the ALJ's statutory analysis was correct (consequently, we do not adopt that portion of the ALJ's order). That is, we agree with the ALJ's reasoning and conclusion that claimant's reconsideration request form was sufficient to raise the premature claim closure issue, even though the form was incorrectly completed. In addition, we agree, for the reasons the ALJ cited, that the March 10, 1997 Notice of Closure prematurely closed the claim.

Claimant's attorney is entitled to an assessed fee for services on review concerning the premature closure issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by 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 March 30, 1998 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, payable by SAIF.

In the Matter of the Compensation of
BARBARA VIEKE, Claimant
WCB Case No. 96-02685
ORDER ON REVIEW
Pozzi, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that dismissed her hearing request as untimely filed. On review, the issues are timeliness of hearing request and, potentially, compensability.

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

On review, arguing that "[t]his case is directly on point with *Ogden Aviation v. Lay*[, 142 Or App 469 (1996)]," claimant contends that there was good cause to excuse the untimely filing because the calendaring error which led to the late filing was committed by a legal assistant in claimant's former attorney's office rather than the former attorney himself. We disagree, and conclude that this case is not controlled by *Lay*.

In *Lay*, the denial letter was received by the claimant's attorney's office, but the attorney's legal secretary failed to follow the normal procedure of placing the denial on the attorney's desk. As a result of the secretary's error, and due to no fault of the attorney or anyone else responsible for filing the hearing request, the request for hearing was not timely filed.

In this case, by contrast, claimant's former attorney actually received the January 12, 1996 denial letter on January 18, 1996, well within the 60-day period for appealing the denial. At that point, the attorney was aware, or should have been aware, that a hearing request must be filed on or before March 12, 1996. The attorney's actual knowledge of the denial letter distinguishes this case from *Lay*, where the attorney was not made aware of the denial. Although claimant's attorney instructed his legal assistant to calendar the denial for 60 days (for filing of a hearing request), (Tr. 13-14), and the legal assistant apparently miscalculated the 60-day period and marked the attorney's calendar for March 13, 1996, the 61st day, the filing delay is attributable not only to the assistant's calendaring error, but also to the attorney's failure to remember the denial and the filing deadline. *Accord EBI Companies v. Lorence*, 72 Or App 75, *rev den* 299 Or 118 (1985) (negligence of an attorney's secretary in failing to return dictation concerning a hearing request did not excuse the primary negligence of the attorney, where the attorney was aware of the exact date on which the hearing request had to be filed and by reason of having dictated the request, forgot about the file and deadline). Because claimant's former attorney bears fault for the late filing of the hearing request, and the attorney's fault is attributable to claimant, we are not persuaded that the circumstances surrounding the late filing support a finding of good cause under ORS 656.319(1)(b). Accordingly, the ALJ's dismissal order shall be affirmed.

ORDER

The ALJ's order dated January 22, 1998 is affirmed.

In the Matter of the Compensation of
BRADLEY D. ANDERSON, Claimant
WCB Case Nos. 97-08201 & 97-07476
ORDER ON REVIEW
Malagon, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation, on behalf of Mike Brown, Inc. (Brown), requests review of those portions of Administrative Law Judge (ALJ) Spangler's order that: (1) set aside its denial of claimant's "new injury" claim for a low back condition; and (2) upheld SAIF's denial, on behalf of JL Goodell Trucking (Goodell), of claimant's aggravation claim for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

On April 11, 1978, claimant sustained a compensable low back injury while working for an employer not a party to this claim. He was diagnosed with a back strain at L3-4. (Exs. 1, 2, 3). On January 11, 1982, claimant suffered a compensable low back strain while working for a different employer not a party to this claim. (Exs. 4 through 8).

On December 11, 1983, claimant suffered a compensable low back strain while employed by American-West Company, Inc. (American-West), insured by SAIF. American-West accepted "acute traumatic injury to lumbar spine complicated by a chronic lumbar spine injury." (Ex. 15).

Between 1984 and 1987, claimant was under evaluation and treatment for low back pain. In 1986 and 1987, an L4-5 herniated disc/disc bulge was diagnosed. (Exs. 30, 35, 37, 39, 43, 56-3).

On July 13, 1993, while employed at Goodell, claimant compensably injured his low back when he stepped out of his truck. Goodell accepted the claim as a disabling lumbosacral strain. (Ex. 57).

After unsuccessful conservative treatment, claimant began treating with Dr. Lewis, orthopedic surgeon, on May 30, 1997. Relying on a May 5, 1997 MRI, Dr. Lewis diagnosed an acute left herniated disc at L5-S1 and recommended surgery. (Exs. 65, 66, 68). On the same date, claimant filed a "Notice of Claim for Aggravation of Occupational Injury or Disease" with Goodell. (Ex. 67).

On July 2, 1997, Dr. Snodgrass, neurologist, and Dr. Schilperoort, orthopedic surgeon, examined claimant on behalf of Goodell. (Ex. 75). They diagnosed a left herniated disc at L4-5 and preexisting degenerative lumbar disease, for which they recommended surgery. They opined that claimant did not experience a new injury in 1997, that the 1993 injury at Goodell did not cause a herniated disc at L5-S1, and that claimant's current condition was due to a combination of the 1978 and 1983 injuries, plus more than ten years of wear and tear from log truck driving. Finally, they stated that the major contributing cause of claimant's current condition and need for treatment was the 1983 injury. (Ex. 75-7).

Dr. Lewis disagreed with the examiners' report, with the exception of the recommendation for surgery. Dr. Lewis opined that claimant experienced a new injury on March 31, 1997 that caused a herniated disc at L5-S1, as revealed on the May 5, 1997 MRI. (Ex. 79).

On September 2, 1997, Goodell denied compensability and responsibility for claimant's L5-S1 disc herniation. (Ex. 80). On September 15, 1997, claimant filed a "new injury" claim for the L5-S1 herniated disc with Brown. (Ex. 81). On September 29, 1997, Brown denied claimant's L5-S1 herniated disc. (Ex. 82). On September 30, 1997, pursuant to a Board Own Motion order, SAIF reopened claimant's 1983 injury claim with American Western under ORS 656.278. (Ex. 83).

Finding that claimant's L5-S1 disc herniation did not combine with his preexisting low back condition, the ALJ concluded that claimant experienced a new, compensable injury on March 31, 1997 for which Brown was responsible. On review, Brown contends that claimant failed to prove that the

March 31, 1997 incident was the major contributing cause of his L5-S1 herniated disc and need for treatment. Even assuming that the "major contributing cause" standard of ORS 656.308(1) and ORS 656.005(7)(a)(B) is applicable, we disagree with Brown's contention.

The key issue in this case involves medical opinion regarding causation. We agree with the ALJ that Dr. Lewis'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). Moreover, as the treating surgeon, Dr. Lewis was in the unique position to observe claimant's low back pathology during surgery. *See Argonaut Insurance Company v. Mageske*, 93 Or App 698, 702 (1988). Finally, Dr. Lewis evaluated the relative contribution of different causes of the L5-S1 disc and need for treatment in formulating his decision as to which was the primary cause. See *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995); *Gregory C. Noble*, 49 Van Natta 764, 766 (1997), *aff'd mem* 153 Or App 125 (1998).

Dr. Lewis initially examined claimant on May 30, 1997 and reported that claimant had a disc herniation on the left at L5-S1 with left L5 radiculopathy. (Ex. 60). He relied on a May 5, 1997 MRI, which showed a left paramedian to lateral disc bulge/protrusion at L5-S1 with nerve root involvement. He noted that that condition was consistent with claimant's symptom complex (tender at the lumbosacral junction and left greater trochanteric region, positive straight leg raising on the left, diminished left L5 motor strength and sensation). (Exs. 65, 68). Dr. Lewis concluded that claimant's work on March 31, 1997, which involved hauling logs on one of the worst roads claimant had experienced in his career, and the history of progressive and excruciating pain that had increased during his March 31, 1997 workday, was the major contributing cause of the disc pathology at L5-S1. (Ex. 62; Tr. 13, 14).

Dr. Lewis based his conclusion regarding the cause of claimant's condition and need for treatment on claimant's history, examination, and a medical record review. Dr. Lewis explained that, although claimant had some preexisting mechanical low back pain problems related to his previous work and repetitive trauma over time, as well as other potential life factors, and a disc at L4-5, these were not the cause of the L5-S1 disc and the need for surgery.[1] Instead, Dr. Lewis concluded that, based upon reasonable medical probability, claimant's work activities on March 31, 1997 were the cause of his herniated disk and the major cause of his need for medical care, including the surgery performed on October 2, 1997.

On the other hand, Dr. Snodgrass and Dr. Schilperoort were convinced that nothing happened on March 31, 1997 to act as a causal mechanism for an injury to claimant's low back. They relied on claimant's statement to them that nothing traumatic occurred on that date. However, as discussed above, claimant's unrebutted testimony established that the logging road he traversed on the morning of March 31, 1997 was unusually bumpy. Claimant also testified that his intense pain arose over a discrete period of time while he was driving a load of logs at work, which is sufficient to establish that he suffered an injury rather than an occupational disease. *See Valtinson v. SAIF*, 56 Or App 184, 187 (1992). Finally, and most important, even though the doctors were aware that the May 5, 1997 MRI revealed a left lateral disc bulge at L5-S1, they did not address that finding in their analysis of the diagnostic imaging studies, limiting their discussion of causation only to the L4-5 level. (*Compare* Exs. 75-2, 75-5). Because they did not evaluate the contribution of claimant's L5-S1 disc to his current low back condition and need for treatment, we do not find their opinion persuasive. *Somers v. SAIF*, 77 Or App 259 (1986).

Because we conclude that Dr. Lewis's opinion is more persuasive than that of Dr. Snodgrass and Dr. Schilderpoort, we find that claimant's truck driving for Brown on March 31, 1997 was the major contributing cause of the L5-S1 herniated disc at L5-S1 and the need for treatment of that condition.

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

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[1] We note that Dr. Lewis also opined that the L5-S1 disc was "not a combined condition." (Ex. 86). We interpret this remark to indicate that Dr. Lewis did not believe that either claimant's preexisting degenerative condition or his earlier compensable low back strains contributed in any meaningful way to the herniated disc at L5-S1.

ORDER

The ALJ's order dated March 9, 1998 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,500, to be paid by the SAIF Corporation on behalf of Mike Brown, Inc.

In the Matter of the Compensation of
EDWARD VIGIL, Claimant
Own Motion No. 98-0250M
OWN MOTION ORDER
Darris K. Rowell, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation has requested suspension of its obligation to process within 90 days claimant's request for own motion relief for his failure to attend an insurer-arranged medical examination (IME) pursuant to OAR 438-012-0035(5). We find that we do not have the authority to grant SAIF's request for the following reasoning.[1]

OAR 438-012-0035(5) provides in part: "If the own motion insurer believes that temporary disability compensation should be suspended for any reason, the insurer may make a written request for such suspension." However, OAR 438-012-0035(5) pertains to suspension of temporary disability compensation in a claim that has been reopened pursuant to ORS 656.278. Here, claimant's claim has not been reopened nor is it in reopened status. SAIF's request for suspension is not of claimant's temporary disability compensation, but rather a request to suspend its obligation to process claimant's request for own motion benefits which is regulated by OAR 438-012-0030. Thus, suspension of benefits pursuant to OAR 438-012-0035(5) is not applicable to SAIF's obligation to process the claim under OAR 438-012-0030.

Further, OAR 438-012-0030 provides that a recommendation must be submitted by the carrier within 90 days of notification of a request for Own Motion relief, regardless of whether the carrier has resolved any compensability or responsibility issues associated with the claim. This rule is mandatory, not permissive. The carrier does not have the option of inaction. However, under extraordinary circumstances, the carrier can specifically request an extension for submission of the recommendation. Here, SAIF has asked for a "suspension" of its obligation to process claimant's claim, not an "extension" for submission of its recommendation. Additionally, even if we treated SAIF's request as one for an extension of time to file its recommendation, on the record, we do not find that there are extraordinary circumstances that would warrant such an extension.

Finally, SAIF's request for suspension of its obligation to process claimant's request own motion benefits is based on claimant's failure to attend an IME. Under ORS 656.325(1), the carrier may suspend benefits for the claimant's failure to cooperate (i.e. refusing to submit to a medical examination) but only with consent of the Director. *Austin v. Consolidated Freightways*, 74 Or App 680 (1985). Thus, only the Director may suspend benefits for failure to cooperate. *Joe O. Reid*, 42 Van Natta 554 (1990). Inasmuch as suspension of benefits for failure to cooperate rests solely with the Director, we are without authority to consider SAIF's request.

Accordingly, as SAIF's request is outside of the scope of our authority and we find no issues which are ripe for consideration at this time, SAIF's request is dismissed.

IT IS SO ORDERED.

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[1] Member Hall has recused himself from further participation in the review of this claim. *See* OAR 438-011-0023.

In the Matter of the Compensation of
RALPH E. KOOZER, Claimant
Own Motion No. 98-0243M
OWN MOTION ORDER

The insurer has submitted claimant's request for temporary disability compensation for claimant's compensable left L-5 nerve root irritation. Claimant's aggravation rights expired on November 1, 1994. The insurer opposes authorization of temporary disability compensation, contending that: (1) claimant's current condition does not require surgery or inpatient hospitalization; (2) claimant's current condition is not causally related to the accepted condition; (3) the insurer is not responsible for the current condition; and (4) surgery or hospitalization is not reasonable and necessary for the compensable injury.

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

Claimant underwent a lumbar laminectomy with removal of an extruded disc and foraminotomy of the S1 nerve root on October 13, 1997. Therefore, claimant's condition worsened sufficient to require surgery. However, the insurer disputes the compensability of and responsibility for claimant's current condition. We 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 and/or if a medical review by the Director had been requested. The insurer responded by letter dated June 29, 1998 and attached a copy of its June 23, 1998 recommendation cover letter.[1] Claimant has not responded to our request nor to the insurer's contentions.

Thus, the issue of whether claimant's need for the October 13, 1997 surgery is related to his accepted L5 nerve root irritation 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 1989 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 1989 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 insurer asserts that it submitted its own motion recommendation in response to inquiries from claimant's employer as to why medical bills had not been paid for following the October 13, 1997 surgery. It requests the Board's "assessment and order as to the compensability of the medical costs." Under ORS 656.327(1), the Director has exclusive jurisdiction over all pending and future disputes arising under ORS 656.327. Although the insurer has contested the compensability of claimant's current condition, it is also requesting the Board make a finding regarding the medical costs. Consequently, assuming that this is a "327" medical services dispute, exclusive jurisdiction over this case now rests with the Director. *Travis J. Thorpe*, 47 Van Natta 2321 (1995); *Thomas L. Abel*, 47 Van Natta 1571 (1995)

In the Matter of the Compensation of
CUPERTINO A. LOPEZ, Claimant
WCB Case Nos. 96-05874 & 95-10774
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Moller and Bock.

Barrett Business Services (Barrett) requests review of those portions of Administrative Law Judge (ALJ) Mongrain's order that: (1) set aside its denial of claimant's current left leg condition insofar as it denied compensability of a post-traumatic degenerative cyst; and (2) upheld the SAIF Corporation's denial of the same condition. On review, the issues are compensability and responsibility. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of his ultimate findings of fact numbered 2 through 4, and which we supplement and summarize as follows.

On July 2, 1994, claimant compensably injured his lower left leg while working for SAIF's insured. He was diagnosed with a contusion of the left medial lower leg with an anterior hematoma in the upper medial pretibial area. (Ex. 1-3). SAIF accepted a left leg contusion.

On July 29, 1994, claimant again compensably injured his left lower leg while working for Barrett. Claimant demonstrated edema and bruising just proximal to the left ankle. Barrett accepted a left tibial contusion. At an August 3, 1994 follow up examination, an organized hematoma 14 x 8 cm. was observed on claimant's left lower leg. During the next eight to ten weeks of follow up, the physicians described the hematoma as decreasing in size, but with persistent tenderness and localized swelling over the medial aspect of the tibia.

On October 7, 1994, SAIF closed claimant's claim by Determination Order that awarded temporary but no permanent disability benefits.

On November 8, 1994, Dr. Wylie found slight swelling of the left ankle and palpable tenderness over the medial aspect of the medial malleolus anterior to the tibia, about 5-6 cm. proximal to the tibiotalar joint.

On January 16, 1995, Dr. Webb reported that claimant experienced pain in the mid-leg region of the tibialis anterior muscle as well as ankle pain. Dr. Webb diagnosed a benign degenerative cyst in the area of the mid-tibialis anterior muscle of the left leg.

On June 21, 1995, claimant sought treatment for painful swelling of his left leg. Dr. Tice was uncertain as to the etiology of claimant's pain and suspected a myofascial/overuse syndrome. Dr. Versteeg described a cyst-like area on claimant's pretibial and anterior compartment of the left leg "that should not interfere with claimant's activities."

On July 28, 1995, as amended October 5, 1995, Barrett denied claimant's claim for treatment of left leg pain as of June 21, 1995, on the grounds that claimant's current condition was not related to his July 29, 1994 injury or work with Barrett, and that the major contributing cause of his current condition and need for treatment was due to preexisting conditions and not his accepted left tibial contusion.

On May 31, 1997, SAIF denied claimant's aggravation claim on the basis that claimant's accepted condition had not worsened and that the July 29, 1994 injury independently contributed to a worsening of his left leg contusion.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's current left leg condition and need for treatment was not compensably related to either his July 2, 1994 left leg injury at SAIF's insured or his July 29, 1994 left leg injury at Barrett. At the same time, however, the ALJ found that claimant's left leg cyst condition was compensable and that responsibility for that condition lay with Barrett. Therefore, the ALJ set aside Barrett's denial insofar as it related to the compensability of the left leg cyst condition.

On review, the parties do not dispute the ALJ's finding that claimant's current condition and need for treatment is not compensable. However, Barrett contends that, because claimant made no formal written request for acceptance of the new cyst condition pursuant to ORS 656.262(7)(a)[1], it is questionable whether compensability of that condition was actually at issue at the time of the hearing. We conclude that compensability was at issue for the following reasons.

Claimant raised the issues of compensability and medical services in his hearing request. In its response, Barrett stated that claimant had not sustained a work-related injury or occupational disease. All parties participated in depositions prior to hearing in which physicians were queried regarding the cause of the cyst condition. Based upon the parties' framing of the issue at hearing as compensability of claimant's "current" condition, and the employer's failure to challenge the propriety of proceeding with litigation of the compensability of claimant's "current" cyst condition at hearing, we conclude that the parties agreed to litigate the issue of the compensability of the cyst. *See Diane S. Hill*, 48 Van Natta 2351, 2356 n2 (1996), *aff'd mem Hill v. Stuart Andersons*, 149 Or App 496 (1997), citing *EBI Companies v. Thomas*, 66 Or App 105 (1983) (parties in a workers' compensation proceeding may agree to litigate issues not properly raised).

We next turn to the merits of the compensability issue.

Dr. Webb opined that a direct blow to the anterolateral leg had produced soft tissue trauma, which, in turn, resulted in a degenerative cyst. Accordingly, because the causal relationship is indirect, the condition is analyzed as a consequential condition pursuant to ORS 656.005(7)(a)(A).[2]

Opinions regarding causation of the cyst condition were provided by Dr. Webb, who became claimant's attending physician in January 1995, and Dr. Versteeg, who first examined claimant in July 1995.

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, however, we find persuasive reasons not to defer to Dr. Webb. Given the complex nature of claimant's condition, including multiple injuries to the same body part, and the passage of time since the two July 1994 compensable injuries, we find Dr. Webb's causation opinion to be based on an inaccurate medical history and lacking in explanation and analysis. *Miller v. Granite Construction*, 28 Or App 473 (1977); *Somers v. SAIF*, 77 Or App 259 (1986); *Moe v. Ceiling Systems*, 44 Or app 429 (1980). Under such circumstances, we find Dr. Webb's opinion to be unpersuasive.

Dr. Webb, who began treating claimant in January 1995, about six months after the original injury, opined that the cyst was the result of blows to the anterolateral aspect of claimant's leg. He based his original opinion on claimant's report of the injury to him. (Exs. 23, 24). Subsequently, after agreeing that claimant, who does not speak English, is a poor historian, he relied primarily on a description of a contusion and hematoma on the anterior portion of claimant's leg, without a description of medial symptoms, made by Ms. Pylkki, physician's assistant (PA). (Ex. 61-9, -10, -22). However, PA Pylkki's findings specifically noted tenderness and a healing ecchymotic abrasion on the medial distal aspect of claimant's left leg, which was confirmed by Dr. Naugle on two separate occasions. (Exs. 11, 14-2). In addition, the emergency department physicians also noted that the areas of physical findings were located more medially. (Exs. 5-1, 6-2, 7).

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[1] ORS 656.262(7)(a) provides, in part: "Notwithstanding any other provision of this chapter, the worker may initiate a new medical condition claim at any time." ORS 656.262(7)(a) further provides that the worker must clearly request formal written acceptance of any new medical condition and the carrier shall provide written notice of acceptance or denial within 90 days after receipt of the claim. *See also* ORS 656.262(6)(d) (providing, inter alia, that a worker who believes a condition has been incorrectly omitted from the acceptance notice first must communicate in writing to the carrier the worker's objections to the notice before alleging a "de facto" denial at hearing).

[2] 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."

Dr. Webb's assumptions that claimant received two blows to the anterior lateral muscle of claimant's leg are contradicted by the contemporary medical records, which indicate injury specifically to the medial portion of the leg. Moreover, Dr. Webb does not explain how, if the two blows to claimant's leg were both in a medial location on the tibia, those blows contributed to the cyst that developed in or on the mid anterior lateral muscle of the left leg. Therefore, because Dr. Webb's opinion regarding the cause of claimant's cyst condition is not based on an accurate history, nor is it well-explained, we do not find it persuasive.

The ALJ also relied on the opinion of Dr. Versteeg to support compensability. The ALJ's conclusion that the degenerative cyst was due to the compensable contusion injury was, in part, based on his assumption that Dr. Versteeg believed that the contusion injuries caused the cyst. This is not what Dr. Versteeg opined in his deposition. After reviewing claimant's medical records, Dr. Versteeg opined that claimant experienced new bruising as a result of the July 29, 1994 injury at Barrett that enlarged the hematoma claimant had experienced as a result of the July 2, 1994 injury at SAIF's insured. (Exs. 60-14, 60-37). However, after closer examination of the records that discussed the location of claimant's contusions, he opined that the location of the cyst in the mid anterior lateral leg was not consistent with the contemporary medical history of the blows to the medial area of claimant's leg. (Ex. 60-28, -34, -35). Finally, Dr. Versteeg stated that he was unable to relate the cyst, with any degree of medical probability, to either of the compensable injuries. (Ex. 60-29, -33, -34).

Thus, based on this medical record, we conclude that claimant has failed to establish compensability of his cyst condition. Moreover, because his cyst condition is not compensable, we need not address the issue of responsibility.

ORDER

The ALJ's order dated December 5, 1997 is reversed in part and affirmed in part. That portion of the order that set aside Barrett Business Services' denial of claimant's left leg cyst is reversed. The denial is reinstated and upheld. The attorney fee award of $2,000 is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
NORMAN D. BAILEY, Claimant
WCB Case No. C8-01501
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Emmons, Kropp, et al, Claimant Attorneys
John Motley (Saif), Defense Attorney

Reviewed by Board Member Hall and Haynes.

On July 1, 1998, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for his compensable injury. We approve the proposed disposition.

A CDA is "a written agreement executed by all *parties* in which a claimant agrees to release rights, or agrees to release an insurer or self-insured employer from obligations, under ORS 656.001 to 656.794 except for medical services, in an accepted claim." OAR 438-009-0001 (emphasis added); *see also* ORS 656.236(1)(a) (the *parties* to a claim, by agreement, may make such disposition of any or all matters regarding a claim, except for medical services, as the parties consider reasonable, subject to such terms and conditions as the Workers' Compensation Board may prescribe).

The CDA indicates that the employer at the time of claimant's injury or occupational disease was a noncomplying employer (NCE). In addition, the agreement contains the signatures of SAIF's adjuster and legal counsel[1], claimant and his attorney, and a representative of the Department of Consumer and

[1] SAIF is the statutory processing agent for the Department of Consumer and Business Services.

Business Services, whose approval was necessary to obtain reimbursement from the Workers' Benefit Fund. Although the agreement also provides signature lines for the NCE, those signature lines have been left blank.

ORS 656.236(9) provides that an NCE is not a "party" to a CDA. Therefore, we find that the CDA has been executed by all "parties," and that the signature of the NCE is not necessary for Board approval of the CDA. *See James Rydberg*, 47 Van Natta 1107 (1995). Under such circumstances, we find that the agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board, and is not unreasonable as a matter of law. *See* ORS 656.236(1). Accordingly, the parties' CDA is approved. An attorney fee of $1,000 also 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.

July 23, 1998 Cite as 50 Van Natta 1455 (1998)

In the Matter of the Compensation of
JASON J. LAFOYA, Claimant
WCB Case No. 96-07965
ORDER ON RECONSIDERATION
Parker, Bush & Lane, Claimant Attorneys
Lundeen, et al, Defense Attorneys

The insurer requests reconsideration of that portion of our June 25, 1998 Order on Remand that awarded an assessed fee of $3,500 for claimant's counsel's services on Board review and before the Court of Appeals. Noting that no further briefing occurred on remand, and asserting that claimant's services before the court should have consisted merely of a request for remand in light of *Carothers v. Robert Westlund Construction*, 149 Or App 457 (1997), the insurer asserts that claimant's attorney "has done nothing to earn an additional $3,500 on remand." Having received claimant's response to the insurer's reconsideration request, we now proceed with our reconsideration.

In our Order on Review, we reversed the ALJ's order that held that claimant was an Oregon subject worker temporarily in Washington when injured. In doing so, we relied on our decision in *Rodney W. Carothers*, 48 Van Natta 2372 (1996). Claimant appealed our determination that he was not an Oregon subject worker to the Court of Appeals.

While this case was pending appellate review, the court reversed our order in *Carothers*. However, claimant filed an extensive brief (14 pages) before the court prior to the *Carothers* decision. Moreover, claimant has explained why it was necessary to further proceed before the court after *Carothers* was decided. Given this explanation, as well as the fact that briefing was required before the court, we disagree with the insurer's assertion that resolution of court proceedings need only have involved a request for remand in light of *Carothers*. In addition, the insurer neglects to mention that claimant's counsel provided services before the Board in response to the insurer's request for review of the ALJ's order. Claimant did not receive an attorney fee award for those services until our Order on Remand.

Therefore, on reconsideration of our attorney fee award, we adhere to our prior conclusion that a reasonable attorney fee for claimant's counsel's services on Board review and before the Court of Appeals is $3,500. Accordingly, we withdraw our June 25, 1998 Order on Remand. On reconsideration, as supplemented herein, we adhere to and republish our order.[1] The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] We do not award an assessed fee for claimant's counsel's services rendered in response to the insurer's request for reconsideration of our attorney fee award. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

In the Matter of the Compensation of
JIMMY C. McCABE, JR., Claimant
WCB Case No. 97-10090
ORDER ON REVIEW
Bischoff, Strooband & Ousey, 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) Crumme's order that directed it to recalculate claimant's permanent total disability benefits. On review, the issue is rate of permanent total disability benefits.

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

On review, SAIF contends that the ALJ should have relied on OAR 436-060-0025(5) to calculate claimant's benefits. SAIF argues that the rule applies because the evidence shows that claimant was not "regularly employed." SAIF relies on Lowry v. Du Log, Inc., 99 Or App 459 (1989).

We conclude that the ALJ properly calculated claimant's benefits pursuant to ORS 656.210(2)(a), which applies when a worker is regularly employed. As the ALJ noted, "regularly employed" means "actual employment or availability for such employment." ORS 656.210(2)(c). Here, we conclude that the record supports a finding that claimant was available for work six days a week, as required by the employer.

We further conclude that Lowry is distinguishable. In that case, the court concluded that, although the claimant was "regularly employed," he was also paid on other than a daily or weekly basis. Consequently, the statute authorized the director to prescribe the method of establishing the worker's weekly wage. 99 Or App at 461. Here, however, there is no evidence that claimant was paid on "other than" a daily basis. Therefore, the ALJ correctly relied on ORS 656.210(2)(a), rather than the Director's rule.

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, 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 April 10, 1998 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
WAYNE T. SAUNDERS, Claimant
WCB Case No. 97-07774
ORDER ON REVIEW
Rasmussen & Tyler, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Podner's order that: (1) affirmed an Order on Reconsideration that awarded 13 percent (19.5 degrees) scheduled permanent disability for the loss of use or function of the right hand; (2) awarded 14 percent (21 degrees) scheduled permanent disability for the loss of use and function of the left hand; and (3) awarded no scheduled permanent disability for loss of use of function of claimant's legs. On review, the issue is extent of scheduled permanent disability.[1] We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of the last paragraph on page 3 and with the following supplementation.

After returning to modified duty in November 1996, claimant continued to experience spastic gait, numbness in his legs and arms and instability in ambulation. (Exs. 27, 31, 36).

A March 12, 1997 MRI of claimant's cervical spine revealed some atrophy at the C5-6 level. (Ex. 35).

On April 24, 1997, Dr. Rosenbaum performed a closing examination. Rosenbaum found decreased pin perception of the right upper extremity, thorax and right lower extremity consistent with residual spinal cord impingement. (Ex. 36).

CONCLUSIONS OF LAW AND OPINION

On September 30, 1996, claimant compensably injured his neck after which he developed gait instability. Dr. Rosenbaum, his attending physician, surgically decompressed a herniated disc at C5-6. A Determination Order awarded 19 percent unscheduled permanent disability, 14 percent scheduled permanent disability for the loss of use or function of each arm, and 23 percent scheduled permanent disability for the loss of use or function of each leg. Claimant requested reconsideration and an arbiter panel was appointed. An Order on Reconsideration increased claimant's unscheduled permanent disability to 23 percent. In addition, in lieu of the Determination Order awards of scheduled permanent disability for each arm, the Order on Reconsideration awarded 14 percent scheduled permanent disability for the left hand and 13 percent for the right hand. Finally, the Order on Reconsideration found that claimant was not entitled to scheduled permanent disability awards for his legs.

The sole issue at hearing was whether claimant is entitled to an impairment rating based on motor loss in his upper and lower extremities under OAR 436-035-0110(11) and 436-035-0230(12). Deferring to the findings of the medical arbiter panel, the ALJ found claimant was not entitled to scheduled permanent disability for motor loss.

On review, claimant contends that he is entitled to an award of scheduled permanent disability based on motor loss. He relies on the closing report of Dr. Rosenbaum, his attending physician, to support the awards of scheduled permanent disability. The insurer argues that we should rely on the opinion of the arbiter panel. We disagree.

Evaluation of a worker's disability is as of the date of issuance of the reconsideration order. ORS 656.283(7). Only disability that is due to the compensable injury gives rise to entitlement to an award. ORS 656.214. In evaluating claimant's permanent disability, we do not automatically rely on a

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[1] Claimant was also awarded a total of 23 percent unscheduled permanent disability for his cervical condition. This award is not disputed by the parties.

medical arbiter's opinion in evaluating permanent impairment. *See Raymond L. Owen*, 45 Van Natta 1528 (1993) (impairment is established by a preponderance of medical evidence, considering the medical arbiter's findings and any prior relevant impairment findings), *aff'd Roseburg Forest Products v. Owen*, 129 Or App 442 (1995), *rev den* 320 Or 271 (1994). Instead, we rely on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment. *See Carlos S. Cobian*, 45 Van Natta 1582 (1993).

Motor Loss in the Upper Extremities

We adopt and affirm the ALJ's opinion regarding motor loss in claimant's upper extremities. OAR 436-035-0110(11); 436-035-0007(25).

Motor Loss in the Lower Extremities

The rule pertaining to the lower extremities asks a physician to determine whether motor loss due to brain or spinal cord damage results in "difficulty with elevations, grades, steps and distances." OAR 436-035-0230(12)(a).

Dr. Rosenbaum performed a closing examination on April 24, 1997. He found decreased pin perception in the right lower extremity consistent with residual spinal cord impingement.[2] He also found hyperreflexia, positive Babinski signs and clonus, as well as residual incoordination and spasticity of the lower extremities, with some sensory loss, which limited claimant's ability to coordinate his lower extremities and to walk. Dr. Rosenbaum also stated that claimant was not capable of performing dextrous type activity with his lower extremities, which included ladder climbing. (Ex. 36).

At their examination, the medical arbiter panel noted that claimant's gait was shaky. They found mild motor loss in the lower extremities, consistent with claimant's history of a herniated disc at C5-6, bladder frequency, ankle clonus, and positive right Babinski. They also stated that claimant was permanently precluded from balancing and climbing. However, in an addendum to their original report, the arbiters stated that they were unable to unequivocally identify true *strength* loss and assigned no permanent impairment due to motor strength testing, and, in a second addendum, they rated claimant's *motor loss* in the lower extremities at 0%, based on their opinion that claimant had no loss of motor *strength*.

We do not find this apparent change of opinion persuasive. Motor loss is treated as a separate impairment from loss of strength for determining impairment values under the "standards." *Compare* OAR 436-035-0230(10) (sets forth criteria for valuing impairment due to loss of strength), with OAR 436-035-0230(12) (sets forth separate criteria for valuing motor loss). In light of such circumstances, and lacking an adequate explanation from the arbiters regarding their apparent change of opinion regarding claimant's ratable impairment due to motor loss in the lower extremities, we do not consider their opinion (which appears to consider strength and motor loss as equivalent impairments) to be persuasive.

Instead, we find Dr. Rosenbaum's findings regarding claimant's motor loss in the lower extremities to be more persuasive than that of the arbiters, as they are based on a well-founded evaluation of claimant's impairment. Moreover, Dr. Rosenbaum's findings were confirmed by the arbiters' findings of a shaky gait, ankle clonus and positive Babinski sign. Therefore, based on Dr. Rosenbaum's findings, we conclude that claimant has established that he is entitled to an impairment value of 23 percent scheduled permanent disability for each leg. OAR 436-035-0230(12)(a); 436-035-0007(25). Consequently, we modify the ALJ's order to increase claimant's scheduled permanent disability award for each leg from zero to 23 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).

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[2] This finding is consistent with a March 12, 1997 MRI of claimant's cervical spine that revealed cord atrophy at the C5-6 level.

ORDER

The ALJ's order dated February 23, 1998 is modified. In addition to the Order on Reconsideration's award of 23 percent (73.6 degrees) unscheduled permanent disability for his neck injury, 13 percent (19.5 degrees) scheduled permanent disability for the loss of use or function of the right hand, and 14 percent (21 degrees) scheduled permanent disability for the loss of use and function of the left hand, claimant is awarded 23 percent (34.5 degrees) scheduled permanent disability for the loss of use and function of the right leg and 23 percent (34.5 degrees) for the loss of use and function of the left leg. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's counsel. In the event 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.*

July 23, 1998 Cite as 50 Van Natta 1459 (1998)

In the Matter of the Compensation of
ROSE M. WAKEFIELD, Claimant
WCB Case No. 97-07394
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that affirmed an Order on Reconsideration awarding no permanent disability. On review, the issue is extent of scheduled permanent disability.

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

Relying on *SAIF v. Danboise*, 147 Or App 550 (1997), claimant contends that the medical arbiter's range of motion measurements must be considered to be valid. Apparently, claimant further contends that, because Dr. Bald, the medical arbiter, provided valid measurements, his report should be considered the most persuasive and reliable concerning claimant's impairment.

We agree with the ALJ that the preponderance of medical opinion establishes a different level of impairment than that determined by the medical arbiter. Along with the reasons provided by the ALJ, we note that Dr. Bald's report, although acknowledging that the accepted condition was only "left ankle strain," provided the "Impression" of "Left ankle strain/Achilles' tendinitis." (Ex. 61-4). Dr. Bald further noted "significant limitations" due to the "accepted condition of left ankle strain/Achilles' tendinitis." (*Id.* at 5). Such evidence shows that at least some of Dr. Bald's impairment findings were not based solely on the accepted left ankle strain condition.

Moreover, the only reference in Dr. Bald's report to prior treatment of claimant's left ankle is a fracture in 1982. (*Id.* at 3). In contrast, the record contains evidence that claimant has a more extensive history of treatment to her left ankle, (Ex. 62-5), indicating that Dr. Bald did not have an accurate history.

Thus, even assuming that Dr. Bald's impairment measurements are valid, based on the ALJ's reasoning and the preceding discussion, his report is not sufficiently persuasive to prove entitlement to scheduled permanent disability.

ORDER

The ALJ's order dated January 5, 1998 is affirmed.

In the Matter of the Compensation of
MARK WHITAKER, Claimant
WCB Case No. 97-08418
ORDER DENYING RECONSIDERATION
Susan L. Frank, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Claimant requests reconsideration of our July 10, 1998 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order that: (1) declined to award an assessed attorney fee under ORS 656.386(1); (2) declined to award an attorney fee for allegedly unreasonable resistance to the payment of compensation under ORS 656.382(1); and (3) declined to award a penalty for allegedly unreasonable processing of claimant's injury claim pursuant to ORS 656.262(11). Specifically, claimant requests that we reexamine our determination that *Galbraith v. L.A. Pottsratz Const.*, 152 Or App 790 (1998), and *Kimberly Quality Care v. Bowman*, 148 Or App 292 (1997), are factually distinguishable and that, under the circumstances of this case, the employer's response to claimant's request for hearing did not constitute a "denied claim" for purposes of ORS 656.386(1).

After reviewing claimant's motion, we have nothing further to add to our prior order. Consequently, claimant's request for reconsideration is denied. The parties' rights of appeal shall continue to run from the date of our July 10, 1998 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
SCOTT D. CHAMBERS, Claimant
WCB Case Nos. 97-02881 & 97-02558
ORDER ON RECONSIDERATION
Brothers & Ash, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney
Reinisch, McKenzie, et al, Defense Attorneys

The self-insured employer (Express Personnel) requests reconsideration of our June 29, 1998 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order that: (1) set aside its compensability and responsibility denials of claimant's "new injury" claim for his current low back condition; and (2) upheld the SAIF Corporation's denials of claimant's aggravation claim for the same condition. Specifically, the employer contends that a recent Court of Appeals decision applies to this matter. Having also received claimant's response to the employer's motion, we proceed with our reconsideration of this matter.

On reconsideration, the employer notes that our order found that the 1997 work incident was the major cause of claimant's condition and need for treatment. Consequently, we concluded that, because causation had been proven as to a specific employment, it was not necessary to resort to judicially created rules which govern the initial assignment of responsibility in successive employment cases. However, the employer argues that, in *Safeco Ins. Co. v. Victoria*, 154 Or App 574 (1998), the court held that proof of major causation as to one employer did not constitute proof of "actual causation" in determining whether the last injurious exposure rule should be applied to assign responsibility.

We need not address whether the authority cited by the employer is applicable in this case. As the employer acknowledges, if we adhere to the factual conclusions reached in our prior order, the aforementioned court case will not affect the outcome. In other words, if we continue to rely on Dr. Newby's opinion, the result in this case will be the same under either an "actual causation" or a "last injurious exposure rule" analysis.[1]

The employer contends that our order relied on Dr. Newby's opinion primarily because Dr. Newby was claimant's treating doctor. We disagree with the employer's characterization of our order on review. Our order first explained that we found Dr. Newby's opinion to be persuasive as it considered claimant's degenerative condition and provided an explanation for his belief that claimant's current condition was due, in major part, to work. *Following* that discussion, we also noted that Dr. Newby was both claimant's treating doctor and surgeon. Moreover, after reviewing the remainder of the employer's arguments, we continue to find that Dr. Newby's opinion is persuasive for the reasons set forth in our prior order.

Consequently, we conclude that, based on Dr. Newby's opinion, responsibility was properly assigned to the employer (Express Personnel) by the ALJ. Accordingly, we withdraw our prior order. On reconsideration, as supplemented herein, we republish our June 29, 1998 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] Based on Dr. Newby's opinion, claimant's employment with the employer (Express Personnel) independently contributed to his current disability. Additionally, the employer cannot prove that claimant's employment with SAIF's insured was the sole cause of his condition or that it was impossible that claimant's employment with Express Personnel caused his condition.

In the Matter of the Compensation of
LINDA K. FISTER, Claimant
WCB Case No. 95-05569
ORDER ON REMAND
Max Rae, Claimant Attorney
David L. Runner (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *Fister v. South Hills Health Care*, 149 Or App 214 (1997), *rev den* 326 Or 389 (1998). The court has reversed and remanded our prior order, which declined to consider claimant's testimony regarding her adaptability factor in determining her unscheduled permanent disability for lumbar, thoracic and cervical spine conditions. *Linda K. Fister*, 48 Van Natta 1550 (1996). Holding that we erred in considering the SAIF Corporation's argument, first raised on review, that claimant's testimony was inadmissible, the court has remanded for reconsideration.[1] We proceed with our reconsideration.

FINDINGS OF FACT

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

On reconsideration of the Determination Order, claimant was determined to be medically stationary on August 12, 1994. (Ex. 35-2).

On May 11, 1993, claimant compensably injured herself when she slipped and fell. SAIF accepted a claim for a cervical, mid-back, and low back strain and scalp contusions. On August 25, 1994, claimant's claim was closed by Determination Order that awarded temporary disability but no permanent disability. (Ex. 29). Claimant requested reconsideration and appointment of an arbiter panel. On May 1, 1995, an Order on Reconsideration issued that awarded 14 percent unscheduled permanent disability. (Ex. 35).

Claimant requested a hearing. On November 21, 1995, an Opinion and Order issued that awarded 31 percent unscheduled permanent disability. That award was made in lieu of the May 1, 1995 Order on Reconsideration award.

CONCLUSIONS OF LAW AND OPINION

Claimant was found to be medically stationary on August 12, 1994, and her claim was closed by Determination Order on August 25, 1994. (Exs. 29, 35-2). The standards in effect on the date of the Determination Order control. OAR 436-035-0003(2). Therefore, the disability standards contained in Workers' Compensation Department Administrative Orders Nos. 6-1992 and 93-056 apply to this claim. *Id.*

We republish our reasoning and conclusions regarding claimant's impairment value. Accordingly, after reconsideration, we continue to conclude that claimant has total impairment of 29 percent. Furthermore, we note that the parties do not dispute the age factor (0) or the education factor (4)[2] assigned by the Appellate Reviewer. Thus, only the adaptability factor remains to be determined.

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[1] The Board permitted the parties the opportunity to file supplemental briefs following issuance of the court's remand order. The parties have submitted such briefs, which address the value of claimant's adaptability factor in determining the extent of her unscheduled permanent disability award under the applicable standards.

[2] We note that this education factor consists of the sum of the value of claimant's formal education and the value of her Specific Vocational Preparation (SVP). The Appellate Reviewer found that claimant was allowed a value of +1 for formal education because she had not earned a high school diploma or GED certificate by the time of determination. *Former* OAR 436-35-300(2)(b). In addition, the Appellate Reviewer found that the highest SVP claimant attained in the last five years prior to determination was her job at injury [Certified Nurse's Assistant (CNA)], which the Appellate Reviewer assigned as SVP 4. (Ex. 35-5). The parties do not dispute these findings. An SVP of 4 is assigned a value of 3. *Former* OAR 436-35-300(4). The total value for the education factor is obtained by adding the formal education value (1) and the SVP value (3) for an education value of 4. *Former* OAR 436-35-300(6).

Adaptability is measured by comparing a worker's Base Functional Capacity (BFC) to the Residual Functional Capacity (RFC) at the time of becoming medically stationary. *Former* OAR 436-35-310(2). Here, there is no dispute that claimant's RFC is "medium/light." The dispute focuses solely on claimant's BFC, with claimant contending that her BFC is "heavy" and SAIF contending that it is "medium." Claimant has the burden of proving the nature and extent of any disability resulting from the compensable injury. ORS 656.266.

Here, the parties do not dispute the Appellate Reviewer's finding that the highest SVP claimant attained in the last five years was her at-injury job. (Ex. 35-5). Thus, we find that claimant has met the SVP requirements pursuant to *former* OAR 436-35-300(3). *Former* OAR 436-35-310(4)(c). Therefore, claimant's BFC is determined under *former* OAR 436-35-310(4)(a), which provides for determination of a worker's BFC using:

> "The highest strength category assigned in the DOT [Dictionary of Occupational Titles][3] for the most physically demanding job that the worker has successfully performed in the five (5) years prior to determination. When a combination of DOT codes most accurately describes a worker's duties, the highest strength for the combination of codes shall apply." [Footnote added].

The parties do not dispute that the most physically demanding job claimant performed in the five years prior to determination is her at-injury job as a CNA. The dispute arises over whether the duties of claimant's at-injury job more closely fit within the DOT description of a nurse's assistant [DOT 355.674-014] or an orderly [DOT 355.674-018]. The DOT assigns the nurse's assistant job a strength requirement of "medium," whereas it assigns the orderly job a strength requirement of "heavy." After reviewing the record, including claimant's testimony, we find that a combination of the two DOT codes for nurse's assistant and orderly most accurately describes claimant's at-injury CNA job.

Claimant's job included getting patients up, feeding, bathing, and dressing them. When dressing or changing the patients, claimant had to lift them. The patients weighed from 100 to 150 pounds. She lifted the patients into and out of their beds and wheelchairs, and helped them walk. She turned the patients in their beds without any help, changed their beds, collected soiled linen, and cleaned their rooms. She also took the patients' temperature and blood pressure. She washed the bodies of deceased patients, which required turning them. She had help lifting combative patients. However, she sometimes had no help lifting noncombative patients who were unable to assist themselves. (Tr. 6-8, 17-21).

Many of these duties overlap and are included in the DOT descriptions of both the nurse's assistant position and the orderly position. DOT 355.674-014, 355.674-018. However, several duties are only included in the DOT description of the orderly position, especially important is that the orderly position includes lifting of patients, whereas the nurse's assistant position does not. Also, the orderly position includes bathing deceased patients, whereas the nurse's assistant position does not. Given the overlapping nature of the duties of both positions, and the fact that claimant performed several duties listed exclusively within the orderly job description, including heavy lifting, we conclude that the combination of the DOT codes for both the nurse's assistant and the orderly positions most accurately describes claimant's job. Therefore, pursuant to *former* OAR 436-35-310(4)(a), claimant's BFC is "heavy," the strength requirement of the orderly position. DOT 355.674-018.

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[3] *Former* OAR 436-35-270(3)(a) provides:

"(3) As used in rules 436-35-270 through 436-35-310, the following definitions shall apply unless the context requires otherwise:

"(a) 'Dictionary of Occupational Titles' or (DOT) means the publication of the same name by the U. S. Department of Labor, Fourth Edition Revised 1991."

SAIF argues that claimant does not qualify for a BFC of "heavy" because she did not establish the frequency of lifting required under *former* OAR 436-35-310(4)(e)[4] and *former* OAR 436-35-310(3)[5] to prove her job was "heavy." Specifically, SAIF argues that claimant's testimony that she lifted over 50 pounds "every time I go to work, every day," did not establish that her CNA job required an ability to frequently (*i.e.*, up to 2/3 of the time) lift or carry objects weighing 50 pounds. (Tr. 7-8). We disagree.

As discussed above, claimant's BFC is determined pursuant to *former* OAR 436-35-310(4)(a), which provides that a worker's BFC is the highest strength category assigned in the DOT for the most physically demanding job the worker has successfully performed in the five years prior to determination. On the other hand, as SAIF points out, *former* OAR 436-35-310(4)(e) states that the weight classifications as defined in *former* OAR 436-35-310(3) apply to establish BFC's. Furthermore, the definitions of the various weight classifications include requirements regarding frequency of lifting and/or carrying. *Former* OAR 436-35-310(3). Thus, at first glance, there could be a conflict between a BFC determined in reference to the DOT as required by *former* OAR 436-35-310(4)(a) and a separate analysis of a worker's BFC using the weight classifications defined in *former* OAR 436-35-310(3). However, after further examination of the DOT, we conclude that this possible conflict does not exist.

Oregon has adopted evidentiary rules that govern judicial notice of adjudicative facts and law. *See* ORS 40.060 et seq. Pursuant to ORS 40.065(2) (ORE 201(b)), we may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." Moreover, *former* OAR 436-35-310(4)(a) provides an explicit mandate to use the DOT to determine strength categories. In addition, *former* OAR 436-35-270(3)(a) goes so far as to explicitly identify which version of the DOT applies in rules 436-35-270 through 436-35-310. Given these explicit mandates for the use of the DOT, it is appropriate to take administrative notice of the definitions of the strength categories used in the DOT codes. *See Donald L. Odell*, 49 Van Natta 1872 (1997) (Member Bock, concurring) (appropriate to take administrative notice of DOT Code not cited by the parties in determining which DOT Code most closely fit the claimant's job duties).

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[4] *Former* OAR 436-35-310(4)(e) provides:

"The following classifications shall apply to establish BFCs: sedentary (S), light (L), medium (M), heavy (H) and very heavy (VH) as defined in section (3) of this rule."

We note that the current version of this rule is found at OAR 436-035-0310(4) and contains the same language. *See* WCD Admin. Order 98-055, effective July 1, 1998.

[5] *Former* OAR 436-35-310(3) provides, in relevant part:

"(3) For the purposes of applying this rule the following definitions shall apply:

"* * * * *

"(h) 'Medium (M)' means the worker can occasionally lift 50 pounds and can lift or carry objects weighing up to 25 pounds frequently.

"* * * * *

"(j) 'Heavy (H)' means the worker has the ability to occasionally lift 100 pounds and the ability to frequently lift or carry objects weighing 50 pounds.

"* * * * *

"(m) 'Occasionally' means the activity or condition exists up to 1/3 of the time.

"(n) 'Frequently' means the activity or condition exists up to 2/3 of the time.

"(o) 'Constantly' means the activity or condition exists 2/3 or more of the time."

We note that the current version of this rule is found at OAR 436-035-0310(3) and contains the same language as quoted above. *See* WCD Admin. Order 98-055, effective July 1, 1998.

In reaching this conclusion, we recognize that, in *Groshong v. Montgomery Ward Co.*, 73 Or App 403 (1985), the court held it was improper for the Board to take judicial notice of a DOT Code on review. However, we find *Groshong* distinguishable. First, *Groshong* was decided at a time when the applicable administrative rules did not specifically reference the DOT and require that it be used as a basis for assigning a strength category and specific SVP value, as do the rules applicable to the present case. *See former* OAR 436-35-300(3)(a); OAR 436-35-310(4)(a). In fact, the court's opinion was premised upon the absence of a reference to the DOT in the administrative rules. *Groshong*, 73 Or App at 407. Furthermore, in *Groshong*, the court objected to the Board's use of DOT data to develop facts (evidence) concerning the claimant's job duties. However, here, we are not relying on the DOT to develop facts concerning the claimant's actual work duties -- those are already in the record by virtue of claimant's testimony. Rather, we are using the DOT just as the administrative rules require: as a "standard" for rating the strength requirements of the claimant's job at injury. Therefore, it is appropriate to take administrative notice of the definitions of the various strength "standards" provided by the DOT.

The DOT defines "occasionally" as an "activity or condition [that] exists up to 1/3 of the time." *Dictionary of Occupational Titles*, 4th Ed., Rev. 1991, Appendix C, Page 1013. It defines "frequently" as an "activity or condition [that] exists from 1/3 to 2/3 of the time." *Id.* It defines "constantly" as an "activity or condition [that] exists 2/3 or more of the time." *Id.* These definitions track those provided in *former* OAR 436-35-310(3)(m), (n), and (o). Finally, the DOT defines "medium" and "heavy" work as follows:

> "M-Medium Work - Exerting 20 to 50 pounds of force occasionally, and/or 10 to 25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly to move objects. Physical Demand requirements are in excess of those for Light Work.
>
> "H-Heavy Work - Exerting 50 to 100 pounds of force occasionally, and/or 25 to 50 pounds of force frequently, and/or 10 to 20 pounds of force constantly to move objects. Physical Demand requirements are in excess of those for Medium Work." *Id.*

These definitions of "medium" and "heavy" work are equivalent to the definitions of those terms provided in *former* OAR 436-35-310(3)(h) and (j). By definition, when a DOT code identifies a job as medium or heavy, it takes into consideration the frequency of exertion and the weight involved. Thus, if a worker's job duties fit within a DOT code or a combination of DOT codes, the worker has met the frequency and weight of lifting required by *former* OAR 436-35-310(3).

Here, we have found that claimant's job duties fit within a combination of DOT 355.674-014 and 355.674-018, which the DOT assigns "medium" and "heavy" strength factors, respectively. Based on our above reasoning, these DOT strength factor assignments consider the required amount and frequency of lifting. Therefore, we find that claimant has met her burden of proving that her at-injury job required a "heavy" strength factor.[6]

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[6] SAIF cites *Consuela Trujillo*, 49 Van Natta 1555 (1997), in support of its argument that claimant has not established the required frequency of heavy lifting . We find *Trujillo* distinguishable. In *Trujillo*, the evidence was inconsistent regarding whether the claimant's at-injury job required "medium" or "heavy" strength. A job analysis stated that the job required "medium" strength. However, claimant's affidavit stated that rolls of vinyl weighing between 160 to 200 pounds were carried between three people and rolls of netting material weighing 160 pounds were carried between two people. We relied on the job analysis as providing the appropriate strength category. In reaching this conclusion, we relied on several factors. First, the claimant's affidavit did not establish a BFC of "heavy" because the heaviest loads described by the claimant were shared by a number of people, resulting in no one person carrying the occasional lifting of 100 pounds as required by "heavy" work under *former* OAR 436-035-0310(4)(e). Second, the claimant's affidavit did not discuss whether the lifting ability was rare, occasional or frequent. Third, we rejected the claimant's argument that the DOT for "Lumber Handler," which had a strength category of "heavy" accurately described the claimant's at-injury job.

Here, the evidence is consistent regarding claimant's at-injury job. Claimant's testimony regarding the lifting requirements of her job is not disputed. In other words, there is no job description, or any other evidence, that describes claimant's CNA job differently than does claimant. Moreover, we find that claimant's at-injury job is most accurately described by a combination of DOT codes, the highest strength of which is "heavy." Finally, *Trujillo* did not analyze the definitions of the strength classifications as defined the DOT and the rules, as we have done in the present case.

Comparing claimant's BFC of "heavy" with her RFC of "medium/light" results in an adaptability factor of 4. *Former* OAR 436-35-310(6).

Having determined all of the factors, we assemble them to calculate claimant's disability. Claimant's age and education value (4) is multiplied by the adaptability value of (4) for a total value of 16. That value is added to claimant's impairment value of 29 for a total award of 45 percent unscheduled permanent disability. *Former* OAR 436-35-280(4) through (7).

Accordingly, on reconsideration, the ALJ's order dated November 21, 1995 is modified. In addition to the awards by the ALJ's order and the May 1, 1995 Order on Reconsideration, which totaled 31 percent (99.2 degrees) unscheduled permanent disability, claimant is awarded 14 percent (44.8 degrees) unscheduled permanent disability, for a total award to date of 45 percent (144 degrees) unscheduled permanent disability. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's attorney. However, the total "out-of-compensation" attorney fee granted by the ALJ's and Board orders shall not exceed $3,800.

IT IS SO ORDERED.

In the Matter of the Compensation of
NICHOLAS A. GRAND, Claimant
WCB Case No. 97-06362
ORDER ON REVIEW
Mitchell & Associates, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that upheld the insurer's denial of his claim for L2 spondylosis and degenerative disc disease in the cervical, thoracic and lumbar spine. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following changes. In the fifth paragraph on page 2, we change the last sentence to read: "The defect at L2 was later characterized as spondylolysis. (Exs.22, 28, 33, 37-33)." In the third paragraph on page 3, we replace the last sentence with the following:

> "At hearing, the insurer's attorney asserted that evidence after the denial issued set forth a combined condition and the insurer asked to 'verbally reissue' the denial. (Tr. 2). Claimant's attorney did not object or request a postponement on the 'new' denial. (Tr. 3)."

We change the last paragraph on page 3 to read:

> "On October 16, 1997, claimant was examined by Dr. Stewart, medical arbiter, who believed that all of claimant's symptoms were directly related to the thoracolumbar strain and none of his symptoms were caused by his preexisting degenerative disc disease or spondylolysis. (Ex. 33-5)."

In the second paragraph on page 6, we change the first sentence to refer to "Drs. Reimer and Marble." We change the third sentence in that paragraph to refer to "Dr. Gritzka." In the third paragraph on page 6, we change the third sentence to read: "Dr. Gritzka diagnosed claimant with a chronic cervicothoracic strain. (Ex. 31-8)."

ORDER

The ALJ's order dated February 19, 1998 is affirmed.

In the Matter of the Compensation of
RUTH L. McINTIRE, Claimant
WCB Case Nos. 97-05025 & 97-01888
ORDER ON RECONSIDERATION
Robert J. Guarrasi, Claimant Attorney
Lundeen, et al, Defense Attorneys
Steven A. Wolf (Saif), Defense Attorney

On June 18, 1998, we abated our May 20, 1998 Order on Review that: (1) set aside the SAIF Corporation's denial of claimant's aggravation claim for her current right shoulder condition; (2) upheld Liberty Northwest's denial of claimant's "new injury" claim for the same condition; and (3) found SAIF responsible for the Administrative Law Judge's (ALJ's) $3,800 carrier-paid attorney fee award. This action was taken in response to SAIF's motion for reconsideration. Having received responses from claimant and Liberty, we proceed with our reconsideration.

On reconsideration, SAIF argues that neither our order nor the ALJ's order found that claimant's counsel "actively and meaningfully" participated at hearing as required by ORS 656.307(5). In response, claimant contends that SAIF did not previously raise any objection to the ALJ's award of an attorney fee.

We acknowledge that it is our customary practice to consider only issues raised by the parties at the hearing. *See Gunther H. Jacobi*, 41 Van Natta 1031, 1032 (1991). *See also Fister v. South Hills Health Care*, 149 Or App 214, 218-19 (1997). However, in this case, the fee was first ordered to be paid by SAIF on Board review. At hearing, Liberty was found responsible for claimant's claim and for the assessed attorney fee. As a result of the ALJ's decision, there would have been no reason for SAIF to take a position regarding the attorney fee.

On review, we reversed the ALJ's responsibility determination and assigned responsibility to SAIF. Consequently, because we also found that the hearings level attorney fee award should be paid by SAIF, we conclude that SAIF's challenge to our attorney fee award was not untimely. *See Anthony Foster*, 45 Van Natta 1647, 1781, 1997, 2055 (1993). We, therefore, address the merits of SAIF's motion.

SAIF argues that the matter should be remanded to the ALJ to make findings in accordance with OAR 438-015-0010(4) and *Schoch v. Leupold & Stevens*, 325 Or 112 (1997). More specifically, SAIF contends that there has been no finding whether claimant's counsel "meaningfully" participated in the proceeding as required by ORS 656.307(5).

We have previously rejected similar arguments regarding the applicability of *Schoch*. As explained in *Russell L. Martin*, 50 Van Natta 313 (1998), an ALJ is not obligated to make specific findings regarding the rule-based factors in a case where there was no specific attorney fee request (or statement of services), and the parties had not submitted to the ALJ any argument as to how the rule-based factors should be weighed in determining a reasonable fee. In *Martin*, we concluded that under such circumstances, *Schoch* was distinguishable.

Here, there is no indication that a specific attorney fee request was made to the ALJ or that the parties submitted any argument regarding the factors. Consequently, we conclude that the ALJ did not err in failing to make specific findings, and we decline to remand on that basis. Moreover, we conclude that the record is adequately developed for purposes of review on the issue of claimant's counsel's participation. *See Allen T. Knight*, 48 Van Natta 30 (1996) (Because our review of the matter is *de novo* under *amended* ORS 656.307, we may find facts from which to determine whether claimant's counsel is entitled to an assessed fee under *amended* ORS 656.307(5)). *Cf. Darrell W. Vinson*, 47 Van Natta 356 (1995).

Having dispensed with the remand issue, we turn to the question of whether claimant's counsel is entitled to an attorney fee award for services rendered at the hearing level in this "307" proceeding. Pursuant to the statute, if the "claimant appears at [a "307"] proceeding and actively and meaningfully participates through an attorney, the Administrative Law Judge may require that a reasonable fee for the claimant's attorney be paid by the employer or insurer determined by the Administrative Law Judge to be the party responsible for paying the claim." ORS 656.307(5).

We have concluded that, where the claimant had a material, substantial interest in the responsibility dispute and actively advocated a position on that issue, the claimant actively and meaningfully participated in the "307" hearing. *See Darrell W. Vinson*, 47 Van Natta at 359. Entitlement to an attorney fee award under ORS 656.307 is also not dependent on advocating responsibility for the carrier who is ultimately found responsible. *Vinson*, 47 Van Natta at 358; *Shelley C. Nikolaus*, 48 Van Natta 750 (1996).

SAIF argues that the record does not support a conclusion that claimant's counsel advocated that one carrier or another should be found responsible. On reconsideration, claimant does not dispute that assertion. Rather, claimant urges us to "reject the narrow definition of 'meaningful'" and to find that counsel's efforts in filing claims and a request for hearing are sufficient under the statute.

We decline to adopt claimant's definition of meaningful participation.[1] Such efforts establish that claimant's counsel's services were *active*; they do not support a conclusion that such efforts were "meaningful." Moreover, the statute indicates that the participation is to take place at the .307 proceeding or hearing. Because claimant has not shown that her counsel's participation at hearing was meaningful, we agree with SAIF that the ALJ's assessed attorney fee award must be reversed.

Accordingly, with the above modification and supplementation, we republish our May 20, 1998 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] Claimant effectively disputes the Board's interpretation of "meaningful" as set forth in *Vinson*. We continue to adhere to our decision in that case.

In the Matter of the Compensation of
CARL E. SETZER, Claimant
Own Motion No. 98-0211M
OWN MOTION ORDER OF ABATEMENT
Pozzi, Wilson, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation requests reconsideration of our June 23, 1998 Own Motion Order, in which we authorized reopening of claimant's 1979 claim for the payment of temporary disability compensation.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
GREGORY C. NOBLE, Claimant
WCB Case No. 97-07332
ORDER ON REVIEW
Malagon, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Bock and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Black's order that: (1) set aside its denial of claimant's current right knee condition; and (2) assessed a penalty for an allegedly unreasonable denial. On review, the issues are *res judicata*, compensability, and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Res Judicata/Compensability

We begin with a summary of the facts and the history of the claim.

Claimant injured his right knee at work on October 28, 1995.[1] He filed a claim, which the insurer denied on February 1, 1996. Claimant requested a hearing. On July 22, 1996, a prior ALJ upheld the insurer's denial. (The record for that hearing closed on June 20, 1996). Claimant requested review.

Dr. Lange performed surgery on claimant's right knee on April 23, 1997.

On June 16, 1997, we reversed the prior ALJ's order and set aside the denial, reasoning that claimant carried his burden of proof by establishing that his work injury was the major contributing cause of his need for surgery for his combined condition under ORS 656.005(7)(a)(B). *Gregory C. Noble*, 49 Van Natta 764 (1997); *see also Bonnie J. Brown*, 50 Van Natta 121 (1998) (discussing *Noble* and relevant court cases before and after *Noble*).

On March 18, 1998, the Court of Appeals affirmed our prior order without opinion. *Liberty Northwest Insurance Corporation v. Noble*, 153 Or App 125 (1998).

Meanwhile, on August 29, 1997, the insurer issued a denial of claimant's right knee condition, on the basis that "employment conditions and/or work exposure were not the major contributing cause of [claimant's] disability and need for treatment as of April 23, 1997 [the date of surgery]." (Ex. 28-2). Claimant requested a hearing.

The ALJ held that the insurer's denial was procedurally proper under ORS 656.262(6)(c).[2] However, the ALJ set aside the denial, reasoning that the case presents no issues not addressed by our prior order. We reach the same result.

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[1] Claimant had preexisting right knee degenerative joint disease (DJD) in all three right knee compartments at the time of his 1995 work injury. He had undergone eight right knee surgeries between 1972 and 1988.

[2] 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."

As a threshold matter, we consider the effect of the prior litigation.

"Under the doctrine of issue preclusion, if an issue of fact or law is actually litigated and determined in a valid and final decision and the determination of that issue is essential to the decision, the determination is conclusive in a subsequent proceeding between the parties, whether on the same or a different claim. *Drews v. EBI Companies*, 310 Or. 134, 139-40, 795 P.2d 531 (1990)." *Pepsi Cola Bottling Co. v. Walton*, 147 Or App 698, 701 (1997).

The parties in the present case are the same as at the prior hearing. Our order in the prior matter is final. Our order set aside the insurer's denial of claimant's injury claim, finding that claimant's work injury was the major contributing cause of his need for surgery for this combined condition. The surgery for claimant's compensable combined condition was performed on April 23, 1997.

Thus, the compensability of the April 23, 1997 surgery and claimant's condition as of that date were actually and necessarily determined by our prior order.[3] As we have stated, the parties are the same and our order is final. Under these circumstances, the insurer is precluded from denying claimant's April 23, 1997 condition and surgery.[4] *See Jeld-Wen, Inc. v. Bartz*, 142 Or App 433, 436 (1996) ("Collateral attacks on final order of the Board are not permitted.") (citations omitted); *Weyerhaeuser v. Pitzer*, 123 Or App 1, 4 (1993) (where compensability of a condition was essential to a prior referee's order, the employer was precluded from relitigating that issue); *Cox v. SAIF*, 121 Or App 568 (1993) (compensability may not be relitigated once finally and conclusively determined); *David R. Sills*, 48 Van Natta (1996) (where the issue is the same as previously litigated, a party may not rely on new evidentiary facts to avoid the prior final determination).

The insurer argues that the issue now is not the same as at the prior proceeding because the prior ALJ did not address ORS 656.262(6)(c) and new medical evidence establishes that claimant's need for surgery was not injury-related after all. However, as we have explained, the issue is the same as at the prior hearing. The insurer's reliance on ORS 656.262(6)(c) does not raise a "new issue" for *res judicata* purposes. *See, e.g., Cox v. SAIF*, 121 Or App at 570 (Board erred in holding that the compensability of the conditions may be relitigated subsequent to a change in the law creating a new standard for compensability).

We acknowledge that the conclusive effect of *res judicata* may be abrogated by a statute or valid rule. *See Drews*, 310 Or at 141-42 ("Where a statutory scheme contemplates that the contentions arising from a transaction or series of connected transactions may be split, splitting as contemplated by the statutory scheme is not merged or barred by a former adjudication concerning the overall transaction.") (citation omitted). However, that does not change the result in this case.

Under ORS 656.262(6)(c), the insurer's acceptance of claimant's right knee conditions (pursuant to our order as affirmed by the Court of Appeals)

> "shall not preclude [it] 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." (Emphasis added).

Thus, the statutory scheme specifies the situation where a second proceeding is not precluded by the finality of the first proceeding, *i.e.*, where the compensable injury ceases to be the major contributing cause of the combined condition. *See id.*, 310 Or at 143.

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[3] Dr. Lange suspected that claimant had a torn MCL before the 1997 surgery, but his operative report does not mention the MCL. (*See* Ex. 22). This does not affect the *issue* litigated and determined at the prior proceeding, which was whether the injury caused the need for treatment, whatever the ultimate diagnosis. *See Carling v. SAIF*, 119 Or App 466 (1993) (a claimant need not prove a specific diagnosis to establish compensability); *Adam J. Delfel*, 46 Van Natta 2392 (1994) (same).

[4] The court has also applied a fifth requirement in the *res judicata* analysis. For example, in *Stanich v. Precision Body and Paint, Inc.*, 151 Or App 446 (1997), the court stated that issue preclusion bars relitigation in a subsequent proceeding if the above four requirements are satisfied and "the party sought to be precluded had a full and fair opportunity to be heard on the issue[.]" *Stanich*, 151 Or App at 451 (citation omitted). The insurer does not contend that it did not have a full and fair opportunity to be heard on the compensability issue at the first hearing.

In this case, there is no evidence that the compensable 1995 injury *ceases* to cause claimant's right knee condition, only new evidence addressing the same issue and claim previously adjudicated --the compensability of claimant's condition and need for treatment as of April 23, 1997.

We have previously held that ORS 656.262(6)(c) presumes a change in circumstances or a change in the condition such that the compensable injury "is no longer" the major contributing cause of the claimant's combined condition. *See Richard L. Markum*, 48 Van Natta 2204 (1996); *see also State Farm Ins. Co. v. Lyda*, 150 Or App 554 (1997). Here, because the evidence challenging compensability merely addresses the same condition previously denied (but finally determined to be compensable), it does not suggest that the work injury "is no longer" the cause of the condition. Absent the required change, the statute does not permit the insurer to deny and relitigate the compensability issue.[5]

We assume, without deciding,[6] that the denial addresses claimant's right knee condition *after* April 23, 1997,[7] and "as of April 23, 1997." (*See* Ex. 28-2). We would set aside that portion of the denial on the merits, because we would find Dr. Lange's opinion more persuasive than those of the independent examiners, Drs. Strukel and Donahoo.

After performing claimant's April 23, 1996 surgery, Dr. Lange opined that the 1995 work injury was the major cause of claimant's "decline in functional ability after the accident." (Ex. 30A). We note that this "post surgery" opinion is consistent with (though not exactly the same as) the doctor's previous opinion that claimant's need for surgery was due in major part to the work injury. We also note that, as claimant's treating surgeon, Dr. Lange was in a particularly good position to observe and evaluate claimant's right knee condition (including his DJD). *See Argonaut Insurance Company v. Mageske*, 93 Or App 698 (1988).

Drs. Strukel and Donahoo reviewed claimant's history and interpreted Dr. Lange's operative report. (Exs. 30, 31). The examiners' opinions focus on a perceived inconsistency between Dr. Lange's preoperative diagnosis and the procedures performed during surgery. The examiners essentially reasoned that, because claimant did not have a torn MCL, his need for treatment on April 23, 1996 was due to DJD. We do not find the examiners' reasoning particularly persuasive. Moreover, considering Dr. Lange's unique "hands on" advantage, we cannot say that the persuasiveness of his opinion is diminished by his arguably inaccurate preoperative diagnosis. (*See* n.3, *supra*). Finally, we note that the examiners' opinion regarding the etiology of claimant's condition as of April 23, 1996 is contrary to the law of the case.[8] *See Kuhn v. SAIF*, 73 Or App 768 (1985).

Under these circumstances, we find no persuasive reason to discount Dr. Lange's opinion regarding the etiology of claimant's current right knee condition. *See Argonaut Insurance Company*, 93 Or App at 702; *Weiland v. SAIF*, 64 Or App 810 (1983).

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[5] If it did, few compensability litigations would ever be final. If new medical opinions legally supported new denials without a change in circumstances, nothing would prevent carriers from relitigating the same claim indefinitely if they obtained new medical opinions.

[6] On this record, we cannot say that there is a claim for "post-surgery" treatment or disability. Absent a "post-surgery" claim, a purported denial thereof would be ineffective. However, assuming there is such a claim, we note that it would not be precluded by the prior adjudication.

[7] We note that September 29, 1997 is the latest reference to claimant's "then current" right knee condition. On that date, Dr. Lange opined that the condition was not yet medically stationary. (Ex. 30A-1).

[8] "The law of the case doctrine

'is a general principle of law and one well recognized in this state that when a ruling or decision has been once made in a particular case by an appellate court, while it may be overruled in other cases, it is binding and conclusive both upon the inferior court in any further steps or proceedings in the same litigation and upon the appellate court itself in any subsequent appeal or other proceeding for review.' *State v. Pratt*, 316 Or. 561, 569, 853 P.2d 827, *cert. den.* 510 U.S. 969, 114 S.Ct. 452, 126 L.Ed.2d 384 (1993). (Citations omitted.)." *Blanchard v. Kaiser Foundation Health Plan of the Northwest*, 136 Or App 466, 470, *rev den* 322 Or 362 (1995).

In summary, we set aside the insurer's denial of claimant's right knee condition "as of April 23, 1997," because relitigation of that compensability issue is barred by former adjudication. In addition, assuming that the denial encompasses a "post April 23, 1997" condition, we would set aside that portion of the denial also, on the merits.

Penalties

The ALJ assessed a penalty, reasoning that the insurer had no additional medical evidence supporting its denial and the denial was unreasonable in light of our prior order finding the same condition compensable. The insurer argues that its denial was supported by Dr. Lange's surgical report and the independent examiners' subsequent opinions interpreting that report.

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)).

Here, the insurer had the surgical report, but not the interpretive reports, at the time of the denial. Considering the surgical report in light of ORS 656.262(6)(c) and the insurer's colorable argument that the report represents a change supporting its denial under the statute, we conclude that the insurer had a legitimate doubt regarding its liability for the claim under the particular circumstances of this case. Accordingly, the ALJ's penalty assessment is reversed.

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 denial 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 respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 9, 1998 is reversed in part and affirmed in part. That portion of the order that assessed a penalty is reversed. The remainder of the order is affirmed. For services on review, claimant is awarded a $2,000 attorney fee, payable by the insurer.

In the Matter of the Compensation of
MARK A. WOLF, Claimant
WCB Case No. 97-09990
ORDER ON REVIEW
Richard F. McGinty, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Johnson's order that directed it to recalculate claimant's temporary disability rate. On review, the issue is rate of temporary disability.

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

In mid-August 1995, claimant began working for the employer as a cable installer. During his first four weeks on the job, claimant was in training and was paid an hourly wage. Thereafter, on September 11, 1995, claimant began working under a new wage agreement and was paid at a "piece work" rate.

The employer closed its business between Christmas and New Year's Day. Claimant worked on December 22, 1995 and was scheduled to return to work on January 2, 1996. Claimant was injured playing football on New Year's Day, however, and was unable to return to work until Monday, January 15, 1996.

On February 2, 1996, claimant compensably injured his right ankle when he fell from a ladder while cutting down an old cable. His injury required surgery. Claimant's recovery from the injury and surgery involved complications, including an infection and reactions to medication.

On January 1998, SAIF reviewed claimant's claim file and determined that claimant's temporary disability had been based on an incorrect wage and that he had been overpaid the amount of $2,709.23. SAIF advised claimant that it would "offset" this overpayment against future disability benefits.

At hearing, SAIF's claims auditor testified that claimant's average weekly wage should have been $252.91. In computing claimant's average weekly wage, the auditor added claimant's gross earnings between September 11, 1995 (when claimant's wage earning agreement changed) and February 2, 1996 (the date of injury) and divided those earnings by the number of weeks he worked, excepting only the two week period from January 1, 1996 through January 12, 1996, when claimant was off work due to his football injury. The auditor's calculation therefore included the week between Christmas and New Year's, when the employer was closed and claimant had no earnings.

Relying on *Thomas R. Hellingson*, 49 Van Natta 1562 (1997), the ALJ determined that SAIF's auditor erred in including the holiday vacation week in its computation of claimant's average weekly wage. On review, SAIF contends that its auditor properly included the week in dispute because this week constituted part of the "actual weeks of employment with the employer at injury" under the applicable rule, *former* OAR 436-60-025(5)(a) (WCD Admin. Order 94-055). We disagree.

Former OAR 436-60-025(5)(a) provides, in pertinent part, as follows:

> "For workers employed on call, paid hourly, paid by piece work or with varying hours, shifts or wages, insurers shall use the worker's average weekly earnings with the employer at injury for the 52 weeks prior to the date of injury. For workers employed less than 52 weeks or where extended gaps exist and where there has been no change in the amount or method of the wage earning agreement, insurers shall use the actual weeks of employment with the employer at injury up to the previous 52 weeks. *Where there has been a change in the amount or method of the wage earning agreement during the previous 52-week period, insurers shall use only the actual weeks under the wage earning agreement at time of injury.*" (Emphasis added)

In *Hellingson*, the claimant, who was paid hourly, had taken a two week leave of absence to attend a funeral just prior to his compensable injury. In interpreting the meaning of the phrase "actual weeks worked under the wage agreement" in *former* OAR 436-060-0025(5)(a) (WCD Admin. Order 96-053)[1] we held that weeks in which the claimant did not work or earn wages while on leave of absence should not be included in calculating the claimant's temporary disability rate. In a footnote, we explained that "there is nothing in the first sentence of the rule that requires weeks in which a claimant has no earnings to be factored into a rate of compensation. The first sentence of the rule anticipates irregular or no earnings * * * ." We further explained that our interpretation of the rule was consistent with the statutory scheme, which is based on providing fair, adequate and reasonable income benefits to an injured worker. 49 Van Natta at 1563; *See also* ORS 656.012(2)(a).

Here, it is undisputed that claimant did not work and had no earnings the week of December 25, 1995 because the employer was closed for "Christmas break." Under our interpretation of the phrase "actual weeks worked under the wage agreement" in *Hellingson*, a week in which claimant "did not work or earn wages while on leave" should not be included in calculating his temporary disability rate. For purposes of *former* OAR 436-60-025(5)(a), we see no distinction between a week claimant does not

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[1] With the exception of the word "seasonally" added to the first sentence of the rule, the language of *former* OAR 436-060-0025(5)(a) is unchanged from its predecessor, *former* OAR 436-60-025(5)(a), at issue in this case.

earn wages because he is on personal leave and a week he does not earn wages because the employer is closed for the holidays. Consequently, we agree with the ALJ that SAIF must recalculate claimant's temporary disability rate without considering the week the employer's business was closed as well as the two weeks claimant was off work due to his football injury.[2]

Because we have not disallowed or reduced the compensation awarded to claimant, claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $250 payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated April 3, 1998 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $250, payable by SAIF.

[2] The parties do not dispute that, under the administrative rule and *Hellingson*, the two weeks claimant was off work in January 1996 due to his non-industrial injury should not be considered as actual weeks worked.

In the Matter of the Compensation of
JANNA BAILEY, Claimant
WCB Case No. C8-01584
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Daniel M. Spencer, Claimant Attorney
Sally Anne Curey, Defense Attorney

Reviewed by Board Member Biehl and Haynes.

On July 13, 1998, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

On page 2, number 7, the agreement provides;

"The claim was accepted as non-disabling. As such, the August 12, 1997 Notice of Claim Acceptance constitutes claim closure."

We have previously held that, whether the claim has been accepted as disabling or nondisabling, a notice of acceptance does not constitute closure of a claim. *See Lance J. Thompson*, 49 Van Natta 2052 (1997). Thus, we interpret the CDA as providing that the claim has never been closed. Accordingly, we find that the agreement satisfies OAR 438-009-0022(4)(b) (CDA must give a date of the first claim closure, if any).

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

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

IT IS SO ORDERED.

In the Matter of the Compensation of
TINA M. VALERO, Claimant
WCB Case No. 97-05818
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order that upheld the insurer's denial of her claim for a right arm/wrist condition. On review, the issue is compensability.

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

Claimant, age 31 at the time of hearing, worked for the employer's temporary employment agency from February 17, 1997 through April 15, 1997. During that period, claimant worked at a shoe manufacturing company as a component operator in the tensile department. She worked primarily at a turntable station and a hot melt machine. Her work activity was repetitive and hand intensive, although she was handling materials of low weight that required little exertional force. Claimant worked a compressed work week of three to four 12-hour days, followed by three or four days off. During each shift, claimant had a lunch break, two 15 minute breaks and an optional stretching break of 5 - 10 minutes.

During the course of her work duties on April 15, 1997, claimant developed numbness and tingling in her right hand and forearm. She completed her shift. She awoke the next day with pain and sought treatment with Dr. Thiessen. She has not returned to work.

Claimant treated with Dr. Thiessen on five occasions between April 16, 1997 and June 5, 1997. Dr. Thiessen noted right arm pain of unclear etiology and referred claimant to Dr. Tilson for nerve conduction studies and an orthopedic consultation. A June 2, 1997 electrodiagnostic study by Dr. Jacobs revealed normal functions without findings suggestive of carpal tunnel syndrome. Dr. Thiessen found no true physiologic injury.

On June 3, 1997, claimant was examined by Dr. Radecki at the insurer's request. Dr. Radecki found no objective evidence of a diagnosable condition of the right arm, wrist or hand. Nerve conduction studies showed no abnormalities. Claimant was also examined by Dr. Nolan on September 25, 1997. Dr. Nolan also found no diagnosable condition with respect to claimant's right arm and no objective findings of injury. Dr. Nolan concluded that claimant's work activity was not contributing to her subjective complaints. Dr. Thiessen concurred with the findings of Drs. Radecki and Nolan.

Meanwhile, claimant began treating with Dr. Puziss on July 25, 1997. He diagnosed several conditions of the right hand, wrist and arm and referred claimant to Dr. Long in September 1997 for further electrodiagnostic studies. Dr. Long found mild focal impairment of the right median sensory conduction at the distal edge of the carpal ligament, slightly abnormal residual latencies, right more than left, and slight ulnar compression neuropathy in the proximal forearms, right greater than left.

At hearing, claimant testified that her right hand/arm symptoms have not improved and have actually worsened since April 16, 1997. She testified that she continues to experience pain from her fingertips to her shoulder, that she has difficulty with her household chores and that, at times, she has been unable to hold items such as a soda can or a skillet with her right hand. Claimant also stated that, in the last month and a half, she has been trying to use her left hand instead of her dominant right hand as much as possible. (Tr. 35-36).

Following claimant's testimony, the insurer offered impeachment evidence in the form of a surveillance video tape (recorded on September 20, 23 and 25, 1997), which depicted claimant lifting and holding onto small children, carrying small objects and weeding a flower bed for several minutes with her right hand and arm without apparent difficulty.

Relying on the assessment of Drs. Thiessen, Radecki and Nolan over the contrary opinions of Drs. Puziss, Long and Tilson, the ALJ determined that claimant failed to prove by a preponderance of the evidence that she has a right arm/wrist condition established by medical evidence supported by

objective findings. *See* ORS 656.005(7)(a). Specifically, the ALJ found that, to the extent Drs. Puziss, Long and Tilson noted certain abnormalities, claimant's physical findings and subjective responses to clinical testing were not verifiable indications of a right arm/wrist condition sufficient to meet the standard of "objective findings" for purposes of ORS 656.005(19).

On review, claimant contends that, as a matter of law, she has established "objective findings" of a right arm/hand condition. Claimant also asserts that the causation opinions of Drs. Puziss, Long and Tilson persuasively establish the compensability of her condition. We disagree, for the reasons set forth below.

The insurer's denial asserted that "[i]nsufficient evidence and circumstantial evidence exists to justify a contention that your condition diagnosed as right forearm pain is the result of either an injury or a disease precipitated by your occupational exposure" for the employer. (Ex. 13). Therefore, the denial challenged causation as well as objective findings. Consequently, in addition to establishing "objective findings," claimant must also establish that those findings are the result of her work activities for the employer. *See* ORS 656.005(7)(a); 656.802(2), 656.266.

Here, although Drs. Thiessen and Radecki found no reproducible, measurable or observable evidence of a right hand/arm condition in the first six weeks following claimant's initial onset of symptoms, Dr. Long did note mild defects in his September 18, 1997 electrodiagnostic testing and evaluation of claimant.[1] As claimant notes, nerve conduction test findings can constitute objective findings for purposes of ORS 656.005(19). *See Catherine Gross*, 48 Van Natta 99 (1996) (noting that nerve conduction studies showing a mildly slowed conduction velocity constitute technologic/measurable evidence apart from physical examination findings).

Although claimant may well have shown objective findings of a right arm/hand condition, we are not, on this record, persuaded by a preponderance of the evidence that these findings are causally related to her work activity for the employer. Where the medical evidence on causation is divided, we rely on the opinions which are both well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986). In addition, absent persuasive reasons to do otherwise, we generally rely on the opinion of a worker's treating physician, because of his or her opportunity to observe the claimant over an extended period of time. *See Weiland v. SAIF*, 64 Or App 810 (1983).

Here, we find no persuasive reason not to rely on the assessment of Dr. Thiessen, claimant's first attending physician, who had the opportunity to treat claimant on five occasions in the weeks immediately following her initial onset of symptoms.[2] Dr. Thiessen concluded that claimant had no physiologic injury due to her work activity because of the absence of objective findings over the course of several examinations and the fact that her subjective symptoms did not subside after she stopped working. (Ex. 20). Dr. Thiessen also concurred with the similar assessments of Drs. Radecki and Nathan.

We find the contrary opinions of Drs. Puziss, Long and Tilson conclusory and unpersuasive. First, although Dr. Puziss ultimately became claimant's attending physician, neither he nor Dr. Long had the opportunity to evaluate claimant until several months after the onset of symptoms. *See, e.g., Cody L. Lambert*, 48 Van Natta 115 (1996) (when treatment follows long after key event, Board will not give treating physician's opinion the usual deference). Second, none of these physicians address claimant's inconsistent physical findings and diagnostic test results, nor do they adequately explain the lack of improvement in claimant's subjective symptoms, despite her being off work since April 15, 1997.[3]

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[1] Two prior sets of nerve conduction tests, by Dr. Jacobs on June 2, 1997 and Dr. Radecki on June 3, 1997 were normal and showed no evidence of right median nerve slowing or right ulnar nerve injury. (Exs. 9-2, 10-9).

[2] As noted above, Dr. Thiessen treated claimant between April 16, 1997 and June 5, 1997. He diagnosed right arm pain of unclear etiology.

[3] Indeed, contrary to claimant's testimony at hearing (*i.e.*, that her condition continued to worsen over time and limited her ability to perform housework and lift small objects), Dr. Long reported that claimant had very mild symptoms which were improving over time. (Ex. 22A, pp. 17-20).

Consequently, on this record, we conclude that claimant has failed to prove that she sustained an accidental injury or occupational disease arising out of her work activity for the employer. We therefore uphold the insurer's denial.

ORDER

The ALJ's order dated February 6, 1998 is affirmed.

July 27, 1998 Cite as 50 Van Natta 1477 (1998)

In the Matter of the Compensation of
AMOS PHILLIPS, Claimant
Own Motion No. 98-0299M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable bilateral wrist fractures/disclocations of navicular and semilunar carpal bones and fracture of the right zygoma. Claimant's aggravation rights expired on July 7, 1974. SAIF does not oppose reopening of claimant's claim; however, it contends claimant is not seeking temporary disability compensation as a result of the recent worsening.

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

It is undisputed that claimant's compensable condition requires surgery or hospitalization. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990). 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 submitted a letter to the Board dated July 21, 1998 wherein he asserts: "I am not claiming time loss benefits in regard to the July 1, 1998 revision endoscopic sinus surgery that occured [sic]." It appears from claimant's statement, that claimant is only seeking medical services at this time.

Accordingly, we conclude that claimant has withdrawn his request for Own Motion relief (in other words, he is not seeking temporary disability benefits). Therefore, we dismiss, without prejudice, the request for own motion relief.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
JONATHAN I. EDWARDS, III, Claimant
WCB Case No. 97-08806
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Scheminske, 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 his aggravation claim for a C5-6 disc condition. On review, the issues are compensability and aggravation. We affirm.

FINDINGS OF FACT

Claimant was injured in 1992 when he fell off a ladder. At that time, he was working as a laborer. Claimant sought emergency treatment and was seen for follow-up by Dr. Frank. Dr. Frank diagnosed a degenerated disc at C5-6 and recommended cervical surgery. Claimant obtained a second opinion and decided against the surgery. (Tr. 23-26; Ex. 21-48)

Following the 1992 injury, claimant was off work for about a year. Thereafter, he returned to light duty work. By 1994, he was able to handle heavier duties, and he began working for the employer as a laborer in heavy construction. (Tr. 26-27).

During the course of his work duties on October 16, 1995, claimant developed pain in his neck and arms after holding up a heavy manlift gate for several minutes. (Tr. 29-30; Ex. 2). He sought treatment on October 19, 1995, and was diagnosed with a cervical strain. Dr. Mortimer-Lamb reported no neurological findings associated with claimant's injury, and released claimant for regular work. (Exs. 2, 6). The employer accepted claimant's claim for a nondisabling cervical strain on November 2, 1995. (Ex. 5).

In December 1995, claimant worked for another construction company in a light duty position. (Tr. 32).

On February 10, 1996, claimant fell asleep at the wheel of his car and was involved in a motor vehicle accident. (Tr. 33). He was taken by ambulance to the hospital and admitted for treatment of a closed head injury and multiple facial lacerations. (Ex. 7A). Following the accident, claimant treated with Drs. Schafir, Thompson and Dr. Constein for neck and back discomfort, among other things. (Exs. 7BB, 8, 21-44, 21-45, 21-46).

In July 1997, Dr. Constein referred claimant to Dr. Brett. Dr. Brett noted preexisting cervical spondylosis and degenerative disc disease at C5-6 with a superimposed disc protrusion with nerve root impingement of the C6 roots bilaterally. He recommended an anterior cervical diskectomy. (Ex. 10-2). Dr. Brett also completed an aggravation claim on claimant's behalf arising out of the October 16, 1995 injury. (Ex. 12).

Dr. Brett performed claimant's surgery on August 4, 1997. By September 1997, claimant's radicular pain had resolved and Dr. Brett released him for light duty work. (Exs. 15, 15A).

In September 1997, claimant was examined by Dr. Rosenbaum at the employer's request. Dr. Rosenbaum opined that the major contributing cause of claimant's need for cervical surgery was his preexisting spondylosis, and that his recent cervical condition was not related to his October 16, 1995 injury. (Ex. 16).

In October 1997, Dr. Reimer reviewed claimant's records at the employer's request. Dr. Reimer concluded that the major cause of claimant's current condition and need for treatment was either his preexisting degenerative disease or a combination of his preexisting degenerative disease complicated by the motor vehicle accident in February 1996. Dr. Reimer also reported that claimant's October 1995 injury was relatively minor, and not a contributory factor. (Ex. 20).

CONCLUSIONS OF LAW AND OPINION

Claimant contends that his C5-6 disc condition constitutes an aggravation of his October 16, 1995 compensable injury. The ALJ concluded that claimant failed to establish the compensability of his cervical condition by a preponderance of the evidence and upheld the employer's aggravation denial. On review, claimant asserts that Dr. Brett's opinion is persuasive evidence that his current condition is a compensable aggravation. We disagree.

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 cervical strain as a result of claimant's October 1995 injury. In July 1997, Dr. Brett diagnosed claimant's condition as cervical spondylosis with superimposed disk protrusion and nerve root impingement at C5-6 with bilateral radiculitis. Because claimant's C5-6 disc condition is not an accepted condition, he must first show that the disc condition is compensable in order to establish a worsened condition resulting from the original injury.

The medical evidence establishes that claimant's cervical spondylosis and degenerative disc disease at C5-6 preexisted his October 1995 injury. (*See, e.g.*, Exs. 10-2, 21-35). Insofar as claimant contends that his October 1995 injury combined with his preexisting degenerative disease and spondylosis to produce his disability and need for treatment in 1997, he must show that the compensable injury was the major contributing cause of his combined condition or need for treatment of the combined condition. ORS 656.005(7)(a)(B).

Although Dr. Brett identified claimant's October 1995 injury as the major cause of his C5-6 disc condition and need for surgery, we find, for the reasons discussed below, that Dr. Brett's opinion is unpersuasive and insufficient to outweigh the other expert opinions to the contrary.[1] Indeed, although he is now claimant's attending physician, Dr. Brett did not begin treating claimant until July 1997, more than a year after his October 1995 strain and February 1996 motor vehicle accident. Because Dr. Brett's treatment followed so long after these key events, in this case, we do not give his opinion the greater weight ordinarily accorded to attending physicians' opinions. *See Cody L. Lambert*, 48 Van Natta 115 (1996).

Under the major contributing cause standard, the persuasive medical opinion must evaluate the relative contribution of the different causes and explain why one condition, activity or exposure contributes more to the claimed condition than all other causes or exposures combined. *See Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995). An injury that precipitates symptoms is not necessarily the major contributing cause of the condition. *Id.*; *see also Robinson v. SAIF*, 147 Or App 157 (1997).

Dr. Brett opined that claimant's current condition was a combination of spondylotic disease, superimposed disc protrusion and two work injuries to his neck in 1992 and October 1995, without explaining why the October 1995 injury contributed more to claimant's condition than these other causes. Further, although Dr. Brett concluded that claimant's October 1995 injury precipitated a disc protrusion or nerve root contusion at C6, Dr. Mortimer-Lamb, who treated claimant in the days following his October 1995 injury, specifically noted no neurological findings associated with the injury.[2] (*See* Ex. 2). In addition, Dr. Brett does not persuasively explain why claimant's February 10, 1996 motor vehicle accident (a high speed collision, which required that he be hospitalized, placed in a cervical

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[1] As set forth above, both Dr. Rosenbaum and Dr. Reimer opined that claimant's October 1995 injury involved a relatively minor strain, which was not a major or material cause of his need for surgery. Both doctors concluded that claimant's preexisting cervical spondylosis was the major cause of his disability and need for treatment in 1997. (Exs. 16, 18, 20, 21).

[2] In an October 24, 1995 follow-up examination, Dr. Mortimer-Lamb reported that claimant's cervical strain was resolving, that there were very little in the way of acute findings in the neck and upper back and that "neurological examination remains within normal limits as well, specifically with regard to the upper extremities." (Ex. 4).

collar, treated for head trauma and evaluated for a possible cervical, thoracic and lumbar spine fracture), was not a contributing cause.[3] Finally, although Dr. Brett understood that claimant suffered an immediate and persistent worsening of his neck discomfort and bilateral radicular arm pain following the October 1995 incident (Ex. 17), this history is not supported by the contemporaneous medical records.

As noted above, Dr. Mortimer-Lamb did not document any radicular pain and, in fact, noted that claimant had very little in the way of objective findings when he treated claimant in late October 1995. (Exs. 2, 4). Claimant did not seek further treatment for neck discomfort until two weeks after his February 1996 motor vehicle accident, when he complained to Dr. Schafir of persistent neck pain, radiating down both trapezius muscles. (Ex. 21-44). Moreover, in June 1997, claimant reported to Dr. Thompson that his neck pain had been an ongoing problem since his February 1996 accident, which worsened in February 1997. At that same time, claimant also denied any radiation into his arms. (Ex. 21-47).

In sum, we find that Dr. Brett's opinion is not only lacking in explanation and analysis, but also based on an incomplete and inaccurate history. *See 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, we agree with the ALJ that claimant has failed to sustain his burden of proof.

ORDER

The ALJ's order dated April 13, 1998 is affirmed.

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[3] On February 27, 1996, two weeks after his accident, claimant complained to Dr. Schafir of, among other things, persistent musculoskeletal neck pain, radiating down to the trapezius muscles. (Ex. 21-44). In May 1997, Dr. Thompson reported that claimant had sustained a cervical strain in the motor vehicle accident which had since resolved. (Ex. 21-45).

In the Matter of the Compensation of
DARRELL BARBER, Claimant
WCB Case No. C8-01450
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Raymond T. Smitke, Defense Attorney

Reviewed by Board Member Bock and Biehl.

On June 25, 1998, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for his compensable injury. We approve the proposed disposition.

Parties may dispose of all matters concerning a claim, except for medical services, with a CDA "subject to such terms and conditions as the Workers' Compensation Board may prescribe." ORS 656.236(1). The worker, insurer or self-insured employer may request disapproval of the disposition within 30 days of its submission to the Board. ORS 656.236(1)(a)(C). Notwithstanding this provision, however, the CDA may provide for waiver of the 30 day period if the worker was represented by an attorney at the time the worker signed the disposition. ORS 656.236(1)(b). This rule requires that the first page of the CDA contain a "statement indicating whether or not the parties are waiving the "30-day" approval period of ORS 656.236(1)(a)(C) as permitted by ORS 656.236(1)(b)."

The first page of the agreement includes the required statement indicating that the parties do not wish to waive the "30-day" cooling off period. However, the body of the document on page 4, number 19, provides that the parties request a waiver of the 30-day statutory period. Nonetheless, because claimant is unrepresented, the Board is without statutory authority to waive the "30-day" cooling off period. *See Kathleen McKay*, 49 Van Natta 2062 (1997). Thus, consistent with the first page of the document, we conclude that the "waiver" language was left in the body of the agreement inadvertently. Thus, we do not interpret the agreement as attempting to waive the 30 day period.

We conclude the agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved.

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

IT IS SO ORDERED.

July 28, 1998 Cite as 50 Van Natta 1481 (1998)

In the Matter of the Compensation of
NANCY B. FAST, Claimant
WCB Case No. 97-10016
ORDER ON RECONSIDERATION
Alice M. Bartelt (Saif), Defense Attorney

Claimant, *pro se*, requests reconsideration[1] of our June 29, 1998 Order on Review that: (1) adopted and affirmed the Administrative Law Judge's (ALJ's) order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for a cervical spine condition; and (2) declined to remand to the ALJ for the admission of additional evidence. On reconsideration, claimant again requests that we consider the evidence submitted to the Board on her behalf following her request for review of the ALJ's order.

We withdraw our order for reconsideration. After conducting our reconsideration and reviewing claimant's arguments, we have nothing to add to our prior order.[2] In other words, for the reasons addressed in our initial order, we continue to be unpersuaded that the record has been improperly, incompletely, or otherwise insufficiently developed. Therefore, we continue to deny claimant's motion for remand.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our June 29, 1998 order effective this date. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] Because it is unclear whether SAIF was sent a copy of claimant's request for reconsideration, we are attaching a copy of it to SAIF's copy of this order.

[2] We note that claimant's motion for reconsideration suggests a different interpretation of the May 29, 1998 letter from Dr. Cross than we made in our initial order. However, even under this different interpretation, Dr. Cross' letter is not reasonably likely to affect the outcome of this case. In this regard, Dr. Cross' letter stated that he was contacted by claimant's husband and given a copy of an administrative decision that was "evidently in [claimant's] favor." Dr. Cross stated that the administrative decision found that claimant had a ruptured disc due to her work activities and had to leave work as a result, a finding with which Dr. Cross agreed. In our initial order, we interpreted Dr. Cross' reference to "an administrative decision" to mean ALJ Brazeau's order that was before us on review. Under that interpretation, we found that Dr. Cross' opinion regarding the ALJ's order was not reasonably likely to affect the outcome of this case. We noted that Dr. Cross obviously misinterpreted the ALJ's denial as being favorable to claimant, whereas it actually upheld the denial of claimant's claim. However, the "administrative order" to which Dr. Cross referred was more likely the decision from the Employment Department finding claimant eligible for unemployment benefits, a decision in claimant's favor. Nevertheless, as we found in our initial order, the decision from the Employment Department is not relevant to the issue before us, *i.e.*, the cause of claimant's cervical condition. Therefore, it follows that Dr. Cross' agreement with the Employment Department decision is also not relevant to the causation issue before us.

In the Matter of the Compensation of
DUANE A. FERREN, Claimant
Own Motion No. 96-0171M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Malagon, Moore, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests review of the insurer's August 12, 1997 Notice of Closure which closed his claim with an award of temporary disability compensation from January 29, 1996 through August 5, 1997. The insurer declared claimant medically stationary as of August 5, 1997. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the August 12, 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).

With his request for review of SAIF's closure, claimant contended that he was not medically stationary at the time of closure because his attending physician had recommended he submit to a drug treatment program which he believed to be caused in major part by his accepted injury. Claimant made a formal request to SAIF for acceptance of his drug addiction condition. SAIF issued a compensability denial of claimant's then current drug addiction condition on which claimant filed a request for hearing with the Hearings Division. (WCB Case No. 98-00169).

On March 18, 1998, we postponed review of the August 12, 1997 Notice of Closure until the pending litigation had been resolved. An Order of Dismissal issued on June 4, 1998. That order has not been appealed. Thus, claimant's drug addiction condition and ensuing hospitalization remain in denied status. Consequently, we will not address the effect of, if any, claimant's drug addiction condition and need treatment had on his medically stationary status at the time of closure as SAIF has not accepted claimant's drug addiction condition as compensable.

On August 5, 1997, claimant was examined by claimant's treating physician, Dr. Kitchel. Dr. Kitchel opined that claimant had "reached maximum medical improvement as of 8/5/97." His opinion is unrebutted.

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

Accordingly, we affirm SAIF's August 12, 1997 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
RONALD D. FULLER, Claimant
WCB Case No. 95-04992
ORDER ON RECONSIDERATION
Pozzi, Wilson, et al, Claimant Attorneys
Rick Dawson (Saif), Defense Attorney

On June 26, 1998, we withdrew our May 28, 1998 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order that in part found a Determination Order procedurally invalid based on inadequate notice. We took this action to consider the SAIF Corporation's contention that we lacked authority to procedurally invalidate a Determination Order. Having received claimant's response, we proceed with our reconsideration.

In 1987, claimant was awarded permanent total disability. In December 1993, SAIF notified claimant that he was scheduled for an "independent medical examination." After claimant underwent the examination in February 1994, SAIF requested the Department to reconsider claimant's permanent total disability award. The Department issued a Determination Order finding claimant no longer was permanently and totally disabled and awarding unscheduled and scheduled permanent disability.

The ALJ found that the Determination Order was not procedurally valid and set it aside based on SAIF's lack of notice to claimant and claimant's attorney when it submitted the results of its examination to the Department. On review, we adopted and affirmed this portion of the ALJ's order. In a subsequent portion of our order, we specifically stated that we agreed with the ALJ that the Determination Order was invalid because SAIF did not comply with *former* OAR 436-30-065(2) when it failed to notify claimant and claimant's attorney that it had submitted the results of its reexamination to the Department.[1]

Relying on *Kemp v. Workers' Compensation Department*, 65 Or App 659 (1983), *mod* 67 Or App 270, *rev den* 297 Or 22 (1984), and *Estella M. Rogan*, 50 Van Natta 205 (1998), SAIF asserts that we are not authorized to invalidate the Determination Order. Specifically, SAIF contends that, because ORS 656.262(11), 656.382, 656.745(2) and 656.447(1)(b) already impose sanctions for SAIF's noncompliance, the Board lacks "inherent authority" to declare the Determination Order procedurally invalid.

SAIF misses the point of our holding. *Former* OAR 436-30-065(2) described the manner in which a "request" for redetermination must be submitted to the Director. Section (6) of the rule provided that the Director shall issue a Determination Order either reducing or affirming the permanent total disability award "[u]pon receipt of a request for reduction of permanent total disability pursuant to section (2) of this rule." Inasmuch as SAIF failed to comply with the requirements mandated by section (2) of the rule in presenting its submission to the Director, its presentation did not qualify as a valid "request. . .pursuant to section (2)" of the rule and the Director therefore lacked authority under section (6) of the rule to issue a Determination Order in response to SAIF's request.

Rather than "unilaterally enlarging" sanctions for this violation of the Department's rule as SAIF asserts, we are applying the procedural rule and finding that SAIF's submission to the Director did not constitute a "request" for redetermination as described in the rule. Thus, because the ensuing Determination Order was based on an invalid "request" for redetermination, it follows that the Determination Order was also invalid and that claimant's permanent total disability benefits must be restored until such time as SAIF submits a proper "request" for redetermination in compliance with the procedural rule and the Director determines that claimant is no longer entitled to such benefits.

Consequently, our decision that the Determination Order is procedurally invalid is not a *sanction* for SAIF's noncompliance with the rule.[2] That is, we are not penalizing SAIF for failing to comply with

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[1] *Former* OAR 436-30-065(2) (WCD Admin. Order 5-1992) states that, when requesting the Department to reduce permanent total disability, the carrier must "notify the worker, and the worker's attorney, if represented[.]"

[2] SAIF also argues that the remedy for failing to provide claimant's attorney with a copy of its request" (in violation of ORS 656.331(1)(a)) is not the invalidation of the "request." Inasmuch as our decision is based on SAIF's noncompliance with the requirements of *former* OAR 436-30-065(2), we decline to further address SAIF's contentions regarding ORS 656.331 and the holding of *Linda D. Santacruz*, 44 Van Natta 803 (1992). To the extent that our previous order referred to ORS 656.331, those comments are eliminated from our decision on reconsideration.

the rule's requirement to notify claimant and his attorney; instead, we are holding that SAIF's conduct resulted in the procedural invalidity of the Determination Order *ab initio*. To the extent that SAIF argues that the *former* rule enlarges any statutory requirements, we continue to find that the Director is statutorily authorized under ORS 656.726(3)(g) to prescribe procedural rules for and conduct hearings, investigations and other proceedings and that the promulgation of *former* OAR 436-30-065(2) is within the Director's statutory authority.

Accordingly, on reconsideration, as supplemented and modified herein, we republish our May 28, 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
BARBARA M. JOHNSON, Claimant
Own Motion No. 98-0045M
OWN MOTION ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation requests reconsideration of our May 12, 1998 Own Motion Order, in which we reopened the above referenced claim for the payment of temporary disability compensation. SAIF contends that claimant was not in the work force at the time of her current disability. We disagree.

SAIF submitted its own motion recommendation on January 26, 1998. It recommended reopening claimant's claim for the payment of temporary disability compensation. Further, in its recommendation, in answer to the work force question, SAIF stated that claimant was "receiving PTD benefits." It additionally noted that the "PTD is on appeal." In an effort to clarify SAIF's position regarding claimant's work force status, we requested the parties' position regarding SAIF's work force contentions and we specifically requested the parties address the effect, if any, our June 27, 1997 Order on Review had on SAIF's recommendation.[1] Claimant responded to our request by letter dated February 18, 1998. Claimant contended that our findings in the June 27, 1997 order were based on an incomplete record and that she would submit additional work force evidence should "SAIF Corporation decide to contest the Own Motion reopening."

On March 6, 1998, we reminded the parties that the Board's decision in its own motion authority to award temporary disability benefits was not completely discretionary and that claimant had to statutorily qualify for those benefits before we could award them. *Wausau Ins. Companies v. Morris*, 103 Or App 270 (1990). We further noted that we would only consider the record before us in making our determination regarding reopening claimant's claim. The parties were again requested to advise the Board, of their positions regarding claimant's work force status. Claimant responded by letters dated March 11, March 27 and March 31, 1998 and submitted her affidavit and medical documentation regarding her work force status. SAIF did not respond to either of the Board's requests nor to any of claimant's submissions. Indeed, it was only after we issued our May 12, 1998 order, that SAIF raised an objection to the reopening of claimant's claim.

On May 12, 1998, after reviewing the record before us, we authorized reopening of claimant's claim for the provision of temporary disability compensation beginning the date she was hospitalized for surgery. We based our findings on claimant's affidavit in support of her willingness to work and her attending physician's opinion as to the "futility" standard.

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[1] In our January 30, 1998 request for the parties' positions we specifically cited that portion of the our June 27, 1997 Order on Review which found that: "This record does not establish that, but for the compensable injury, claimant is willing to seek regular and gainful employment or that she has made reasonable efforts to gain employment."

In its request for reconsideration, SAIF raises our findings in our June 27, 1997 Order on Review in support of its position that claimant was not in the force. However, as stated above, we considered the record we had before us, which, in this case, necessarily included our June 27, 1997 order. Therefore, when we concluded that claimant was in the work force at the time of her current disability, we had taken our June 27, 1997 order into consideration.

SAIF provides no new argument to dispute our findings in our May 12, 1998 Own Motion Order. In our order, we explained our reasoning supporting our conclusion that claimant was in the work force at the time of her current disability. After further consideration, we have nothing to add to our analysis of the persuasiveness of the existing medical evidence or our determination that, on this record, claimant was willing to work but that it was futile for her to seek work due to her compensable condition.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our May 12, 1998 order effective this date. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
GEORGE D. SMITH, Claimant
WCB Case No. 96-09440
ORDER OF DISMISSAL
Malagon, Moore, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Claimant has requested Board review of Administrative Law Judge (ALJ) Nichols' July 21, 1997 order. We have reviewed the request to determine whether we have jurisdiction to consider the matter. Because the record does not establish that the Board received a timely request for review within 30 days of the ALJ's order, we dismiss.

FINDINGS OF FACT

On July 21, 1997, the ALJ issued an order upholding the SAIF Corporation's denial of claimant's respiratory illness condition.

On July 16, 1998, the Board received from SAIF a copy of a handwritten letter from claimant addressed to the Board. The letter, dated August 18, 1997, requested Board review of ALJ Nichols' order.

On July 22, 1998, the Board issued a computer-generated acknowledgment of claimant's request for review.

CONCLUSIONS OF LAW AND OPINION

An ALJ's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. *See* ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the ALJ. ORS 656.295(5). Compliance with ORS 656.295 requires that statutory notice of the request be mailed or actual notice be received within the statutory period. *Argonaut Insurance Co. v. King*, 63 Or App 847, 852 (1983).

Filing means the physical delivery of a thing to any permanently staffed office of the Board, or the date of mailing. OAR 438-005-0046(1)(a). If filing of a request for Board review of an ALJ's order is accomplished by mailing, it shall be presumed that the request was mailed on the date shown on a receipt for registered or certified mail bearing the stamp of the United States Postal Service showing the date of mailing. OAR 438-005-0046(1)(b). If the request is actually received by the Board after the date of filing, it shall be presumed that the mailing was untimely unless the party filing establishes that the mailing was timely. *Id.*

Here, the 30th day after the ALJ's July 21, 1997 order was August 20, 1997. Although SAIF received a copy of a request for review from claimant, the record fails to show that the *Board* received claimant's request for review. For instance, there is no receipt for registered or certified mail showing the date of mailing; nor is there any correspondence from the Board prior to July 22, 1998 acknowledging a request for review. Consequently, we find that claimant did not prove that he filed a request for review at any time prior to the expiration of the statutory appeal period.[1]

Considering our receipt of SAIF's copy of claimant's letter as a request for review, claimant's filing is untimely. Therefore, because claimant did not prove that he filed a timely request for review, we lack jurisdiction to review the ALJ's order. *See* ORS 656.289(3). Accordingly, claimant's request for Board review is dismissed.

IT IS SO ORDERED.

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[1] Claimant may submit information for our consideration showing that he mailed a request for review within 30 days of the ALJ's order, and provided copies of the request to the other parties. Because our authority to reconsider this order expires within 30 days after the date of this order, claimant must file any written submission as soon as possible.

In the Matter of the Compensation of
DONALD A. WESTLAKE, Claimant
WCB Case No. 97-08301
ORDER ON RECONSIDERATION
Doblie & Associates, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Claimant requests reconsideration of our June 29, 1998 Order on Review which reversed an Administrative Law Judge's (ALJ's) order that affirmed an Order on Reconsideration award of 32 percent (102.4 degrees) unscheduled permanent disability for his left shoulder condition. Claimant submits with his motion copies of the transcript of Dr. Jacobson's deposition and claimant's attorney's written closing argument in WCB Case 98-00033. The insurer's response, which objects to our consideration of claimant's submission, has also been received. We treat claimant's submission as a motion for remand. *See Judy A. Britton*, 37 Van Natta 1262 (1985).

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

ORS 656.283(7) provides that "[e]vidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing * * *." Here, the proffered evidence consists of a transcript of Dr. Jacobson's May 6, 1998 deposition and claimant's attorney's June 10, 1998 written argument in another (compensability) case involving claimant (WCB 98-00033). Neither document was submitted at the reconsideration proceeding because they were not in existence at that time. Therefore, neither document is admissible in this "extent of disability" proceeding under ORS 656.283(7). Because the proffered evidence will not likely affect the outcome of the case, we deny claimant's motion for remand.

Accordingly, we withdraw our June 29, 1998 order. On reconsideration, as supplemented herein, we adhere to and republish our June 29, 1998 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES D. ALDRIDGE, JR., Claimant
WCB Case No. C8-01663
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Barbara Woodford, Defense Attorney

Reviewed by Board Member Bock and Moller.

On July 21, 1998, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

On page 2, paragraph 12, the CDA provides that claimant has settled a third party lawsuit for $25,000 and that the insurer's statutory share is $11,111.12. Page 3, paragraph 13 of the CDA provides that, in consideration for a partial release by the insurer of $2,632 of its lien, claimant releases his rights to all worker's compensation benefits allowed by law.

Generally, we disapprove CDAs in which the consideration consists of a carrier's reduction of a lien, but the CDA contains no information concerning the amount of the third party settlement or judgment and /or the amount of the carrier's lien. *E.g., Michael Salber*, 48 Van Natta 757 (1996). We reach this conclusion because we are unable to ascertain the "value" of any consideration flowing to the claimant as a result of the third party settlement and the carrier's waiver of its lien. *Id.*

In *Anthony G. Allen*, 49 Van Natta 460 (1997), the sole consideration for the CDA was the carrier's waiver of $80,000 of its $250,000 statutorily recoverable third party lien. The CDA did not provide the specific amount of the third party settlement. However, the parties expressly stipulated that the insurer's statutory share would be approximately $250,000. Although the exact amount of the third party lien was not known, the amount of the insurer's otherwise recoverable lien and the amount of its waiver were known. Under those circumstances, we found that the "value" of the consideration flowing to claimant under the CDA ($80,000) was sufficiently ascertainable to gain our approval.

In the present case, the CDA provides the amount of the third party settlement, but does not expressly identify the total amount of the carrier's lien. However, the parties have indicated that the insurer's "statutory share" from the third party settlement would be $11,111.12 and that the consideration for the CDA is the insurer's waiver of $2,632 of its "statutory share."

Although the total amount of the insurer's lien is not expressly identified, we interpret the parties' representation that the insurer's "statutory share" would be $11,111.12 to mean that the insurer would otherwise be able to recover all of that specified amount from the third party settlement. Under such circumstances, we find that the "value" of the consideration flowing to claimant under the agreement (*i.e.*, the insurer's $2,632 waiver of its otherwise recoverable third party lien) is sufficiently ascertainable to gain our approval. *See Carol Van De Hey*, 50 Van Natta 1187 (1998).

Accordingly, as interpreted herein, the CDA is in accordance with the terms and conditions prescribed by the Board. Therefore, the parties' CDA is approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
MICHAEL R. GALLAGHER, Claimant
WCB Case Nos. 97-04683 & 96-04320
ORDER ON REVIEW
Cobb & Woodworth, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Moller and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Thye's order that declined to address claimant's request for procedural temporary disability benefits for periods between June 15, 1993 and April 4, 1996. The insurer moves for dismissal of claimant's request for review as untimely. In the alternative, the insurer moves to strike claimant's brief on the same basis. On review, the issues are dismissal, motion to strike, scope of review and procedural temporary disability benefits. We deny the insurer's motions and modify the ALJ's temporary disability ruling.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact and Ultimate Fact.

CONCLUSIONS OF LAW AND OPINION

Motion to Dismiss/Motion to Strike

The insurer moves to dismiss claimant's request for review as untimely. The insurer relies on the fact that the request for review did not reference the correct claim and case numbers. In the alternative, the insurer moves to strike claimant's brief on the same ground. We deny both motions.

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. Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the ALJ. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice received within the statutory period. *Argonaut Insurance Co. v. King*, 63 Or App 847, 852 (1983). The necessary function of notice statutes is to inform the parties of the issues in sufficient time to prepare for an adjudication. *Nollen v. SAIF*, 23 Or App 420, 423 (1975), *rev den* (1976).

It is well established that a party requests Board review of an ALJ's order, not a claim or case number. ORS 656.295(1); *Dorothy I. Adams*, 48 Van Natta 2190 (1996); *Grover Johnson*, 41 Van Natta 88 (1989). Although an ALJ's conclusions and opinions in consolidated cases may be separately stated, if the ALJ's decisions are contained in one final order, we retain jurisdiction to consider all matters contained therein. *Riley E. Lott, Jr.*, 42 Van Natta 239 (1990).

In the present case, claimant's requests for hearing in his neck injury claim and separate left wrist claim were consolidated for hearing. ALJ Thye issued his opinion in both matters in a single January 16, 1998 Opinion and Order. That order referenced the claim and case numbers in both matters. Claimant filed a timely request for review that carries the claim and case numbers for his left wrist claim (Claim No. WC960RO435; WCB Case No. 97-04683), whereas claimant's brief on review addresses entitlement to procedural temporary disability under the separate neck injury claim (Claim No. 93360000203; WCB Case No. 96-04320). Nevertheless, claimant's request for review expressly referenced ALJ Thye's January 16, 1998 order, which addresses entitlement to procedural temporary disability under the neck injury claim. Given these circumstances, we conclude that claimant's request for review provided the requisite statutory notice of the issue claimant intended to litigate on review. Thus, claimant's failure to include the correct case and claim number is not fatal to his appeal. Consequently, we retain jurisdiction to consider claimant's request for review, and the insurer's motion to dismiss and motion to strike are denied.

Temporary Disability

Claimant contends that he is entitled to procedural temporary disability benefits for specific periods between June 15, 1993 and April 4, 1996. The ALJ declined to address this issue, reasoning that

claimant did not raise the issue for litigation at hearing but, instead, preserved the issue in case there was a change in case law. After reviewing claimant's brief on review, the hearing transcript, and the parties' written closing arguments at hearing, we conclude that claimant intended to litigate the procedural temporary disability issue at hearing, but recognized that he would not prevail under controlling Board decisions. *See Jim R. Reed*, 49 Van Natta 753 (1997) (insurer has no affirmative statutory duty to verify time loss); *Debbie I. Jensen*, 48 Van Natta 1235 (1996), *aff'd* 152 Or App 449 (1998) (enforcement of fourteen day limitation on retroactive authorization of procedural time loss). *See also Daral T. Morrow*, 48 Van Natta 497 (1996); *Delores Holmes*, 47 Van Natta 2359 (1995).

Accordingly, we address the merits of the procedural temporary disability issue, adhere to the rationale expressed in our prior decisions in *Reed, Jensen, Morrow and Holmes*, and decline to award the requested procedural temporary disability benefits under claimant's neck injury claim.

ORDER

The ALJ's January 16, 1998 order is modified. Claimant's request for procedural temporary disability benefits is denied on the merits. The ALJ's order is otherwise affirmed.

July 29, 1998 Cite as 50 Van Natta 1489 (1998)

In the Matter of the Compensation of
L. LOUIS LEHMANN, Claimant
WCB Case No. 97-06074
ORDER DENYING RECONSIDERATION
Linerud Law Firm, Claimant Attorneys
Reinisch, et al, Defense Attorneys

On June 26, 1998, we affirmed an Administrative Law Judge's (ALJ's) order that upheld the self-insured employer's partial denial of claimant's left brachial plexus injury claim. Contending that we neglected to address his primary contentions regarding the ALJ's analysis of the medical evidence, claimant seeks reconsideration of our decision and reversal of the ALJ's order. Inasmuch as our June 26, 1998 order has become final, we are without authority to consider claimant's contentions.

A Board order is final unless within 30 days after the date of mailing of copies of such order, one of the parties appeals to the Court of Appeals for judicial review. ORS 656.295(8). The time within which to appeal an order continues to run, unless the order has been "stayed," withdrawn or modified. International Paper Co. v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656, 659 (1986).

Here, the 30th day following our June 26, 1998 order was Sunday, July 26, 1998. Thus, the final day for us to reconsider our decision was Monday, July 27, 1998. *Steve H. Salazar*, 49 Van Natta 5 (1997). Claimant's request for reconsideration was mailed to the Board on July 25, 1998, within the 30-day appeal period. Nevertheless, by the time the reconsideration request was received by the Board (July 28, 1998) and brought to our attention, the 30-day period of ORS 656.295(8) had expired.

Inasmuch as our June 26, 1998 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.[1] *See* ORS 656.295(8); *Steve H. Salazar*, 49 Van Natta at 5; *Donald J. Bidney*, 47 Van Natta 1097 (1995). Consequently, we lack authority to reconsider our order.

Accordingly, claimant's request for reconsideration is denied.

IT IS SO ORDERED.

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[1] As we have noted on prior occasions, we attempt to respond to motions for reconsideration as expeditiously as possible. *Darlene E. Parks*, 48 Van Natta 190 (1996); *Connie A. Martin*, 42 Van Natta 495, *recon den* 42 Van Natta 853 (1990). Notwithstanding these stated intentions, the ultimate responsibility for preserving a party's rights of appeal must rest with the party. *Id.*

In the Matter of the Compensation of
FREDERICK W. HODGEN, Claimant
WCB Case Nos. 97-07769 & 97-01296
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Mannix, Nielsen, et al, Defense Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation, on behalf of Eastern Oregon Training Center (SAIF/EOTC), requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) set aside its compensability/responsibility denial of claimant's claim for a low back/left hip injury; and (2) upheld SAIF/Hodgen Distributing Company's (SAIF/Hodgen) denial of claimant's claim for the same condition. SAIF/Hodgen cross-requests review of that portion of the ALJ's order that: (1) set aside its denials of claimant's claim to the extent they denied claimant's "right to compensation," but upheld the denials to the extent they denied responsibility; (2) awarded a $1,000 attorney fee payable by SAIF/Hodgen with regard to the compensability portion of its denial; and (3) awarded a $500 attorney fee for the responsibility issue payable by SAIF/Hodgen. Claimant cross-requests review of the ALJ's order seeking clarification of whether the order shifted responsibility for claimant's entire low back condition to SAIF/EOTC or found SAIF/EOTC responsible for only a separate left hip injury. On review, the issues are compensability, responsibility and attorney fees. We affirm in part, modify in part, and reverse in part.

FINDINGS OF FACT

Claimant sustained prior low back injuries in 1979 and 1982. In August 1985, while working for Hodgen Distributing (SAIF/Hodgen), claimant sustained another low back injury. The 1985 claim was accepted for a lumbosacral strain. By a 1988 stipulation, claimant was awarded 15 percent unscheduled permanent disability which was in addition to a prior 20 percent unscheduled award for a low back injury. Claimant later received another award of 23 percent unscheduled permanent disability for the 1985 low back injury claim.

In 1992, claimant had surgery for a herniated L4-5 disk.

In a 1993 Stipulation and Order, SAIF/Hodgen rescinded a denial of claimant's claim for an L4-5 disc bulge and agreed that this condition was an accepted part of the 1985 claim.

In May 1995, claimant sought treatment for low back pain after trying to pull a three wheeler out of his garage. In March 1996, claimant was undergoing physical therapy for a low back strain. An MRI performed in March 1996 showed no significant disc herniations, but showed degenerative disc disease at the L4-5 and L5-S1 levels. In June 1996, claimant was treated in the emergency room for a three wheeler ATV accident which caused a thoracic spine strain.

In August 1996, Dr. Waldram requested that SAIF/Hodgen authorize palliative physical therapy to enable claimant to continue working.

On September 14, 1996, claimant slipped at work while escorting a resident of EOTC down a hallway. The incident caused hip and low back pain. Claimant sought emergency room treatment on September 16, 1996. Claimant was released by Dr. Waldram to regular work on September 24, 1996.

Claimant was treated in the emergency room on November 8 and November 28, 1996 for low back pain.

On December 13, 1996, SAIF/EOTC issued a compensability/responsibility denial of the September 14, 1996 incident.

On March 4, 1997, claimant underwent an MRI of the hips which showed no evidence of avascular necrosis or other significant bony or musculoskeletal pathology. Claimant was treated in the emergency room twice in May 1997 and once in June 1997 with injections of toradol for low back pain.

Claimant was examined by Dr. Jessen, on behalf of SAIF/Hodgen, on June 17, 1997.

On July 30, 1997, SAIF/Hodgen issued a partial denial of claimant's low back strain as unrelated to the accepted 1985 injury. SAIF/Hodgen amended its denial on December 9, 1997 to deny responsibility only. The denial letter gave SAIF/Hodgen's position that claimant had sustained a new injury to his low back and left hip on September 14, 1997 for which SAIF/EOTC was responsible. On the same date it issued its amended denial, SAIF/Hodgen requested designation of a paying agent pursuant to ORS 656.307.

CONCLUSIONS OF LAW AND OPINION

Compensability/Responsibility

The ALJ found that the evidence established compensability of a left hip injury occurring on September 14, 1996. SAIF/EOTC acknowledges that a slipping incident occurred on September 14, 1996, but argues that claimant's preexisting conditions combined with the incident and were the major cause of claimant's need for treatment and disability. SAIF/EOTC further contends that claimant did not sustain a new hip injury and that responsibility for claimant's low back condition remains with SAIF/Hodgen.

SAIF/Hodgen conceded prior to hearing that claimant's claim is compensable, but argues that a new compensable injury occurred on September 14, 1996 and that responsibility for claimant's ongoing low back condition shifts to SAIF/EOTC. Claimant argues that the September 14, 1996 incident is the major contributing cause of his low back condition and a new left hip strain, and argues that responsibility for the ongoing low back condition has shifted to SAIF/EOTC.

There are four medical opinions that address the nature and cause of claimant's current low back/hip condition. Dr. Waldram, an orthopedist who performed claimant's 1992 low back surgery, and who treated claimant's low back condition after the September 1996 incident, opined that claimant was experiencing further degeneration at the L4-5 level which required lumbar discectomy in 1992. Dr. Waldram opined that the further degeneration was related to claimant's original [1985] injury and was still work-related. (Ex. 66).

Dr. Weeks, who treated claimant's low back/left hip condition, indicated, in a check-the-box opinion, that claimant suffered a new muscle strain of the left hip in the September 14, 1996 incident. Dr. Weeks also indicated his agreement that the September 14, 1996 incident was the major contributing cause of the left hip muscle strain.

In a chart note, Dr. Wisdom indicated that claimant probably had an aggravation of an underlying back problem.

Dr. Jessen, who examined claimant on one occasion on behalf of SAIF/Hodgen, authored a report and gave deposition testimony. In her report, it was Dr. Jessen's opinion that the major contributing cause of claimant's pain was physical inactivity, obesity and other personality factors that cause him to have an exaggerated reaction to pain.

In her deposition testimony, Dr. Jessen indicated that claimant had a back strain as a result of the September 14, 1996 incident and that the incident was the major contributing cause of the immediate need for treatment. Dr. Jessen opined that deconditioning and inactivity were the primary cause of claimant's back pain. Dr. Jessen characterized the September 14, 1996 incident as a new injury, explaining that the injury exacerbated claimant's preexisting condition. However, Dr. Jessen also opined that the preexisting problems claimant had were more than 50 percent of the cause of his need for treatment and disability from the outset of the September 1996 incident.

We first find, based on a preponderance of the evidence, that claimant has not established a new left hip condition arising from the September 14, 1996 incident that is distinguishable from the low back condition. In this regard, the emergency room physician who saw claimant after the incident noted left hip pain, but diagnosed a "lumbar strain." (Ex. 48). Dr. Wisdom saw claimant on September 19, 1996 and concluded that claimant "probably has an aggravation of underlying [sic] back problem." (Ex. 51).

An MRI of the hips was negative with no significant bony or musculoskeletal pathology noted. (Ex. 57). Dr. Waldram has described claimant's condition as being further degeneration at the L4-5 level related to the 1985 injury.

Only Dr. Weeks indicates that claimant has a left hip strain. The remainder of the medical evidence does not support a conclusion that there is a left hip strain or other left hip condition separate from the low back condition. We find Dr. Weeks' check-the-box opinion unpersuasive on the ground that it is conclusory. Thus, we do not find that a new left hip condition was caused by the September 14, 1996 incident.

Claimant has an accepted claim for a lumbar strain and an L4-5 disc bulge with SAIF/Hodgen. 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, SAIF/Hodgen accepted claimant's 1985 claim for lumbosacral strain and subsequently accepted a disc bulge at L4-5 as part of the 1985 claim. We find, based on this record, that claimant's current low back condition involves the same condition as the 1985 claim. In this regard, Dr. Waldram has indicated that claimant is experiencing further degeneration at the L4-5 level which was related to his original (1985) injury. Dr. Wendler, who treated claimant in the emergency room a few days after the September 14, 1996 incident diagnosed claimant's condition as lumbar strain which was a condition accepted under the 1985 claim. Dr. Jessen also believed that claimant had a back strain related to the September 14, 1996 incident. (Ex. 66A-21). Dr. Weeks diagnosed a left hip strain, but as we explained above, we do not find his opinion to be persuasive. Thus, based on the preponderance of the evidence, we find that claimant's current condition involves the same low back strain/L4-5 condition that was processed under the 1985 claim. Accordingly, SAIF/Hodgen remains responsible for that condition unless it can establish that claimant established a new compensable injury involving the same condition. ORS 656.308(1); 656.005(7)(a)(B).

To establish a new compensable injury, claimant must prove that the September 14, 1996 incident was the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition. ORS 656.005(7)(a)(B). Based on the medical evidence, we do not find that claimant sustained a new compensable injury on September 14, 1996. Dr. Jessen characterized the September 14, 1996 incident as a "new injury" that exacerbated claimant's preexisting condition. However, Dr. Jessen felt that the preexisting problems claimant had were more than 50 percent of the cause of his need for treatment and disability from the outset of the September 1996 incident.[1] Dr. Waldram related claimant's condition to the 1985 injury. There is no persuasive medical evidence that the September 14, 1996 injury was the major contributing cause of claimant's disability and need for treatment. Under such circumstances, we find that responsibility for claimant's low back condition remains with SAIF/Hodgen. Accordingly, we reverse the ALJ's decision to the contrary and uphold SAIF/EOTC's denial.

Attorney Fees

The ALJ awarded a $2,000 attorney fee payable by SAIF/EOTC and a $1,000 attorney fee payable by SAIF/Hodgen for claimant's counsel for services at hearing regarding the compensability issue. Prior to the hearing, SAIF/Hodgen rescinded the compensability portion of its denial and requested a paying agent pursuant to ORS 656.307.

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[1] At one point in her deposition testimony, Dr. Jessen indicated that the September 14, 1996 injury was the major contributing cause of claimant's need for treatment. (Ex. 66-21). After reading the entirety of her deposition testimony, however, we are persuaded that Dr. Jessen meant that the September 1996 incident precipitated claimant's need for treatment, but that the major contributing cause of claimant's disability and need for treatment was his preexisting conditions (deconditioning, inactivity and personality factors). Thus, we do not interpret Dr. Jessen's opinion as supporting the occurrence of a new compensable injury under ORS 656.005(7)(a)(B).

SAIF/Hodgen initially denied compensability as well as responsibility. Prior to hearing, SAIF/Hodgen amended its denial to deny only responsibility. In cases involving denied claims where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the ALJ, a reasonable attorney fee shall be allowed. ORS 656.386(1).

Here, SAIF/Hodgen issued a partial denial of claimant's low back strain on July 30, 1997. The denial denied that the 1985 injury was the major contributing cause of the strain. On December 9, 1997, SAIF/Hodgen amended its denial to deny only responsibility. In addition, SAIF/Hodgen requested a paying agent pursuant to ORS 656.307. Claimant's attorney filed a hearing request regarding the July 30, 1997 denial and participated in the deposition of SAIF/Hodgen's medical expert, Dr. Jessen.

Based on its denial, we find that SAIF/Hodgen denied the claim on the express ground that claimant's low back condition was not compensable or otherwise did not give rise to entitlement to compensation. *See* ORS 656.386(1). Thus, we find that there was a "denied claim." Moreover, considering claimant's counsel's efforts in submitting a hearing request and participating in the deposition of Dr. Jessen, we conclude that claimant's attorney was instrumental in obtaining compensation for claimant through the rescission of SAIF/Hodgen's denial prior to hearing.

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that the ALJ's award of a $1,000 attorney fee was reasonable. 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. Thus, we affirm the ALJ's award of a $1,000 attorney fee payable by SAIF/Hodgen. We have not considered any services subsequent to SAIF/Hodgen's pre-hearing rescission of its compensability denial in determining a reasonable fee. *See Amador Mendez*, 44 Van Natta 736 (1992).

The Board's policy has been to hold a carrier ultimately determined not responsible for a claimant's condition responsible for an attorney fee if the carrier denies the compensability of the claim and the responsible carrier only denied that it is responsible for the claim. *Ronald L. Swan, Sr.*, 47 Van Natta 2412 (1995).

Here, although SAIF/EOTC was not determined to be responsible for the low back condition, we find that it is responsible for an attorney fee award under ORS 656.386(1) because it created the need for claimant to establish the compensability of the claim at hearing.[2] Under such circumstances, we find that SAIF/EOTC should pay an attorney fee pursuant to ORS 656.386(1). *See Safeway Stores, Inc. v. Hayes*, 119 Or App 319 (1993) (court upheld assessment of fee under former ORS 656.386(1) against carrier that necessitated a claimant's participation to establish the compensability of the claim even though that carrier was not ultimately responsible).

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that the ALJ's award of a $2,000 attorney fee was reasonable. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated. Thus, we affirm the ALJ's award of a $2,000 attorney fee payable by SAIF/EOTC.

The ALJ also awarded a $1,000 attorney fee pursuant to ORS 656.308(2)(d) with $500 payable by each carrier. Because we have upheld SAIF/EOTC's responsibility denial and have set aside the responsibility denial of SAIF/Hodgen, SAIF/Hodgen as the responsible carrier will pay the entire $1,000 fee.

Finally, 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/Hodgen. In

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[2] Although SAIF/Hodgen's first denial raised an issue of compensability, it subsequently amended its denial prior to hearing to deny only responsibility. Thus, it was SAIF/EOTC's denial that necessitated claimant's participation at the hearing in order to establish compensability.

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 on review regarding the attorney fee and responsibility issues. *Dotson v. Bohemia, Inc.*, 80 Or App 233 *rev den* 302 Or 35 (1986); *Liberty Northwest Ins. Corp. v. Gordineer*, 150 Or App 136 (1997) (maximum award under ORS 656.308(2)(d) for prevailing over a responsibility denial is $1,000 for all levels of review, absent a showing of extraordinary circumstances).

ORDER

The ALJ's order dated January 20, 1998 is reversed in part and affirmed in part. That portion of the ALJ's order that set aside the denial of SAIF/EOTC is reversed. SAIF/EOTC's responsibility denial is reinstated and upheld. SAIF/Hodgen's denials are set aside and the claim is remanded to SAIF/Hodgen for processing in accordance with law. In lieu of the ALJ's $500 attorney fee awards payable by each carrier under ORS 656.308(2)(d), claimant is awarded a $1,000 attorney fee award under ORS 656.308(2)(d) payable by SAIF/Hodgen. The remainder of the ALJ's order is affirmed. For services on Board review, claimant's attorney is awarded $1,000 payable by SAIF/Hodgen.

In the Matter of the Compensation of
JACK B. ROY, Claimant
WCB Case No. 97-00659
ORDER WITHDRAWING ORDER OF DISMISSAL
Schneider, et al, Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney

Claimant requests reconsideration of our July 20, 1998 Order of Dismissal. In that order, we found that claimant's request for Board review of the Administrative Law Judge's June 3, 1998 order was not timely because he filed the request on Monday, July 6, 1998, when the request was due on July 3, 1998. In requesting reconsideration, claimant points out that, because Friday, July 3, 1998 was a legal holiday, his request for review, which was mailed by certified mail to the Board on July 6, 1998, was timely filed.

Claimant is correct. *See, e.g., Sandy K. Preuss*, 50 Van Natta 1028 (1998); *Anita L. Clifton*, 43 Van Natta 1921 (1991). Accordingly, we withdraw our July 20, 1998 order and reinstate claimant's request for Board review. The following revised briefing schedule has been implemented. Claimant's appellant's brief must be filed within 21 days from the date of this order. The SAIF Corporation's respondent's brief must be filed within 21 days from the date of mailing of claimant's brief. Claimant's reply brief must be filed within 14 days from the date of mailing of SAIF's brief. Thereafter, this case will be docketed for Board review.

IT IS SO ORDERED.

In the Matter of the Compensation of
HARRY F. HOLT, Claimant
WCB Case No. 97-10245
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Biehl and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that affirmed the Order on Reconsideration awarding 21 percent (67.20 degrees) unscheduled permanent disability for the right shoulder and no scheduled permanent disability. On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings with the following correction. In lieu of the ALJ's finding that claimant did not sustain "a separate loss of function of the right arm," we find that claimant's compensable injury has resulted in loss of repetitive overhead use of the right arm, as well as limitations on reaching with that arm or using that arm to carry more than 10 pounds.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that he is entitled to an award of scheduled disability for loss of repetitive use of his right arm. The ALJ awarded unscheduled disability for impairment in claimant's injured right shoulder but declined to award scheduled disability for the right arm. The ALJ reasoned that the right arm restriction was a "positional problem," rather than a separate loss of function of the right arm due to an injury, condition or symptom in that body part. We disagree and reverse.

Generally, a worker is entitled to a disability rating for permanent impairment caused by a compensable injury, including the compensable condition, a consequential condition and direct medical sequelae. OAR 436-035-0007(1). Furthermore, ORS 656.214(5) authorizes a separate award for scheduled disability where an injury to an unscheduled body part results in referred *disability*, i.e., loss of use, in a scheduled body part. *Foster v. SAIF*, 259 Or 86 (1971).

The Board addressed this issue in *Alvena M. Peterson*, 47 Van Natta 1331 (1995). In that case, the medical record established that the claimant was limited in her ability to repetitively use her right arm as a result of chronic shoulder inflammation due to a compensable shoulder injury. Citing *Foster v. SAIF*, the Board awarded scheduled disability of the right arm, even though the claimant had not experienced permanent injury or symptoms in that arm.

The Board reached a similar conclusion in *Winifred H. Seidel*, 49 Van Natta 1167, *on recon* 49 Van Natta 1545 (1997). In that case, the Board awarded scheduled PPD based on a medical record establishing that the claimant was permanently restricted from climbing, crawling and repetitive pulling with his arms as a result of a compensable injury to both shoulders. The Board reasoned that the restriction on the arms was not simply a positional problem because the medical arbiter "specifically enumerated the arms as restricted body parts." *See also Danny L. Hernandez*, 50 Van Natta 501 (1998) (scheduled disability awarded where treating physician identified restricted repetitive use in both arms and did not attribute that restriction to "positional problems").

Finally, in *William L. Fischbach*, 48 Van Natta 1233 (1996), the Board declined to award scheduled disability for loss of repetitive overhead use of the left arm related to a compensable left shoulder injury. In reaching that decision, the Board noted that the medical record in that case did not identify any symptoms causing loss of function in claimant's left arm. Thus, the Board reasoned that the claimant's restricted left arm use was simply a "positional problem." *See also Kim S. Anderson*, 48 Van Natta 1876 (1996) (claimant not entitled to scheduled disability for alleged arm disability where arbiter only identified restricted use of the shoulders).

In the present case, the ALJ relied on *Fischbach* and declined to award scheduled permanent disability based on his finding that claimant's right arm restriction was a positional problem, rather than a separate loss of function of the right arm due to an injury, condition or symptom in that body part. We, instead, conclude that this case is more analogous to *Peterson, Seidel* and *Hernandez* than to *Fischbach*. Here, the restrictions placed on the repetitive use of claimant's right arm are not simply positional problems created by his compensable right shoulder injury. Rather, the medical record establishes that claimant's right arm is a permanently restricted body part. Specifically, the medical arbiter opined that claimant has some limitation in reaching with his right arm, and should limit his use of that arm above shoulder height. The arbiter also restricted claimant's right arm lifting to 10 pounds. We rely on the medical arbiter's findings, which are based on a complete, well-reasoned evaluation of claimant's impairment. Based on those findings, we conclude that the medical record establishes that claimant's right arm was a permanently restricted body part and not merely subject to a positional problem. Accordingly, claimant is entitled to the requested award of scheduled disability for loss of repetitive use of the right arm.

ORDER

The ALJ's order dated April 8, 1998 is reversed. The December 5, 1997 Order on Reconsideration is modified. In addition to the Reconsideration Order award of 21 percent (67.20 degrees) unscheduled permanent disability for the right shoulder, claimant is awarded 5 percent (9.6 degrees) scheduled permanent disability for loss of use or function of the right arm. Claimant's attorney is awarded an attorney fee equal to 25 percent of the increased compensation made payable by this order, not to exceed $3,800, payable by the SAIF Corporation directly to claimant's attorney.

In the Matter of the Compensation of
JOANNE K. KRAUS, Claimant
WCB Case No. 97-09356
ORDER ON REVIEW
Malagon, 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) Martha Brown's order that: (1) declined to award a penalty and attorney fee for the SAIF Corporation's allegedly unreasonable failure to pay interim compensation; (2) declined to award a penalty and attorney fee for SAIF's allegedly unreasonable delay in accepting claimant's left carpal tunnel syndrome claim; and (3) declined to award an attorney fee for obtaining a pre-hearing acceptance of the left carpal tunnel syndrome claim. On review, the issues are 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

Claimant has an accepted 1993 claim for right carpal tunnel syndrome. In April 1997, claimant was diagnosed with left carpal tunnel syndrome. In November 1997, claimant's attorney requested a hearing concerning the left carpal tunnel syndrome condition. In February 1998, SAIF accepted a claim for left carpal tunnel syndrome and paid interim compensation for the period of July 15 through August 27, 1997. Claimant then filed a supplemental hearing request.

Penalties

Claimant contends that she is entitled to a penalty because SAIF did not deny or accept a claim for left carpal tunnel syndrome within 90 days after such claim was made and it did not timely pay

interim compensation. Specifically, claimant contends that reports from the treating physician constituted a "claim" which initiated SAIF's duty to process. The ALJ found that SAIF did not act unreasonably because its claims processor contacted claimant's attorney's office and was informed that a claim for carpal tunnel syndrome would be filed.

Claimant challenges the ALJ's conclusion, asserting that any communication between the claims processor and her attorney's office was not relevant because, based on her physician's reports, she had already filed a claim for carpal tunnel syndrome.

ORS 656.262(11)(a) provides that, if the carrier "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim," the carrier is liable for penalty based on the "amounts then due." Here, claimant does not dispute the ALJ's finding that all benefits had been paid. Consequently, whether or not SAIF acted unreasonably, in the absence of "amounts then due," SAIF is not liable for a penalty. *See Ellis v. McCall Insulation*, 308 Or 74, 78 (1989) (no penalty can be assessed when there are no amounts "then due").

Attorney Fee

ORS 656.386(1) in relevant part provides:

> "(a) * * * In such cases involving denied claims where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge, a reasonable attorney fee shall be allowed.
>
> "(b) For purposes of this section, a 'denied claim' is:
>
> "(A) 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[.]"

When there is a claim made as defined by ORS 656.005(6), and the remaining requirements of ORS 656.386(1) are met, the worker is entitled to an assessed attorney fee. *See Stephenson v. Meyer*, 150 Or App 300, 304-05 (1997) (claim under ORS 656.005(6) is legal predicate to assessment of attorney fee pursuant to ORS 656.386(1)). Thus, we first address whether claimant made a claim under ORS 656.005(6).

That statute states that "claim" "means 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." Here, claimant's physician sent a report to SAIF stating that claimant's work activities caused her left carpal tunnel syndrome and that claimant required surgery for her condition. (Ex. 5). The report further requested that SAIF provide information "with respect to the status of the left carpal tunnel claim in order that surgery may be scheduled." (*Id.*)

Because the report requests workers' compensation benefits on behalf of claimant, and also attributes the condition for which benefits were sought to claimant's employment, we find that claimant filed a claim for her left carpal tunnel syndrome.[1] Thus, we proceed to address whether there was a "denied claim" under ORS 656.386(1).

In *Galbraith v. L.A. Pottsratz Construction*, 152 Or App 790 (1998), the carrier responded to the claimant's request for hearing by stating that the claimant was "entitled to no relief." The court decided that such response constituted a "denied claim" under ORS 656.386(1) because, "[b]y taking the position

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[1] We do not consider the left carpal tunnel syndrome claim as coming under ORS 656.262(7)(a) as a "new medical condition claim." Claimant does not relate the left carpal tunnel syndrome to her previously accepted right carpal tunnel syndrome. Instead, claimant's treating physician attributes the left carpal tunnel syndrome to a different period of work exposure. Consequently, we find that the left carpal tunnel syndrome condition qualifies as an "initial" claim under ORS 656.262(6)(a) and not a "new medical condition claim" under ORS 656.262(7)(a).

that [the] claimant was not entitled to have his claim * * * accepted as compensable, [the carrier] necessarily refused to pay any benefits on those injuries other than the previously paid medical expenses." 152 Or App at 794-95.

Here, after claimant filed his request for hearing, SAIF's counsel wrote to claimant's attorney's office that, based on a telephone conversation between SAIF's claims adjuster and a person at claimant's attorney's office, it had expected claimant's attorney to file a claim for left carpal tunnel syndrome. (Ex. 7). The letter further stated that the "claim never arrived, and the next thing we received was the request for hearing." (*Id.*) SAIF's counsel also wrote that "SAIF has taken the request for hearing to be a claim and is currently investigating compensability." (*Id.*) The letter continued, however, with the statement that, "[o]bviously, SAIF has no obligation to pay time loss, or to otherwise process, a claim that your firm neglected to file." (*Id.*) SAIF did not otherwise respond to the request for hearing.

We find that SAIF's attorney's letter to claimant's counsel constitutes a "denied claim" under ORS 656.386(1). In particular, although the letter stated that SAIF was "currently investigating compensability," it further indicated that SAIF was under no "obligation to pay time loss, or to otherwise process" a claim for left carpal tunnel syndrome. By taking this position, we find SAIF's conduct similar to the carrier's response in *Galbraith* that the claimant was "entitled to no relief." That is, because SAIF indicated that claimant was not entitled to compensation in response to a request for hearing, we conclude that it "refuse[d] to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation." *See Galbraith*, 152 Or App at 794-95.

Furthermore, we conclude that, by filing a request for hearing, claimant's attorney was instrumental in obtaining a rescission of the denial before the hearing. Consequently, because this case also involves a "denied claim," claimant's attorney is entitled to 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 "pre-hearing" services in securing SAIF's acceptance of claimant's left carpal tunnel syndrome is $1,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated. We further note that claimant's counsel is not entitled to an attorney fee for services rendered subsequent to SAIF's pre-hearing acceptance. *See Amador Mendez*, 44 Van Natta 736 (1992).

ORDER

The ALJ's order dated March 12, 1998 is reversed in part and affirmed in part. That portion of the order declining to award an attorney fee under ORS 656.386(1) is reversed. Claimant's attorney is awarded an assessed fee of $1,000, to be paid by the SAIF Corporation. The remainder of the order is affirmed.

In the Matter of the Compensation of
HARRY T. McCREA, JR., Claimant
WCB Case Nos. 93-05231 & 93-02507
ORDER ON REMAND
Cole, Cary, et al, Claimant Attorneys
Dennis L. Ulsted (Saif), Defense Attorney
John M. Pitcher, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *Weyerhaeuser Co. v. McCrea*, 153 Or App 370 (1998). The court reversed our prior order, *Harry T. McCrea, Jr.*, 49 Van Natta 839 (1997), which reversed the Administrative Law Judge's (ALJ's) order upholding Weyerhaeuser's denial of claimant's current low back condition. Citing *Bay Area Hospital v. Landers*, 150 Or App 154 (1997), the court has reversed and remanded for reconsideration.

FINDINGS OF FACT

We adopt the ALJ's findings of fact. We summarize the findings of fact as follows.

Claimant compensably injured his low back on April 27, 1982 while employed by Weyerhaeuser. The accepted back strain was superimposed on Grade I spondylolysis (L5-S1 level) and spondylolisthesis (L4-5 level). The claim was first closed on October 9, 1984 with temporary, but no permanent, disability.

In 1987, a prior ALJ ordered the claim reopened for an aggravation. The claim was last closed April 18, 1988 without an award of permanent disability. In May 1989, another ALJ awarded claimant 10 percent unscheduled permanent disability for his low back condition. Claimant worked for Weyerhaeuser until August 1991 when he began working for SAIF's insured. In August 1992, claimant sought treatment for increased low back pain and stiffness. Weyerhaeuser denied compensability of claimant's current low back condition, while SAIF denied compensability of an occupational disease claim involving the same low back condition.

CONCLUSIONS OF LAW AND OPINION

Addressing the merits, the ALJ found that claimant had not established compensability of his current condition against SAIF or Weyerhaeuser. On this basis, the ALJ upheld the compensability and responsibility denials of Weyerhaeuser and SAIF as to claimant's 1992-1993 low back condition.

On review, we initially affirmed the ALJ's order. *Harry T. McCrea*, 48 Van Natta 157 (1996). In doing so, we held that, although a prior ALJ's permanent disability award in claimant's 1982 low back injury claim with Weyerhaeuser was arguably based, in part, on a symptomatic worsening of claimant's preexisting spondylolisthesis condition, *former* ORS 656.262(10) permitted Weyerhaeuser to deny compensability of the preexisting condition.

Citing *Hiatt v. Halton Company*, 143 Or App 579 (1996), *and Deluxe Cabinet Works v. Messmer*, 140 Or App 548, *rev den* 324 Or 305 (1996) (*Messmer II*), the court reversed our order on the basis that we incorrectly interpreted *former* ORS 656.262(10) and remanded for reconsideration. *McCrea v. Arriola Bros., Inc.*, 145 Or App 598 (1997). In *Messmer II*, the court had determined that the 1995 amendments to ORS 656.262(10) did not effectively overrule its prior decision in *Messmer v. Deluxe Cabinet Works*, 130 Or App 254 (1994) (*Messmer I*), that an employer's failure to challenge a permanent disability award that included an award for a noncompensable condition precluded the employer from contending that the condition was not part of the compensable claim.

On remand, we reversed the ALJ's order in part. We found that the 1989 permanent disability award was based, in part, on claimant's underlying preexisting spondylolisthesis condition. Because the prior award was partly based on the preexisting spondylolisthesis, we found that Weyerhaeuser was precluded from denying that the spondylolisthesis was part of the compensable claim. *McCrea*, 49 Van Natta at 840-841.

Subsequent to the date of our prior Order on Remand, the 1997 legislature enacted HB 2971, which further 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 italicized).

Citing *Bay Area Hospital v. Landers*, (a case where the court reversed a Board decision and remanded for reconsideration in light of the amendment to ORS 656.262(10)), the court has reversed our prior decision and remanded for reconsideration. Consistent with the court's mandate, we proceed with our reconsideration.

In *Keith Topits*, 49 Van Natta 1538 (1997), we held that the 1997 amendments to ORS 656.262(10) legislatively overruled the *Messmer* decisions. In *Topits*, we concluded, based on the plain and unambiguous language of the statute, that a carrier's failure to appeal a permanent disability award does not preclude the carrier from denying a previously rated degenerative condition.

Here, as in *Topits*, Weyerhaeuser is not precluded from denying claimant's preexisting spondylolisthesis under the amended statute (even if claimant's prior permanent disability award was based in part on that condition and Weyerhaeuser failed to appeal the award). *See Judy A. Tucker*, 50 Van Natta 1062 (1998); *Virgie Webb*, 50 Van Natta 1003 (1998). Accordingly, because Weyerhaeuser is not precluded from denying claimant's current low back condition, we proceed to the merits.

After our review of the record, we adopt and affirm the ALJ's[1] reasoning and conclusions with regard to the compensability of claimant's current condition.

Accordingly, on reconsideration of our prior decisions, we affirm the ALJ's order dated July 24, 1994.

IT IS SO ORDERED.

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[1] At the time the July 24, 1994 Opinion and Order was published, ALJ's were then known as "Referees."

In the Matter of the Compensation of
PAULA J. ODOM, Claimant
WCB Case No. 97-09519
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Crumme's order that affirmed an Order on Reconsideration that rescinded the Notice of Closure as premature. On review, the issue is premature claim closure.

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

The ALJ concluded that claimant's claim had been prematurely closed on the basis that her accepted right carpal tunnel condition was not medically stationary. On review, the insurer contends that the Department lacked the authority to rescind the Notice of Closure based on inadequate closing information. *Nancy L. Sabin*, 50 Van Natta 508 (1998); *Estella M. Rogan*, 50 Van Natta 205 (1998).

As we explained in *Rogan*, ORS 656.268(4)(a) sets forth 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. Although we held in *Rogan* 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), it was undisputed in that case and in *Sabin* that the claimant's treating physician had declared the accepted conditions medically stationary and released the worker for regular work prior to the issuance of the Notice of Closure. Thus, the statutory conditions precedent to issuance of the closure notice had been satisfied.

Here, in contrast, after our *de novo* review of the record, we agree with the ALJ's opinion that claimant's accepted condition is not medically stationary, based on the persuasive opinion of Dr. Lynch, claimant's treating physician at the time of closure. Consequently, even if the Department was not authorized to set aside the insurer's closure notice because of a lack of adequate closing information, the issue of premature closure was in dispute and, based on the medical record, claimant has established that her claim was prematurely closed because her condition was not medically stationary.

As for the insurer's argument that the Director should have appointed an arbiter pursuant to ORS 656.268(7)(a), that statute provides: "[I]f the director determines that sufficient medical information is not available to estimate disability, the director shall refer the claim to a medical arbiter." 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. Thus, it is questionable whether the Director was "estimating disability." In any event, the record does not support a conclusion that there was insufficient medical information for the Director to make a determination regarding claimant's disability.

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 April 1, 1998 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
ROGELIA ROCHA-BARAJAS, Claimant
WCB Case No. 97-10013
ORDER ON REVIEW
Willner & Associates, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Bock and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order dismissing claimant's request for hearing. On review, the issue is dismissal. We affirm in part and modify in part.

FINDINGS OF FACT

Claimant has an accepted claim for "tendonitis right shoulder." (Ex. 7). The Notice of Acceptance issued on October 31, 1994. (*Id.*)

In January 1997, claimant returned for treatment of her right shoulder. (Ex. 10). In August 1997, claimant's treating osteopath, Dr. Rodriguez, filed a Form 2837 with the Department giving notice of a claim for aggravation. (Ex. 17). This form was accompanied by a chartnote from Dr. Rodriguez. (Ex. 18).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that the claim for aggravation did not satisfy ORS 656.273(3). The ALJ further stated that, because claimant did not file a perfected aggravation claim, the Hearings Division lacked jurisdiction and, thus, dismissed claimant's request for hearing. On review, claimant contends that her claim was sufficient under ORS 656.273(3).

We agree with the ALJ that, because the chartnote accompanying the Form 2837 stated "exacerbation due to home duties," it did not satisfy the statute's requirement that the attending physician's report establish that "claimant has suffered a worsened condition attributable to the compensable injury." *See* ORS 656.273(3). Thus, claimant did not perfect a claim for aggravation.

We disagree with the ALJ, however, that the Hearings Division lacks jurisdiction in this case. In *David L. Dylan*, 50 Van Natta 276, 277 (1998), we explained that a worker must file a perfected claim for aggravation before expiration of his or her aggravation rights; if not, the Hearings Division lacks jurisdiction because any claim for disability compensation falls within the Board's own motion jurisdiction. In *Dylan*, we dismissed claimant's request for hearing on the basis that claimant did not perfect a claim for aggravation before his aggravation rights expired.

Here, because claimant's aggravation rights have not expired, jurisdiction does not fall within the Board's own motion authority. Instead, we only hold that, because claimant did not file a perfected aggravation claim, the insurer's processing obligations were not triggered.

ORDER

The ALJ's order dated March 9, 1998 is modified in part and affirmed in part. Claimant's request for hearing is reinstated. The remainder of the order is affirmed.

In the Matter of the Compensation of
LOWELL D. ARMON, Claimant
Own Motion No. 98-0146M
OWN MOTION ORDER
Coughlin, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation initially submitted claimant's request for temporary disability compensation for claimant's 1978 compensable large central perforation of the tympanic membrane with conductive loss of hearing, right ear. Claimant's aggravation rights expired on May 10, 1984. SAIF opposed reopening on the grounds that claimant was not in the work force at the time of disability.

On April 9, 1998, we referred claimant's request for temporary disability compensation to the Hearings Division. We took this action because litigation concerning the compensability of his current torn medial meniscus, left knee condition was pending before the Hearings Division. (WCB Case No. 98-01116). Additionally, we requested that the Administrative Law Judge (ALJ) issue findings of fact and conclusions of law and opinion on the issue of whether claimant was in the work force at the time claimant's condition worsened.

On June 16, 1998, ALJ Otto issued his Own Motion Recommendation regarding claimant's work force status. In his recommendation, ALJ Otto made reference to an agreement between the parties wherein SAIF accepted claimant's current left knee condition in this claim.[1]

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

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).

SAIF contends that claimant is not in the work force. Claimant contends that he was willing to work, but that it would have been futile for him to seek work due to his compensable injury. Claimant has the burden of proof on this issue.

In support of his position, claimant submitted an April 2, 1998 affidavit attesting to his willingness to work and attempts at working. He states that he has had various small contracting jobs in 1993, 1994 and 1996. Other than these jobs he has not worked since 1993. He asserts that "I have always been willing to work and I would have sought work but for my compensable condition. *** However, if I were released to work and could find a job that I could safely perform with these dizzy spells, I would be willing to do so." We are persuaded that claimant is willing to seek employment, but unable to do so because of his compensable condition.

Further, in order to satisfy the third *Dawkins* criterion, claimant must also establish, along with the "willingness" standard, that it would have been futile for him to seek employment due to his compensable condition. Claimant submitted several medical reports covering the time period between 1993 and 1998, documenting his inability to work and/or seek work due to his compensable condition.

However, we have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction,[2] is the date he enters

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[1] In response to our inquiry, SAIF submitted a copy of its April 9, 1998 Modified Notice of Acceptance wherein it accepted as part of claimant's 1978 claim, his current torn medial meniscus, left knee.

[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).

the hospital for the proposed surgery. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). The relevant time period for which claimant must establish he was in the work force is the time prior to his February 3, 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).

Although none of the medical documents submitted are dated within a few days of his surgery, there is a medical report from Dr. Petrusek, his attending physician, dated April 2, 1998, which summarizes claimant's work ability over the past few years. He opined that claimant's compensable condition "makes it impossible for him to obtain or perform work for which he is qualified because the injury causes him severe balance problems." Dr. Petrusek goes on further to note "[Claimant] was declared disabled for his work in the logging industry many, many years ago and his status has not changed. As a matter of fact, his balance problems appears to be more of problem than ever." Thus, we conclude that claimant has provided a persuasive medical opinion demonstrating that he was unable to work at the time of his current worsening and that it would have been futile for him to seek work due to the compensable condition.[3]

On this record, we conclude that claimant has established that he was willing to work and that it would have been futile for him to seek work due to his compensable injury.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning February 3, 1998, the date he was hospitalized for surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.[4]

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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[3] In his June 16, 1998 Own Motion Recommendation regarding claimant's work force status, ALJ Otto found that claimant was not in the work force at the time of his current disability. However, it would appear from review of ALJ Otto's opinion that he did not have before him the medical documentation which is contained in the Board's file (*i.e.* Dr. Petrusek's persuasive April 2, 1998 doctor's report).

[4] Contemporaneous with this order, is a Board's Own Motion order denying reopening of claimant's 1979 claim for the provision of temporary disability compensation beginning the date he is hospitalized for his current torn medial meniscus, left knee condition.

In the Matter of the Compensation of
LOWELL D. ARMON, Claimant
Own Motion No. 98-0070M
OWN MOTION ORDER
Coughlin, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requested own motion relief in Claim No. 4394335J contending his left knee had "worsened to where [claimant] now needs surgery." Claimant's aggravation rights expired on April 10, 1984. The SAIF Corporation issued a denial of the compensability of claimant's current torn medial meniscus, left knee condition on January 21, 1998. Claimant has appealed that denial. (WCB Case No. 98-01116).

On April 9, 1998, we referred claimant's request for temporary disability compensation to the Hearings Division. We took this action because litigation concerning the compensability of his current torn medial meniscus, left knee condition was pending before the Hearings Division. (WCB Case No. 98-01116). Additionally, we requested that the Administrative Law Judge (ALJ) issue findings of fact and conclusions of law and opinion on the issue of whether claimant was in the work force at the time claimant's condition worsened.

On June 16, 1998, ALJ Otto issued his Own Motion Recommendation regarding claimant's work force status. In his recommendation, ALJ Otto made reference to an agreement between the parties wherein SAIF accepted claimant's current left knee condition in his 1978 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.*

Here, the current torn medial meniscus, left knee condition and ensuing surgery for which claimant requests own motion relief claim, 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 in his 1979 claim. Should claimant's circumstances change and SAIF accept responsibility for claimant's condition in his 1979 claim, claimant may again seek own motion relief.[1]

Accordingly, claimant's request for temporary disability compensation is denied.

IT IS SO ORDERED.

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[1] Contemporaneous with this order, is a Board's Own Motion order reopening claimant's 1978 claim for the provision of temporary disability compensation beginning the date he is hospitalized for his current torn medial meniscus, left knee condition.

In the Matter of the Compensation of
JANET L. BODTKER, Claimant
WCB Case No. 97-09648
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Steve T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Livesley's order that: (1) upheld the insurer's partial denial of claimant's claim for dementia and dysthymia; and (2) declined to assess penalties or penalty-related attorney fees for the insurer's allegedly unreasonable denial. On review, the issues are compensability and penalties/penalty-related fees.

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

We adopt the ALJ's findings, with the exception of his ultimate finding that "[t]here is no evidence that claimant suffered a concussion in the slip and fall of February 3, 1996." We note that a concussion was diagnosed by Dr. Peters, the attending physician at the time of the injury. Nevertheless, even assuming that claimant did sustain a concussion, we would still agree with the ALJ's ultimate conclusion that Dr. Hall's opinion does not establish a compensable claim for dementia or dysthymia under ORS 656.005(7)(a)(A). Dr. Peters has opined that these conditions are not due in major part to the injury. Furthermore, like the ALJ, we give significant weight to Dr. Binder's critique of Dr. Hall's interpretation of the psychological testing. Moreover, we agree with the ALJ's conclusion that Dr. Hall's opinion is fatally flawed because she assumes an inaccurate history of no prior mental problems or counseling.

ORDER

The ALJ's order dated March 24, 1998 is affirmed.

In the Matter of the Compensation of
ALEXANDRA BRANDSTETTER, Claimant
WCB Case No. 97-03967
ORDER ON REVIEW
Richard F. McGinty, Claimant Attorney
Lane, Powell, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Livesley's order that: (1) upheld the insurer's partial denial to the extent that it denied her claim for disc protrusions at L3-4 and L4-5; and (2) did not award an assessed attorney fee for allegedly prevailing over the insurer's denial of degenerative disc disease (DDD) at lumbar disc levels other than L5-S1. On review, the issues are compensability and attorney fees.

We adopt and affirm the ALJ's order, with the following supplementation on the attorney fee issue.

On review, claimant contends that she is entitled to an assessed attorney fee under ORS 656.386(1) for services at hearing which culminated in the ALJ's order setting aside the insurer's partial denial to the extent it denied DDD at lumbar disc levels other than L5-S1. We disagree. In her appellant's brief, claimant concedes that lumbar DDD was found at the L5-S1 disc level only. (App. Br. pp. 5-6). Furthermore, the record is devoid of any claim, made by or on claimant's behalf, for DDD at any lumbar disc level other than L5-S1.

The Court of Appeals has ruled that the existence of a "claim," or written request for compensation, is a legal predicate for an attorney fee award under ORS 656.386(1). *Stephenson v. Meyer*, 150 Or App 300, 304 (1997). Therefore, in the absence of a claim for DDD at disc levels other than L5-S1, ORS 656.386(1) does not authorize an attorney fee for services relating to the portion of the denial which purported to deny DDD at those levels.

ORDER

The ALJ's order dated March 3, 1998 is affirmed.

In the Matter of the Compensation of
YOLANDA ENRIQUEZ, Claimant
WCB Case No. 97-09412
ORDER ON REVIEW
Lawrence A. Castle, Claimant Attorney
Stoel Rives LLP, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Nichols' 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.

The ALJ set aside the insurer's denial of claimant's occupational disease claim. In doing so, the ALJ found no persuasive reasons not to defer to the opinion of Dr. Miller, claimant's attending physician, who opined that claimant's work activities were the primary cause of her condition. (Ex. 18).

On review, the insurer contends that the ALJ's reliance on Dr. Miller's opinion was misplaced because that physician failed to weigh the relative contributions of the potential off-work and work-related causes of claimant's condition. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 321 Or 416 (1995) (Persuasive medical opinion must evaluate the relative contribution of different causes and explain why work exposure or injury contributes more to the claimed condition than all other causes or exposures combined). The insurer asserts that we should instead rely on the opinion of the examining physician, Dr. Button, who opined that claimant's carpal tunnel condition was "idiopathic." (Ex. 12).

We do not find the insurer's argument well-taken. While Dr. Miller did not mention off-the-job factors in his reports addressing causation, we agree with claimant that the record does not establish the existence of off-work factors to weigh. Even Dr. Button reported that were "no obvious pre-existing factors relative to the syndrome." (Ex. 12-4). Dr. Button also noted that there was no history of trauma and that claimant was not involved in off-the-job hobbies or pursuits that would have been a factor in claimant's condition. *Id.* Dr. Button noted that, statistically, carpal tunnel was more frequently observed in older females, but we do not interpret this observation as identifying a potential "cause" of claimant's condition. Moreover, we have previously held that medical evidence grounded in statistical analysis is not persuasive because it is not sufficiently directed to a claimant's particular circumstances. *See Steven H. Newman*, 47 Van Natta 244, 246 (1995); *Catherine M. Grimes*, 46 Van Natta 1861, 1862 (1994); *Mark Ostermiller*, 46 Van Natta 1556, 1558, *on recon* 46 Van Natta 1785 (1994).

In summary, based on our *de novo* review of this record, we do not find Dr. Miller's opinion should be discounted for failing to satisfy the weighing requirements of *Dietz* and similar cases. In addition, we conclude that Dr. Miller had a sufficiently accurate understanding of the nature of claimant's job duties and also provided a well-reasoned explanation for his opinion that claimant's work activities were the primary cause of her carpal tunnel condition. Like the ALJ, we find no persuasive reasons not to defer to Dr. Miller's opinion. *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 insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated April 8, 1998 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
JOHN R. GRAHAM, Claimant
Own Motion No. 98-0240M
OWN MOTION ORDER
Michael A. Bliven, Claimant Attorney
Reinisch, et al., Defense Attorneys

The self-insured employer has submitted claimant's request for temporary disability compensation for claimant's compensable torn medial meniscus, osteocartilaginous loose bodies, right knee, degenerative changes articular cartilage medial compartments, sartorius muscle rupture, right and right thigh muscle tear. Claimant's aggravation rights expired on January 29, 1996. The employer opposes the reopening of the claim on the grounds that: (1) no surgery or hospitalization has been requested; and (2) surgery or hospitalization is not reasonable and necessary.

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

Here, the record submitted to us fails to demonstrate that claimant requires surgery or hospitalization for treatment now or in the near future. As a result, we are not authorized to grant claimant's request to reopen the claim.[1]

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] The employer, with its own motion recommendation, also requests that we authorize it to "reclose the claim without any additional awards of compensation." This request for claim closure apparently stems from ALJ Mills' unappealed April 17, 1998 Opinion and Order which directed the employer to process claimant's "new medical condition" claim in accordance with ORS 656.262(7)(c). Because the ALJ's order has not been appealed and because this matter is before us pursuant to our Own Motion authority, we are not authorized to review the propriety of the ALJ's decision. Thus, we confine our comments to claimant's rights to relief under ORS 656.278. Inasmuch as we have concluded that the claim does not qualify for reopening under ORS 656.278, we cannot "authorize" the closure of a claim that has not been reopened under ORS 656.278. Moreover, even if the claim had been reopened pursuant to ORS 656.278, we would not "close the claim." Pursuant to OAR 438-012-0055(1), a reopened own motion claim "shall be closed by the insurer **without** the issuance of an order of the Board." (emphasis added).

In the Matter of the Compensation of
CARY G. HIGGINSON, Claimant
Own Motion No. 97-0279M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Saif Legal Department, Claimant Attorney

Claimant requests review of the SAIF Corporation's April 10, 1998 Amended Notice of Closure which closed his claim with an award of temporary disability compensation from March 27, 1997 through August 22, 1997. SAIF declared claimant medically stationary as of February 13, 1998.

In his request for review, claimant contended that the "closure is wrong since the operation was unsuccessful and I do not know how much longer I will be able to work." We assume that claimant is contending that he 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 was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the April 10, 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).

By letters dated June 3 and June 23, 1998, 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 June 25, 1998, however, no further response has been received from claimant. Therefore, we will proceed with our review.

On February 13, 1998, claimant was examined by his treating physician, Dr. Jacobson, who reports that he "rate[d] [claimant] medically stationary at this point in time." He further opined that claimant's future treatment was related only to activity modification and that he did not anticipate any significant improvement. This opinion is unrebutted.

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

Accordingly, we affirm SAIF's April 10, 1998 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
ARTHUR F. HOWELL, Claimant
WCB Case Nos. 97-09158 & 97-09156
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Lipton's order that upheld the self-insured employer's denial of claimant's neck and back strain injury claim. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following correction[1] and supplementation.

As noted above, claimant has an accepted cervical/thoracic strain injury related to a July 9, 1997 work incident. Claimant alleges that he also sustained separate neck and back strain injuries in a work incident on July 25, 1997, about two weeks after the first injury. Because this second incident occurred so close in time to the first incident, at a time when claimant was still under medical treatment for the accepted conditions, and some of the same body parts were alleged to be injured in both incidents, the issue of whether the second incident caused an independent injury presents a complex medical question, the resolution of which depends on 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). Furthermore, all doctors rendering any causation opinion concurred with the opinion of Dr. Rosenbaum, examining neurosurgeon, who opined that there was no significant relationship between claimant's symptoms and the July 25, 1997 incident. (Exs. 31, 35, 36, 37, 38A, 40A). Thus, claimant failed to establish that he sustained a compensable injury related to the July 25, 1997 work incident, even without considering whether he proved that the alleged July 25, 1997 injury was established by "medical evidence supported by objective findings." ORS 656.005(7(a);[2] 656.005(19).[3]

ORDER

The ALJ's order dated March 11, 1998 is affirmed.

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[1] Claimant has an accepted claim for a cervical/thoracic strain and contusion related to a July 9, 1997 work incident. (Ex. 11). On November 4, 1997, the employer issued a partial denial for a lumbar strain injury claim, which claimant contended was related to the July 9, 1997 work incident. (Ex. 34). Claimant appealed that denial and the claim was assigned WCB Case No. 97-09156. The ALJ upheld the partial denial. Claimant does not challenge that decision. The employer also issued another denial on November 4, 1997, which denied a neck and back strain injury claim that claimant contended resulted from a July 25, 1997 work incident. Claimant appealed that denial and the claim was assigned WCB Case No. 97-09158. The ALJ upheld that denial, which claimant challenges on review. In the body of his opinion, the ALJ transposed the WCB case numbers, identifying the July 9, 1997 work incident as WCB Case No. 97-09158 and the July 25, 1997 work incident as WCB Case No. 97-09156. We correct that clerical error on review.

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

"A 'compensable injury' is an accidental injury * * * arising out of and in the course of employment requiring medical services or resulting in disability or death, whether or not due to accidental means, if it is established by medical evidence supported by objective findings[.]"

[3] ORS 656.005(19) provides:

"'Objective findings' in support of medical evidence are verifiable indications of injury or disease that may include, but are not limited to, range of motion, atrophy, muscle strength and palpable muscle spasm. 'Objective findings' does not include physical findings or subjective responses to physical examinations that are not reproducible, measurable or observable."

In the Matter of the Compensation of
ROBERTA L. JONES, Claimant
WCB Case No. 97-10247
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

The insurer requests review of Administrative Law Judge (ALJ) Howell's order that set aside its denial of claimant's aggravation claim for her lumbar strain 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 $1,500,[1] 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 April 15, 1998 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,500, to be paid by the insurer.

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[1] In his respondent's brief, claimant's attorney requests a fee of $1,800, including a multiplier. We do not, however, apply a contingency factor or "multiplier" in a strict mathematical sense. *E.g., Lois J. Schoch*, 49 Van Natta 788, 790, n 1 (1997); *Lois J. Schoch*, 49 Van Natta 170, 173, n.1 (1997). Rather, we consider the risk factor *in conjunction with the remaining factors*, particularly, as noted in this order, 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.

In the Matter of the Compensation of
GERALD C. KENISTON, Claimant
WCB Case No. 97-09944
ORDER ON REVIEW (REMANDING)
Bottini, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that upheld the self-insured employer's denial of his injury claim for a neck and bilateral shoulder condition. Submitting post-surgical medical reports, claimant moves for remand of the case to the ALJ for the admission of additional evidence. On review, the issues are remand and compensability. We remand.

The ALJ upheld the employer's denial after concluding that claimant did not carry his burden of proving medical causation. In reaching that conclusion, the ALJ found that the opinion of Dr. Rosenbaum, the examining neurosurgeon who attributed claimant's condition to preexisting cervical spondylosis, was more persuasive than that of Dr. Brett, the treating neurosurgeon who opined that the September 15, 1997 work incident was the major contributing factor in claimant's condition.

On review, claimant submits Dr. Brett's operative report dated February 16, 1998 and narrative report dated February 17, 1998. (Proposed Exs. 25, 26). The reports indicate that claimant underwent cervical disc surgery which was performed by Dr. Brett on February 16, 1998, almost two weeks after the hearing in this matter was convened and closed (February 4, 1998). The reports further indicate that Dr. Brett discovered a sequestrated disc herniation at C6-7 during surgery and that, following surgery, claimant had complete resolution of radicular pain in the left arm. Finally, in the narrative report, Dr. Brett states that "it is certainly clear that [claimant's] need for surgery is a direct result of his work injury on 9-15-97 in all medical probability."

We may remand to the ALJ for the taking of additional evidence if we determine that the record has been improperly, incompletely, or otherwise insufficiently developed. ORS 656.295(5). In order to satisfy this standard, a compelling reason must be shown for remanding. A compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. *See Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Loreta C. Sherwood*, 49 Van Natta 92 (1997).

Because the proffered evidence relates to claimant's surgery which did not take place until almost two weeks after the hearing, we find that the evidence concerns disability and was not obtainable with due diligence at the time of hearing. *See Sherwood*, 49 Van Natta at 92. The remaining question is whether the proffered evidence is reasonably likely to affect the outcome of the case. We conclude it is. We base our conclusion on the fact that there was no confirmed diagnosis of a herniated disc at C6-7 prior to the hearing and that the existence (or non-existence) of such appears significant to the physicians offering opinions in this case.

Therefore, we conclude that the case should be remanded to the ALJ for further development of the record. Accordingly, the ALJ's order is vacated and this matter is remanded to the ALJ to reopen the record for the admission of additional evidence from the parties regarding the post-hearing surgery and the resultant findings regarding the cause of claimant's neck and bilateral shoulder condition. The ALJ may proceed in any manner that will achieve substantial justice. ORS 656.283(7). The ALJ shall then issue a final appealable order resolving this matter.

IT IS SO ORDERED.

In the Matter of the Compensation of
RANDY L. KOKOS, Claimant
WCB Case Nos. 97-08925, 97-08924 & 97-05056
ORDER ON REVIEW
Heiling, Dodge & Associates, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Moller and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Otto's order that upheld the insurer's denial of his injury claim for a left hip condition. The insurer cross-requests review of that portion of the order that set aside its denial of claimant's injury claim for low back and cervical conditions. In its "cross-reply" brief, the insurer moves to strike the last paragraph of claimant's "reply" brief. On review, the issues are motion to strike and compensability.

We grant the motion to strike and adopt and affirm the ALJ's order with the following supplementation.

We first address the insurer's motion. Claimant failed to file an appellant's brief. In its cross-appellant's brief, the insurer waived its right to submit a "respondent's" brief. In his brief entitled a "reply" brief, claimant responded to the issues raised in the insurer's "cross-appellant's" brief, but also submitted a paragraph of argument regarding the issue raised by his request for review. Inasmuch as claimant did not submit an appellant's brief and the insurer waived its right to file a "respondent's" brief, there was nothing to which claimant could "reply." Thus, we grant the insurer's motion to strike the last paragraph of claimant's "reply" brief and have not considered that argument on review. *See Roy E. Shell*, 46 Van Natta 2272, 2273 (1994); *Alvin Woodruff*, 39 Van Natta 1161 (1987); *cf. Darlene F. Reed*, 50 Van Natta 1139 (1998) (although no appellant's brief was filed, the claimant was entitled to file a reply brief because the carrier submitted a respondent's brief).

The ALJ set aside the insurer's October 20, 1997 denial to the extent that it denied the compensability of claimant's internal disc disruptions at L3-4 and L5-S1, left sacroiliac joint dysfunction, left L3-4 facet joint syndrome, and cervical facet joint dysfunction. In doing so, the ALJ relied on the opinion of the attending physician, Dr. Slack, who attributed the disputed conditions to claimant's compensable August 30, 1995 injury.

On review, the insurer contends that its acceptance of a low back strain reasonably apprised claimant of the nature of the compensable low back conditions because the compensable low back strain included the disputed low back conditions. Thus, the insurer asserts that it need not have accepted each diagnosis or medical condition. *See* ORS 656.262(7)(a). We disagree.

Dr. Slack testified that, while the disputed conditions could be "bundled" into claimant's low back "condition," they could not be accurately bundled into "low back strain." (Ex. 87-14, 15). Dr. Slack explained that, as a result of the compensable injury, claimant sustained damage to the "architecture" of the L3-4 and L5-S1 discs and an injury to her left sacroiliac joint and left L4 facet joint. (Ex. 87-15). According to Dr. Slack, claimant's injury was more extensive than a simple low back strain. (Ex. 87-16).

ORS 656.262(7)(a) provides that "an 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." Based on our *de novo* review of Dr. Slack's deposition testimony, we are not persuaded on these facts that the insurer's acceptance of a low back strain reasonably apprised claimant of the nature of the compensable conditions. *Cf. Jim L. Stone*, 49 Van Natta 1152, 1153-54 (1997) (given the complex nature of the claimant's failed back surgery syndrome condition, which consisted of numerous individual components, the carrier's acceptance did not reasonably apprise the claimant of the nature of his compensable condition).

The insurer also cites claimant's counsel's phrasing of a question to Dr. Slack in which counsel expressed his concern that the compensable conditions should be specified to prevent confusion regarding potential future claims. (Ex. 87-15). The insurer contends that the ALJ's reliance on an opinion which allegedly details "potential prospective treatment" was inappropriate. The insurer analogizes this situation to our line of cases that prohibit "prospective denials." *E.g. Gary L. Best*, 46 Van Natta 1694 (1994).

The insurer's argument does not persuade us. Cases such as *Best* were directed at preventing carriers from discouraging future claims for workers' compensation benefits. 46 Van Natta at 1696. Such concerns are obviously not present in this case. Dr. Slack's testimony is not rendered less persuasive simply because claimant's counsel presented a reason why it may be important in the future to have the compensable condition clearly delineated.

The insurer also argues that claimant's disc disruptions are a consequence of degenerative disc disease and that the medical evidence from Dr. Slack does not support a finding that claimant's facet joint syndrome was a result of the compensable injury. Again, we disagree. We concur with the ALJ's reasoning and conclusion that Dr. Slack's opinion establishes that the compensable injury is the major contributing cause of the lumbar disc disruptions and the lumbar facet joint syndrome.

Finally, the insurer asserts that Dr. Slack's opinion is insufficient to prove the compensability of the cervical facet joint dysfunction. Inasmuch as the evidence does not establish the existence of a preexisting cervical condition, we agree with the ALJ that "material contributing cause" is the appropriate legal standard. *Denise A. Baker*, 50 Van Natta 210, 210 n. 1 (1998); *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). Further, we find Dr. Slack's opinion establishes to a degree of medical probability that the compensable injury was a material contributing cause of this condition. (Ex. 87-10, 11).

Claimant's attorney is entitled to an assessed fee for services on review regarding the compensability of the internal disc disruptions at L3-4 and L5-S1, left sacroiliac joint dysfunction, left L3-4 facet joint syndrome, and cervical facet joint dysfunction. 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 $500, 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 February 19, 1998 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $500, to be paid by the insurer.

In the Matter of the Compensation of
MARY D. KOON, Claimant
WCB Case No. 97-07149
ORDER ON REVIEW
Richard M. Walsh, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Hall and Bock.

The employer requests review of Administrative Law Judge (ALJ) Michael Johnson's order that set aside its denial of claimant's occupational disease claim for her bilateral forearm condition. On review, the issue is compensability.

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

On review, the employer argues that the ALJ effectively reversed the burden of proof. Specifically, the employer argues that the ALJ found that the doctors who examined claimant did not agree on a specific diagnosis. While the employer concedes that claimant is not required to show a definite diagnosis to meet her burden of proof, the employer argues that the ALJ rejected the employer's evidence and arguments on the basis that claimant did not need to establish any particular diagnosis, but then relied on the causation opinions of physicians who offered conflicting diagnoses.

We do not agree with the employer's interpretation of the ALJ's order. The ALJ evaluated each expert who provided a causation issue and concluded that Dr. Stringham's opinion was the most persuasive. In discounting the opinions of the doctors who examined claimant on behalf of the employer, the ALJ did not reject the doctors for lack of a particular diagnosis. Rather, the ALJ found that, for example, Dr. Farris focused on general considerations, rather than claimant's particular case. The ALJ also discounted Dr. Farris's opinion because she found that claimant's nominal crocheting activity would contribute to her condition while her repetitive work activities would not be considered as even a potential cause.

With respect to Dr. Strum's opinion, the ALJ noted that the doctor was apparently unaware that claimant was primarily using her left hand to protect her right hand while she was on light duty work. The ALJ also reasoned that, while claimant's modified duty may have been "light," it also required repetitive pinching motions, which aggravated claimant's condition. Consequently, the ALJ was not persuaded by Dr. Strum's opinion that work did not cause claimant's bilateral condition because her left hand problems began while she was on light duty.

Accordingly, we conclude that the ALJ properly assigned the burden of proof to claimant. Furthermore, we agree with the ALJ's assessment of the various expert medical opinions and we conclude that the persuasive medical evidence establishes that work is the major cause of claimant's bilateral forearm condition.

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

ORDER

The ALJ's order dated March 2, 1998 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,200, to be paid by the employer.

In the Matter of the Compensation of
THOMAS E. MOONEY, Claimant
WCB Case Nos. 97-08026, 97-06865 & 97-06452
ORDER ON REVIEW
Coughlin, Leuenberger & Moon, Claimant Attorneys
Bottini, et al, Defense Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Alexsis Risk Management (Alexsis), on behalf of the City of Ontario, requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that set aside its compensability denial of claimant's current L4-5 disc herniation condition. On review, the issues are compensability and responsibility.[1] We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following change. In the sixth paragraph on page 3, we change claimant's weight limit to "60 pounds."

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[1] Because the parties did not raise any issues concerning penalties, premature closure and extent of temporary and permanent disability, we do not address those issues on review.

CONCLUSIONS OF LAW AND OPINION

We briefly summarize the relevant facts. Claimant has two accepted low back injuries. In 1985, claimant experienced low back and left leg pain while working. In December 1986, SAIF accepted a disabling lumbosacral strain/sprain. (Ex. 6). An MRI in January 1988 revealed a herniated disc at L4-5 and Dr. Havlina performed surgery in February 1988. (Exs. 24, 30). The claim was closed by a Determination Order dated October 6, 1988, which awarded 12 percent unscheduled permanent partial disability for claimant's low back condition. (Ex. 38).

The employer has been self-insured since July 1, 1993. On October 28, 1993, claimant felt the onset of back pain while working. (Ex. 77). The 1993 claim was litigated and on February 12, 1996, the Board determined that claimant "sustained a new back strain as a result of the October 28, 1993 accident and such condition combined with his preexisting condition." (Ex. 112-4). The Board concluded that claimant sustained a "new compensable injury," for which Alexsis was responsible. (*Id.*) The Court of Appeals affirmed the Board's February 12, 1996 order without opinion. *Alexsis Risk Management Services, Inc. v. Mooney*, 146 Or App 777 (1997). (Ex. 113). A July 10, 1997 Order on Reconsideration awarded claimant 3 percent unscheduled permanent disability in addition to compensation previously awarded. (Ex. 113D).

In the meantime, claimant experienced a sudden increase in back pain and a new onset of left leg pain in August 1995. (Ex. 105). Claimant returned to Dr. Havlina and an MRI in September 1995 revealed a large focal left L4-5 disc herniation. (Ex. 106). Dr. Havlina performed surgery on September 7, 1995. (Ex. 107).

On July 25, 1997, claimant made claims with SAIF and Alexsis for his L4-5 recurrent herniated disc. (Exs. 114, 114A). On August 4, 1997, SAIF responded by referring to the Board's February 12, 1996 Order on Review and contending that "[r]esponsibility for [claimant's] low back condition after 1993 lies with Alexsis." (Ex. 115). On September 18, 1997, Alexsis denied the claim on the basis that the October 8, 1993 injury ceased to be the major contributing cause of claimant's condition and need for treatment on or about February 12, 1994. (Ex. 117; Tr. 25).

The ALJ found the claim compensable and assigned responsibility for claimant's current L4-5 disc herniation to Alexis. The ALJ reasoned that Alexsis was responsible for claimant's condition beginning with the 1993 injury and ORS 656.308 prohibits assigning responsibility to a previous carrier. Although we agree with the ALJ's conclusion, we replace the ALJ's discussion of compensability and responsibility with the following analysis.

On review, Alexsis argues that the ALJ erred by setting aside its denial of claimant's L4-5 herniated disc claim. According to Alexsis, there are no medical opinions indicating that claimant's 1993 injury made any contribution to claimant's 1995 re-herniation of the L4-5 disc.

In *Daral T. Morrow*, 49 Van Natta 1979, *on recon* 49 Van Natta 2105 (1997), the claimant had a compensable claim with the SAIF Corporation for a 1991 low back injury with a prior employer. The claimant then injured his low back in 1994 while working for a self-insured employer. Both carriers denied responsibility. A litigation order assigned responsibility for the 1994 injury to the self-insured employer under ORS 656.308(1), based on a finding that the claimant had sustained a "new compensable injury." In July 1995, the employer issued a current condition denial on the basis that the 1991 injury had become the major contributing cause of the claimant's need for treatment or disability. The employer did not contend that the claimant's medical treatment and disability was not compensable. We concluded that because the employer had accepted a "new compensable injury" under ORS 656.308(1), the employer could not avail itself of ORS 656.262(6)(c) and (7)(b) to shift responsibility backward for compensable medical treatment or disability. Rather, pursuant to ORS 656.308(1), we determined that the employer remained responsible for future compensable treatment and disability, unless the claimant sustained a "new compensable injury." We concluded that the employer's denial was procedurally invalid and we set it aside on that basis. *See also David E. McAtee*, 50 Van Natta 649 (1998) (applying *Morrow*).

Alexsis argues that the *Morrow* case does not apply in this case. Alexsis contends that the prior responsibility dispute did not shift responsibility for claimant's L4-5 disc herniation to Alexsis. According to Alexsis, the prior litigation concerning the October 1993 incident involved only a strain injury and it did not become responsible for an L4-5 herniated disc condition. We disagree.

We first address Alexsis' assertion that the 1985 injury accepted by SAIF "resulted in surgery for a herniated L4-5 lumbar disc in 1988 that was accepted and covered by SAIF." (Appellant's br. at 2). Although SAIF apparently paid for claimant's 1988 surgery, the payment of medical bills for treatment of a condition does not constitute acceptance of that condition. *See* ORS 656.262(10). SAIF's acceptance of the 1985 injury was expressly limited to a lumbosacral strain/sprain.

For the following reasons, we find that the analysis in *Morrow* applies to this case. As a result of the litigation concerning claimant's October 1993 injury, the Board determined that claimant "sustained a new back strain as a result of the October 28, 1993 accident and such condition combined with his preexisting condition." (Ex. 112-4). The Board concluded that claimant sustained a "new compensable injury," for which Alexsis was responsible. (*Id.*) Contrary to Alexsis' argument, the 1993 litigation did not involve only a strain injury. Rather, the Board concluded that Alexsis was responsible for a new back strain that had combined with his preexisting condition. Claimant's "preexisting condition" included a previous herniated disc at L4-5, for which he had surgery in February 1988. Thus, the record establishes that claimant's preexisting disc condition at L4-5 was processed as part of his prior 1993 injury claim with Alexsis. *See David E. McAtee*, 50 Van Natta at 651 (the claimant's preexisting degenerative disc condition was processed as part of a prior accepted injury claim).

Furthermore, the medical evidence establishes that claimant's current low back condition, an L4-5 disc herniation, is related to the compensable preexisting disc condition at L4-5. Dr. Havlina performed surgery of claimant's L4-5 herniated disc in February 1988 and again on September 7, 1995. (Exs. 30, 107). On August 30, 1995, Dr. Havlina reported that claimant experienced a sudden increase in back pain and a new onset of left leg pain in August 1995. (Ex. 105-1). Claimant indicated that the "pain was just like it was prior to his very first surgery." (*Id.*) An MRI showed that claimant had a large focal left L4-5 disc herniation. (Ex. 106).

On September 8, 1997, Dr. Havlina reported that the 1995 disk herniation "should be considered the aggravation of a pre-existing condition, namely, lumbar disk herniation at L4-5 on the left side from 1985, which resulted in his surgery of 1988." (Ex. 116). He explained that claimant suffered an industrial accident in 1985 that ultimately resulted in disk surgery at L4-5 on the left side in 1988. (*Id.*) Dr. Havlina indicated that a 1991 MRI showed evidence of a recurrent disc at L4-5 on the left side, although surgery was not necessary at that time. Dr. Havlina felt that the original disk herniation, which resulted in L4-5 surgery in 1988, probably predisposed claimant to the recurrent herniation which led to surgery in 1995. (*Id.*)

Dr. Fuller examined claimant on behalf of SAIF and concluded that claimant's recurrent left-sided herniated disc at L4-5 related in major part to the 1985 injury. (Ex. 111-6). He felt that the current 1995 surgery related to claimant's prior discectomy at L4-5. (*Id.*)

The prior litigation for the 1993 injury resulted in a conclusion that claimant had sustained a "new compensable injury" for which Alexsis was responsible. The Board found Alexsis responsible for a new back strain that had combined with claimant's preexisting condition. Claimant's preexisting condition included an L4-5 disc herniation. Consequently, because Alexsis accepted a "new compensable injury" under ORS 656.308(1), Alexsis remains responsible for claimant's current L4-5 disc herniation. Alexsis cannot avail itself of ORS 656.262(6)(c) and (7)(b) to shift responsibility backward. *See Daral T. Morrow*, 49 Van Natta at 1981; *David E. McAtee*, 50 Van Natta at 651. Rather, pursuant to ORS 656.308(1), Alexsis remains responsible for future compensable treatment and disability for claimant's back strain that had "combined with his preexisting condition" (Ex. 112-4), unless he sustains a subsequent "new compensable injury." We find no evidence of a subsequent injury. Therefore, we conclude that Alexsis' current condition denial is procedurally invalid and must be set aside.

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 Alexsis Risk Management, on behalf of the City of Ontario. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 30, 1998 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by Alexsis Risk Management, on behalf of the City of Ontario.

In the Matter of the Compensation of
ENRIQUE TORRALBA, Claimant
WCB Case No. 97-01985
ORDER ON REVIEW
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that dismissed claimant's request for hearing. The self-insured employer moves to dismiss claimant's request for review. On review, the issue is dismissal. We deny the employer's motion and affirm.

FINDINGS OF FACT

On May 1, 1998, a hearing convened before the ALJ. During claimant's testimony, claimant's then-attorney, on behalf of claimant, on the record moved to withdraw claimant's request for hearing. On May 7, 1998, the ALJ issued an Order of Dismissal.

On June 4, 1998, claimant, through another attorney, requested review of the Order of Dismissal. On June 29, 1998, this attorney withdrew as attorney of record for claimant.

CONCLUSIONS OF LAW AND OPINION

The insurer moves to dismiss claimant's request for review on the apparent basis that, because claimant did not file an appellant's brief explaining why we should set aside the Order of Dismissal, we should dismiss claimant's request for review. Alternatively, the employer asks that we expedite review of this case.

Claimant's failure to file a brief does not deprive the Board of jurisdiction to review this case. OAR 438-011-0020(1); *Jerry L. Ruise*, 49 Van Natta 687 (1997). Moreover, 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, e.g., Elvia H. Hillner*, 49 Van Natta 567, recon 49 Van Natta 584 (1997). Accordingly, we deny the employer's motion to dismiss claimant's request for review.

Turning to the merits, the record shows that claimant's hearing request was dismissed in response to claimant's then-attorney's withdrawal of that request. Claimant does not dispute his then-attorney's authority to act on his behalf, nor does he dispute the fact that the ALJ dismissed his request for hearing in response to his then-attorney's withdrawal of the hearing request. Under these circumstances, we find no reason to alter the ALJ's dismissal order. *See David R. Robertson*, 47 Van Natta 687 (1995).

Finally, because we have issued an order, we need not address claimant's request for expedited review.

ORDER

The ALJ's order dated May 7, 1998 is affirmed.

In the Matter of the Compensation of
GEORGE W. WALLER, Claimant
Own Motion No. 97-0090M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Parker, Bush & Lane, Claimant Attorneys

Claimant requests 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 that he is entitled to additional benefits beyond January 8, 1998.

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 January 21, 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).

With his request for review of employer's closure, claimant contended that his claim was prematurely closed as his attending physician had requested approval for surgery on his low back. On March 9, 1998, the employer issued a compensability denial of claimant's current low back condition on which claimant filed a request for hearing with the Hearings Division. (WCB Case No. 98-02059).

On March 26, 1998, we postponed review of the January 21, 1998 Notice of Closure until the pending litigation had been resolved. On June 15, 1998, Administrative Law Judge (ALJ) Otto approved a "Disputed Claim Settlement," which resolved the parties' dispute concerning the compensability of claimant's current low back condition which was pending before the Hearings Division. Pursuant to that settlement, claimant agreed that the employer's March 9, 1998 denial would remain in full force and effect. In addition, claimant stipulated that his request for hearing "shall be dismissed with prejudice," and that the settlement resolved "all issues raised or raisable."

In light of the parties' settlement, claimant's current low back condition remains in denied status. Consequently, we will not address the effect of, if any, claimant's current low back condition and need for treatment had on his medically stationary status at the time of closure as the employer has not accepted claimant's low back condition as compensable.

Claimant underwent an insurer-arranged medical examination (IME) on December 16, 1997. The IME panel opined that claimant's compensable right knee condition was medically stationary at that time and that "it is doubtful that any additional treatment will be necessary. On December 29, 1997, Dr. Schmidt, claimant's attending physician, concurred with the IME panel's conclusions. These 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 employer's closure was proper.

Accordingly, we affirm the employer's January 21, 1998 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
RAYMOND A. GRAVES, Claimant
WCB Case No. 97-06634
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by the Board *en banc.*

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Black's order that: (1) directed it to amend its claim acceptance to include "low back injury with multiple surgeries and chronic back pain"; (2) assessed a 20 percent penalty for its failure to amend its acceptance to include claimant's multiple surgeries as part of the compensable claim; and (3) modified its Notice of Closure to disallow an asserted overpayment of temporary disability. In its brief, SAIF also contends that the ALJ erred in admitting claimant's testimony concerning the overpayment issue. On review, the issues are claim acceptance, penalties, and temporary disability. We modify in part, affirm in part, and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the third paragraph (concerning hearing testimony). We summarize and supplement the findings as follows.

Claimant has a history of low back problems dating back to an industrial injury (with another employer) in 1977. In 1978, he underwent surgery for a right L5-S1 laminectomy, discectomy, and fusion. In 1984, he underwent exploration with decompression at L4-5 with wide resection and foraminotomy, resection of redundant ligament, scar tissue, and overriding superior L4 on lower L3 with full decompression.

Claimant was hired as a truck driver by SAIF's insured on May 20, 1987. On December 4, 1987, claimant compensably injured his low back when he caught his foot while descending from his truck. He was unable to return to work after the injury. SAIF accepted the 1987 injury claim for a disabling lumbosacral strain and began payment of temporary total disability (TTD) benefits. Using the wage information provided by its insured on the 801 claim form, SAIF calculated the TTD rate based on an average weekly wage of $450.

In about October 1988, claimant requested authorization for surgery at the L4-5 disc level. SAIF denied surgical authorization, and claimant requested a hearing. The parties subsequently entered into a Stipulation and Order, which was approved by an ALJ in October 1988. Under the terms of the agreement, the parties "agree[d] to settle all issues raised or raisable" as follows: SAIF rescinded its *de facto* denial of surgery and claimant's hearing request was dismissed. On October 14, 1988, claimant underwent bilateral L4-5 laminectomy, neurolysis, decompression, foraminotomy with L4-5 fusion, with left iliac crest bone graft. In 1989, motion was detected at the L4-5 disc level, indicating a failed fusion, or pseudoarthrosis.

In late 1989, claimant requested a hearing regarding SAIF's untimely payment of TTD benefits and its untimely discovery. The parties entered into a second Stipulation and Order, which was approved by an ALJ in January 1990. Under the terms of the agreement, the parties "agree[d] to settle all issue(s) raised or raisable" as follows: SAIF agreed to pay a 10 percent penalty and an attorney fee, and claimant's hearing request was dismissed.

In about January 1990, claimant requested authorization for surgery to repair and re-fuse the pseudoarthrosis at L4-5. SAIF denied surgical authorization, and claimant requested a hearing. Meanwhile, the injury claim was closed by Determination Order in February 1990 with awards of TTD and permanent partial disability (PPD). The parties subsequently entered into a third Stipulation and Order, which was approved by an ALJ in July 1990. Under its terms, the parties "agree[d] to settle all issues raised or raisable" as follows: SAIF rescinded its surgery denial and agreed to pay for further medical testing; SAIF agreed to reopen the claim for payment of TTD; and claimant's hearing request was dismissed.

In October 1990, SAIF again denied authorization for surgery to repair and re-fuse pseudoarthrosis at L4-5. By Opinion and Order dated November 5, 1990, an ALJ set aside both SAIF's denial of surgery and the February 1990 Determination Order, thus restoring the claim to open status. In December 1990, claimant underwent exploration and repair with re-grafting of the L4-5 pseudoarthrosis. The surgical repair was unsuccessful, and claimant underwent another L4-5 fusion surgery (with Wiltse plates) sometime in late 1991 or early 1992. The plates were removed in July 1992.

SAIF closed the injury claim by Notice of Closure in November 1992 with awards of temporary disability and PPD. Claimant requested reconsideration, and the Department modified the PPD award, but otherwise affirmed the closure notice. By Opinion and Order dated January 7, 1994, an ALJ set aside the closure notice as premature, again restoring the claim to open status.

Due to chronic pain in his low back and legs, claimant was admitted to pain center treatment in July 1996. Upon his discharge, his condition was declared medically stationary and he was released for full-time sedentary work in August 1996. In early 1997, SAIF conducted an internal audit of payments made on claimant's claim. By letter dated March 4, 1997, SAIF informed claimant that his average weekly wage had been recalculated as $296.43, instead of $450, based on his actual earnings during the 28 weeks of employment preceding his 1987 injury, and that future TTD payments would be made at the reduced rate.

SAIF closed the injury claim by Notice of Closure on March 5, 1997 with awards of temporary disability and 43 percent unscheduled PPD. The closure notice set forth the various rates at which his TTD benefits were calculated during the entire period of his temporary disability from the date of injury to his medically stationary date. The closure notice also stated that claimant had been overpaid $67,382.56 and that the overpayment would be deducted from his disability award. By separate letter dated April 3, 1997, SAIF informed claimant that the overpayment had been offset against the entire PPD award, leaving an overpayment balance of $65,213.74.

Claimant requested reconsideration of the March 1997 closure notice, raising the issues of temporary disability, including the TTD rate, and PPD. On reconsideration, the Department's Appellate Review Unit (ARU) declined to review the TTD rates set forth in the closure notice, stating that "temporary disability rates are not subject to review by the [ARU]. This issue has been referred to the Benefits Section for their action."[1] By Order on Reconsideration dated July 14, 1997, the ARU increased claimant's unscheduled PPD award to 45 percent and otherwise affirmed the closure notice. Subsequently, SAIF advised claimant that his increased PPD award had been applied to reduce its overpayment to $64,424.33.

On August 22, 1997, claimant's counsel wrote SAIF, requesting that its claim acceptance be expanded to include the following 13 "conditions": (1) lumbosacral strain; (2) L4-5 disc herniation, decompression with wide resection and foraminotomy; (3) redundant ligament, scar tissue, and overriding superior L4 on lower L3 with full decompression; (4) L5-S1 herniated disc, laminectomy, discectomy fusion, and radiculopathy; (5) L4-5 laminectomy, neurolysis, decompression, foraminotomy with L4-5 fusion, with left iliac crest bone graft; (6) exploration and repair with re-grafting of L4-5 pseudarthrosis; (7) L3-4 arachnoiditis; (8) left and right lower extremity radiculitis with numbness and foot pain; (9) depression; (10) ulcers; (11) gastritis and duodenal erosions; (12) torn right knee meniscus with right knee meniscectomy; and (13) L4-5 urinary and L5-S1 nerve roots injury with sexual dysfunction. By letter dated September 23, 1997, SAIF responded that it would not expand its acceptance because the claimed "conditions" were either medical procedures or subjective complaints.

CONCLUSIONS OF LAW AND OPINION

Claim Acceptance

The ALJ ordered SAIF to amend its claim acceptance, which had been limited to a lumbosacral strain, to accept a "low back injury with multiple surgeries and chronic back pain." The ALJ reasoned that claimant was entitled to the amended acceptance under ORS 656.262(7)(a).

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[1] There is no indication in the record of what action, if any, was taken by the Benefits Section after the referral of the TTD rate issue.

On review, SAIF contends that claimant did not make a clear written request for acceptance of a "low back injury with multiple surgeries and chronic back pain" under ORS 656.262(7)(a) and that the ALJ therefore erred in ordering the amended acceptance. Claimant responds that this case is governed by ORS 656.262(6)(d) rather than ORS 656.262(7)(a) but that the ALJ properly ordered the amended acceptance. We modify the ALJ's order regarding this issue, based on the following reasoning.

We do not need to decide whether this case is governed by ORS 656.262(6)(d) or ORS 656.262(7)(a) because the result would be the same under either provision. ORS 656.262(6)(d) provides, in part:

> "*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 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." (Italics added.)

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 * * *. 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." (Italics added.)

The italicized language in each provision makes clear that a worker is required to make a *written* request to the carrier for amendment of the notice of acceptance to include any additional "condition." In this case, SAIF argues that most of the "conditions" listed in claimant's attorney's August 22, 1997 letter were actually medical procedures or subjective complaints and that neither ORS 656.262(6)(d) nor ORS 656.262(7)(a) requires acceptance of procedures or complaints as part of an injury claim.

In determining legislative intent, we look first to the text and context of the statute. *See PGE v. Bureau of Labor and Industries*, 317 Or 606, 610 (1993). The term "condition" is not defined by statute. In the medical context, however, the term "condition" is defined as "the physical status of the body as a whole or of one of its parts." *Webster's Third New International Dictionary* 473 (unabridged 1993). We therefore conclude that, to qualify as a claim for a "condition" that must be processed in accordance with either ORS 656.262(6)(d) or ORS 656.262(7)(a), the claim must be for a "physical status" of the body or one of its parts.

Claimant's attorney's August 22, 1997 letter requested acceptance of numerous low back surgeries and right knee surgery. (Ex. 54). In response to SAIF's request, claimant's treating physician, Dr. Gombart, described these particular items as medical "procedures" rather than medical "conditions." (Ex. 56). Based on the doctor's unrebutted opinion, we find that the claimed surgeries did not describe a physical status of the body or one of its parts and therefore did not present claims for "conditions" that triggered SAIF's processing obligation under either ORS 656.262(6)(d) or ORS 656.262(7)(a). Accordingly, we reverse the ALJ's order to accept "multiple surgeries" as part of the injury claim.

We also reverse the ALJ's order to accept "chronic back pain" as part of the claim. There is no evidence in the record that claimant made a written request for acceptance of "chronic back pain." Without a written request, we conclude that neither ORS 656.262(6)(d) nor ORS 656.262(7)(a) required SAIF to process, much less accept, that condition as part of the claim.

Turning again to claimant's attorney's August 22, 1997 letter, we find that several of the listed items describe the physical status of the body or one of its parts and therefore qualify as "conditions." With the exception of the lumbosacral strain, which SAIF has already accepted, those conditions are: (1) L4-5 herniated disc; (2) L5-S1 herniated disc; (3) L3-4 arachnoiditis; (4) left and right lower extremity

radiculitis with numbness and foot pain; (5) depression; (6) L4-5 pseudarthrosis; (7) ulcers; (8) gastritis and duodenal erosions; (9) torn right knee meniscus; and (10) L4-5 urinary and L5-S1 nerve roots injury with sexual dysfunction. (Ex. 54). Under either ORS 656.262(6)(d) or ORS 656.262(7)(a), SAIF was required to process these conditions and, if they were found to be compensable, to accept them as part of the claim.

We now review the record to determine if the above-listed conditions are compensable. Claimant has the burden of proving the compensability of those conditions by a preponderance of the evidence in the record. *See* ORS 656.266.

We find no evidence in the record that the right knee condition is related to either the accepted lumbosacral strain or the December 4, 1987 work incident. In addition, Dr. Gombart specifically indicated that he did not recall "a primary diagnosis of depression" and that the claimed ulcers, gastritis, and duodenal erosions had "no injury relationship." (Ex. 56, pp. 3-4).

Turning to the low back conditions, we find no indication in the record that a herniated disc was diagnosed at either L4-5 or L5-S1 anytime after the December 4, 1987 injury. Rather, the record indicates that those conditions may have preexisted the 1987 injury and resulted from a previous injury with another employer in 1977.

The record does show that the L4-5 pseudarthrosis (or failed fusion) was diagnosed after the 1987 injury and that it occurred as a result of unsuccessful fusion surgeries in 1988 and 1990. (Ex. 17-6). Those fusion surgeries, as well as the 1991/1992 fusion surgery that finally repaired the pseudarthrosis, ultimately were processed by SAIF as compensable treatment for the 1987 injury. (Exs. 4, 6, 11, 12, 14, 16). Based on this record, we conclude that the L4-5 pseudarthrosis was primarily caused by, and therefore a compensable consequence of, the 1987 injury and its sequela. *See* ORS 656.005 (7)(a)(A); *Albany General Hospital v. Gasperino*, 113 Or App 411(1992).

During pain center evaluation in May 1996, Dr. Jensen diagnosed a "[s]uggestion of L3-4 arachnoiditis" and later described a "possible arachnoiditis." (Ex. 33-7). However, because there is no medical opinion relating an arachnoiditis at the L3-4 level to the 1987 injury, we conclude that that condition is not compensable.

There is a medical opinion that related claimant's left and right lower extremity radiculitis to the 1987 injury. After an examination for the 1987 injury, Dr. Kitchel stated that claimant's bilateral leg pain was a "work related injury." (Ex. 32-5). His opinion is unrebutted and therefore sufficient to carry claimant's burden of proof regarding that condition, under either the material or major contributing cause standard. *See* ORS 656.005(7)(a).

Finally, Dr. Young rendered an opinion relating claimant's voiding (*i.e.*, urinary) dysfunction to "pain and discomfort associated with [claimant's] general back situation." (Ex. 10). Although Dr. Jensen later wrote that claimant's complaints of urinary hesitancy, frequency and incontinence were of "unknown etiology," (Ex. 33-7), her report does not *rule out* a connection to claimant's back condition. We therefore conclude that Dr. Young's unrebutted opinion carries claimant's burden of proof regarding her urinary dysfunction condition. We find, however, that there is no medical opinion relating any "sexual dysfunction" to the back condition or the 1987 injury; at most, the record indicates that its etiology is "unknown." (Ex. 33-8).

To summarize our conclusions, we hold that claimant has proved the compensability of the following conditions: (1) L4-5 pseudarthrosis; (2) right and left lower extremity radiculitis; and (3) urinary dysfunction. Accordingly, the ALJ's order shall be modified to order the acceptance of these conditions as part of the 1987 injury claim, in addition to the lumbosacral strain.

Penalties

The ALJ assessed SAIF with a 20 percent penalty for its processing of claimant's request for an expanded acceptance. The ALJ reasoned that SAIF's refusal to expand its acceptance beyond the lumbosacral strain to include claimant's multiple surgeries "simply flew in the face of the realities and the facts of actual claims processing that had consistently treated as compensable the surgical procedures."

ORS 656.262(11)(a) authorizes assessment of a penalty of up to 25 percent of compensation due, if a carrier "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." The test for "reasonable" conduct is whether the carrier had a legitimate doubt as to its liability, based on all the evidence available to the carrier at the time of its conduct. *Tattoo v. Barrett Business Service*, 118 Or App 348, 353 (1993).

For the reasons discussed above, we conclude that SAIF was not required to accept the multiple surgical procedures. Those procedures were not "conditions" within the meaning of either ORS 656.262(6)(d) or (7)(a). Nonetheless, we find that SAIF did not have a legitimate doubt as to its liability for additional conditions beyond the lumbosacral strain. The record clearly shows that claimant's L4-5 pseudarthrosis condition was the result of unsuccessful L4-5 fusion surgeries that SAIF processed under the 1987 injury claim. (Ex. 17-6). The record also shows that claimant's bilateral lower extremity radiculitis and urinary dysfunction resulted from his injury-related low back condition. (Exs. 10, 32-5). Under these circumstances, we conclude that SAIF's refusal to expand its acceptance beyond the lumbosacral strain was unreasonable, and affirm the ALJ's penalty assessment.

Temporary Disability

Turning to the temporary disability issue, we begin with a brief summary of the relevant procedural facts. SAIF's March 5, 1997 Notice of Closure awarded claimant temporary disability benefits for the period from December 7, 1987, the date of injury, through August 16, 1996, the medically stationary date. The closure notice set forth the TTD rates at which those benefits were awarded for the entire period of temporary disability and asserted an overpayment of (temporary disability) compensation in the amount of $67,382.56. Claimant requested reconsideration and challenged, among other things, the TTD rates set forth in the closure notice. However, ARU declined to review the TTD rate issue, stating that "temporary disability rates are not subject to review by the [ARU]. This issue has been referred to the Benefits Section for their action." (Ex. 50-2). There is no indication of what action, if any, was taken by the Benefits Section based on the referral. By Order on Reconsideration dated July 14, 1997, the ARU affirmed the closure notice award of the duration (dates) of temporary disability.

At hearing, the ALJ and counsel had a preliminary discussion regarding the admissibility of testimony concerning the temporary disability issue. (Tr. 10-12). During that discussion, SAIF's counsel cited to a Board case, *Noel L. Baier*, 49 Van Natta 290 (1997), which held that "post-reconsideration" testimony regarding a closure award of temporary disability benefits was inadmissible at hearing under ORS 656.283(7). The ALJ ultimately concluded that the *Baier* case was factually distinguishable, and ruled that "post-reconsideration" testimony was admissible at hearing. (Tr. 12). After weighing the testimony, the ALJ concluded that the TTD rates set forth in the closure notice were incorrect, and set aside the asserted overpayment of compensation.

On review, SAIF contends that the ALJ erred in admitting "post-reconsideration" evidence regarding the TTD rate issue and setting aside its asserted overpayment. Claimant responds that SAIF was barred, by issue/claim preclusion or by waiver, from establishing its overpayment of temporary disability in the closure notice and that the TTD rate issue was not subject to the prohibition on "post-reconsideration" evidence in ORS 656.283(7). We reverse the ALJ's order concerning this issue.

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 * * *." In *Noel L. Baier*, we applied ORS 656.283(7) to bar the admission of "post-reconsideration" testimonial evidence at a hearing regarding temporary disability awarded by a Notice of Closure. 49 Van Natta at 291.

Claimant argues that *Baier* is factually distinguishable because the dispute in that case was over the beginning and ending *dates* for temporary disability, not over the TTD *rate*. That distinction is without significance, however. Whereas the closure notice in *Baier* apparently provided only the beginning and ending dates for temporary disability, the closure notice in this case set forth *both* the dates *and* rates of temporary disability. Because claimant's TTD rates were manifest in SAIF's closure notice itself, and claimant challenged those rates on reconsideration, we conclude that the rates were an "issue regarding a notice of closure" within the meaning of ORS 656.283(7). *Cf. Blaine P. Hosey*, 50 Van Natta 360, 361 (1998) (where TTD rate was not manifest in the closure notice, the TTD rate issue was not

an issue that arose from the closure notice and had to be raised at reconsideration). Accordingly, ORS 656.283(7) barred the admission of "post-reconsideration" testimonial evidence at hearing.[2] *See Baier*, 49 Van Natta at 291.

Claimant argues that SAIF's inclusion of TTD rates in its closure notice exceeded the closure requirements under the Director's rule, OAR 436-030-0036(1), and that the Director (and his delegate, ARU) lacked jurisdiction to review TTD rates in the reconsideration proceeding. We disagree. ORS 656.268(4)(b), which prescribes the information that must be provided in the closure notice, states in part:

> "The notice [of closure] must inform the worker of the amount of any further compensation, including permanent disability compensation to be awarded; of the *amount and duration of temporary total or temporary partial disability compensation;* of the right of the worker to request reconsideration by the Department of Consumer and Business Services under this section within 60 days of the date of the notice of claim closure; of the aggravation rights; and of such other information as the Director of the Department of Consumer and Business Services may require." (Italics added.)

As previously stated, to determine legislative intent, we begin our analysis with the text and context of the statute. *See PGE* , 317 Or at 610-11. Under ORS 656.268(4)(b), a carrier is required to include in its closure notice the "duration" and "amount" of temporary disability benefits. The term "amount" is most reasonably interpreted as encompassing both the rate at which temporary disability benefits are paid and the time period for which benefits are paid. *Id.* at 611 (words of common usage typically should be given their plain, natural, and ordinary meaning). Thus, based on the text of the statute, we conclude that the legislature intended that closure notices could provide information to claimants of the rates, as well as the beginning and ending dates, of temporary disability benefits awarded at the time of claim closure.[3]

Claimant is correct that the Director's rules in effect at the time of the March 1997 claim closure did not *require* a carrier to state the TTD rate in the closure notice. *Former* OAR 436-030-0036 provided:

> "(1) Temporary disability shall be determined pursuant to OAR 436-060 Chapter 656 and this rule, less time worked. Beginning and ending dates of authorized temporary disability shall be noted on the Determination Order or Notice of Closure, as well as the statements 'Less time worked' and 'Temporary disability was determined in accordance with the law.'
>
> "(2) Except as provided for in section (3) of this rule, a worker is not entitled to any award for temporary disability for any period of time in which the worker is medically stationary.

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[2] We recognize that the record does not contain an express objection by SAIF's counsel to the admission of "post-reconsideration" testimonial evidence at hearing. Nevertheless, we conclude that SAIF's argument that such evidence was inadmissible was "preserved" for appeal. Based on our review of the preliminary discussion that took place prior to the receipt of testimony at hearing, we find that counsel for both parties effectively agreed to seek a preliminary ruling by the ALJ on the admissibility of the testimony. We find no evidence that SAIF's counsel agreed to be bound by the ALJ's ruling. On the contrary, SAIF's counsel cited the ALJ to a Board case (*Noel L. Baier*) supporting the proposition that "post-reconsideration" testimonial evidence on the temporary disability issue was inadmissible at hearing. (Tr. 10). Because the parties sought the ALJ's evidentiary ruling in advance of claimant offering testimony, and there is no suggestion that SAIF was waiving its right later to dispute the ruling, we conclude that SAIF's evidentiary issue was properly preserved for Board review. *See Rogue Valley Medical Center v. McClearen*, 152 Or App 239, 243 (1998).

[3] Our conclusion comports with our analysis of the rate issue in the permanent disability context. In *Ferral C. Crowder*, 48 Van Natta 2322, 2323 (1996) (Board Member Hall dissenting), we held that, where the rate of the PPD award was apparent from the determination order itself, the PPD rate issue arose from the determination order and therefore had to be raised at the reconsideration proceeding.

> "(3) Awards of temporary disability shall include the day the worker is medically stationary or the statutory closure date, unless temporary disability is not authorized for another reason at that time." (WCD Admin. Order 96-052).[4]

However, the Director's rules also did not bar a carrier from stating the TTD rate in the closure notice. In fact, the rules are silent on the question of whether the TTD rate should be stated in the closure notice. Because the rules are silent, we conclude, based on the aforementioned text of ORS 656.268(4)(b), that SAIF was authorized, if not required, to set forth the claimant's TTD rates in its closure notice.[5] Because SAIF actually did so, making the TTD rate issue manifest in the closure notice, claimant was required to raise the issue, and submit evidence on that issue, at the reconsideration proceeding before ARU.

Furthermore, when claimant raised the TTD rate issue at the reconsideration proceeding, ARU was obligated to review that issue as part of its reconsideration. ORS 656.268(4)(e) provides that "[i]f a worker objects to the notice of closure, the worker first must request reconsideration by the department under this section." ORS 656.268(6)(d) provides that "[t]he reconsideration proceeding shall be completed within 18 working days from the date the reconsideration proceeding begins, and shall be performed by a special evaluation appellate unit within the department." Thus, the legislature charged the Department with the duty to establish an evaluation appellate unit (*i.e.*, ARU) that would be responsible for performing the reconsideration of issues regarding a closure notice.[6]

Finally, we reject claimant's argument that SAIF was barred, either by issue/claim preclusion or by waiver, from recalculating claimant's TTD rates in the closure notice and asserting an overpayment of compensation based on the recalculated rates. Waiver is "the intentional relinquishment of a known right." *Drews v. EBI Companies*, 310 Or 134, 150 (1990). Waiver must be plainly and unequivocally manifested, either "in terms or by such conduct as clearly indicates an intention to renounce a known privilege or power." *Great American Ins. v. General Ins.*, 257 Or 62, 72 (1970). Based on our review of the record, we find no evidence that SAIF manifested the unequivocal intention to renounce its right to recalculate claimant's TTD rates in the closure notice and assert an overpayment of compensation based on the recalculated rates.

Furthermore, we conclude that there has not been the finality of adjudication that is required for issue or claim preclusion to apply in this case. As the Court of Appeals stated in *Cravens v. SAIF*, 121 Or App 443, 447 (1993), even if a carrier could and should have raised the issue of the correct TTD rate in earlier litigation, the amounts of compensation, including temporary disability, are subject to adjustment until final closure of the claim. ORS 656.268(13) provides:

> "*Any* determination or *notice of closure* made under this section *may include necessary adjustments in compensation paid or payable* prior to the determination or notice of closure, including disallowance of permanent disability payments prematurely made, *crediting temporary disability payments against current* or future permanent or *temporary disability awards* or payments and requiring the payment of temporary disability payments which were payable but not paid." (Italics added.)

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[4] The current version of OAR 436-030-0036 is not substantially different from the former version. *See* WCD Admin. Order 97-065.

[5] Even if OAR 436-030-0036 could be interpreted to bar a carrier from stating the TTD rate in the closure, we would conclude that the rule was an invalid attempt to limit the terms of the statute, and gave no effect to the rule. *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).

[6] Although ARU refused to review the TTD rate issue, claimant nevertheless had an ample opportunity to submit all available evidence regarding that issue to ARU. Had claimant availed himself of this opportunity, we could have reviewed this evidence in the Director's reconsideration record, irrespective of ARU's refusal to review the TTD rate issue. Therefore, we disagree with the dissent's invocation of due process concerns.

Here, because the final closure of claimant's claim did not occur until the issuance of the March 1997 closure notice,[7] SAIF was statutorily authorized to make adjustments to compensation, including his "substantive" temporary disability,[8] in the closure notice. In other words, ORS 656.268(13) is a statutory exception to the issue/claim preclusion doctrine, which permitted SAIF to make adjustments to claimant's temporary disability award and credit prior payments against that award. Accordingly, SAIF was not barred from recalculating claimant's TTD rate and asserting its overpayment based on the recalculated rate.

Turning to the merits of the TTD rate issue, and after excluding the "post-reconsideration" testimonial evidence that was admitted by the ALJ at hearing, we begin by noting that claimant has the burden of proving his entitlement to additional temporary disability benefits by a preponderance of the evidence in the record. *See* ORS 656.266.

Based on our review of the documentary evidence in the record, we conclude that claimant has not carried his burden of proof. On the original 801 claim form that was completed in December 1987, an employer representative indicated that, during employment from May 20 through December 4, 1987, claimant worked 10 hours per day, five days per week, at an hourly wage of $9. (Ex. 1). That information supports a finding that claimant earned an average weekly wage of $450.

However, according to the record of SAIF's internal audit in early 1997, payroll records received from the employer showed that claimant actually received gross earnings of $8,418.49 during the entire 28.04 weeks of his employment with the employer. (Ex. 42). This undisputed earnings amount, when averaged over the 28.04 weeks, shows that claimant earned an average weekly wage of $296.43, far less than the $450 amount that claimant would have earned had he been regularly employed for 50 hours per week (as indicated on the 801 form). Thus, the audit information in the record supports a finding that claimant was not regularly employed. The ALJ also made this finding and it is not challenged by claimant on review. Accordingly, claimant's weekly wage is not computed in accordance with ORS 656.210(2).

Having found that claimant was not "regularly employed," we turn to the question of whether there were "extended gaps" in claimant's employment. The ALJ found the existence of such gaps based on claimant's testimony at hearing. We have excluded that testimony as inadmissible evidence, leaving no evidence in the record to support a finding of extended gaps. Absent such evidence, we disagree with the ALJ's conclusion that claimant's weekly wage must be computed using "intent at time of hire as confirmed by employer and worker." *See former* OAR 436-60-020(7)(a) (WCD Admin. Order 10-1987). Instead, we conclude that SAIF properly averaged claimant's gross wages over the period of his employment. Because claimant does not dispute the accuracy of SAIF's computation of the average weekly wage, we reverse the ALJ's order on this issue and affirm both the temporary disability awarded in the closure notice and the asserted overpayment based on the recalculated TTD rates.

ORDER

The ALJ's order dated December 24, 1997 is reversed in part, modified in part, and affirmed in part. The portion of the order that modified the Order on Reconsideration to set aside the overpayment of compensation asserted in the Notice of Closure and recalculate claimant's TTD rate, is reversed. The Order on Reconsideration is affirmed. The portion of the order that directed SAIF to issue an amended notice of acceptance is modified to direct SAIF to accept an L4-5 pseudarthrosis, bilateral lower extremity radiculitis, and urinary dysfunction, in addition to the lumbosacral strain. The remainder of the order is affirmed.

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[7] Although the claim was closed on three prior occasions, those closures were rescinded, either voluntarily or by litigation order.

[8] "Substantive" entitlement to temporary disability, which is based on the extent to which the claimant was actually disabled during the pendency of the open claim, is not determined until the claim is closed. *Shaw v. Rebholz*, 152 Or App 328, 332 (1998).

Board Members Hall and Biehl dissenting in part.

We agree that SAIF was required to expand its claim acceptance and that it was liable for a penalty for refusing to do so, but for the following reasons, we must dissent from the majority's reversal of the ALJ's TTD rate calculation.

This case presents unique facts that distinguish it from *Noel L. Baier*. For one thing, the *rate* of TTD was not at issue in *Baier*. For another, ARU did not decline to review the temporary disability issue in *Baier*. In this case, by contrast, the TTD rate is at issue and ARU expressly declined to address the issue at reconsideration, referring it, instead, to the Benefits Section. The provisions of ORS 656.268 contemplate that the Department will review issues raised at reconsideration before the matter proceeds to hearing and that the parties will be given a meaningful opportunity to develop the reconsideration record regarding those issues. Given the statutory scheme and ARU's express refusal to review the TTD rate issue in this case, due process requires that the reconsideration order be vacated and this claim remanded to ARU to allow claimant a meaningful opportunity to be heard on that issue.[1]

Moreover, claimant must be given a meaningful opportunity to develop the reconsideration record regarding the TTD rate issue before proceeding to hearing and being subject to the prohibition of "post-reconsideration" evidence. Unlike the majority, we are not prepared to conclude that no material prejudice resulted from ARU's refusal to review the issue. Had ARU reviewed the issue at reconsideration, as contemplated by the statute, it is quite conceivable that ARU would have requested further evidence and ensured that the reconsideration record was fully developed on that issue. Because only ARU can take this action, and it did not, it is imperative that this claim be remanded to ARU to fulfill its obligation to review the issue and develop a complete record.[2] For these reasons, we respectfully dissent.

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[1] Consistent with our position in *Blaine P. Hosey*, 50 Van Natta 360 (1998) and Member Hall's dissenting opinions in *Benjamin G. Santos*, 49 Van Natta 1429 (1997) and *Ferral C. Crowder*, 48 Van Natta 2322 (1996), we remain persuaded that TTD and PPD *rate* issues are not "issues regarding a notice of closure or determination order" within the meaning of ORS 656.283(7). While acknowledging that Board case law is contrary to our position, we would conclude (on a clean slate) that claimant was not required to raise the TTD rate issue at the reconsideration proceeding, and that the prohibition against receipt of "post-reconsideration" evidence does not apply here.

[2] Such evidence could include affidavits setting forth the substance of the testimony that was received by the ALJ at hearing, but excluded by the majority on Board review. As the ALJ indicated, the substance of that testimony would support a finding that claimant's TTD rate should be based on wages using "intent at time of hire" in accordance with *former* OAR 436-60-020(7)(a).

In the Matter of the Compensation of
LAURA E. FERGUSON, Claimant
WCB Case No. 97-09391
ORDER ON RECONSIDERATION
Westmoreland & Mundorff, Claimant Attorneys
Lundeen, et al, Defense Attorneys

The insurer requests reconsideration of our July 10, 1998 Order on Review which adopted and affirmed the Administrative Law Judge's (ALJ's) order that affirmed the Order on Reconsideration award of 7 percent (10.5 degrees) scheduled permanent disability for the loss of use or function of the left leg (knee). The insurer contends that our unpublished order in *Wilma D. Moorefield*, WL 351114 (1995), is controlling precedent in this case and that it should therefore be applied to reduce claimant's award to zero, or it should be disavowed. Claimant has filed a response to the insurer's motion, and we now proceed with our reconsideration.

By "adopting" the ALJ's order, we expressed our complete agreement with his distinction of *Moorefield* from this case. That is, we agreed that the holding of *Moorefield* was limited to the particular facts of that case. Contrary to the insurer's assertion, we find no statement in *Moorefield* setting forth a rule of law that in all cases where an intervening injury (involving the same body part as that injured in the earlier industrial accident) occurs before the medical arbiter's examination, the medical arbiter's

impairment findings either lack any probative value or are less persuasive than the attending physician's findings. Thus, our adoption of the ALJ's order was an implicit rejection of the insurer's interpretation of *Moorefield* and its precedential value. Like the ALJ, we found that under the particular facts of this case (which include the medical arbiter's express acknowledgment of the intervening injury and his express opinion that claimant's disability was due to the compensable injury), the medical arbiter's impairment findings were more persuasive. We find it unnecessary to disavow prior case law to arrive at this fact-driven conclusion.

Accordingly, our July 10, 1998 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our July 10, 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
STANLEY W. JACOB, Claimant
WCB Case No. 97-05461
ORDER ON REVIEW
Dolores Empey, 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) Herman's order that: (1) set aside its denial of claimant's claim for hypertension; and (2) awarded a $4,500 attorney fee for claimant's counsel's services at hearing. On review, the issues are compensability and attorney fees.

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

The ALJ set aside SAIF's denial of claimant's claim and awarded a $4,500 attorney fee indicating that the file reflected "considerable efforts by claimant's counsel in preparing and trying this complex medical case." The ALJ awarded the fee "[a]fter considering the factors as outlined in OAR 438-015-0010(4)."

On review, SAIF cites *Schoch v. Leupold & Stevens*, 325 Or 112, *on remand* 49 Van Natta 788 (1997), and contends that the ALJ's order is insufficient because the ALJ did not make specific findings of fact concerning each of the eight factors listed in OAR 438-015-0010(4). On this basis, SAIF argues that we should "vacate the attorney fee award" and make our own specific findings regarding each factor.

The record contains no specific attorney fee request and no indication that the parties specifically argued how the attorney fee factors should be weighed in determining a reasonable fee.

In *Russell L. Martin*, 50 Van Natta 313 (1998), we found that an ALJ was not obligated to make specific findings regarding the rule-based factors in a case where there was no specific attorney fee request (or statement of services), and the parties had not submitted to the ALJ any argument as to how the rule-based factors should be weighed in determining a reasonable fee. Under such circumstances, we concluded that *Schoch* was distinguishable. *Martin*, 50 Van Natta at 314. *See also McCarthy v. Oregon Freeze Dry, Inc.*, 327 Or 84 *on recon* 327 Or 185 (June 11, 1988) (Court of Appeals would satisfy its obligation to make findings under attorney fee statute by including a brief description or citation to the factor or factors relied on in denying an award of attorney fees; standing alone, absence of explanatory findings to support an award or denial of attorney fees is not a ground for reversal). Accordingly, we conclude that it was sufficient for the ALJ to state that she had considered the rule-based factors, with particular emphasis on two of the factors (time expended and complexity of the issue). *See Deborah F. Morgan*, 50 Van Natta 1374 (1998); *Sherlie A. Dial*, 50 Van Natta 1405 (1998).

On review, SAIF now submits specific arguments regarding the factors contained in OAR 438-015-0010(4) and argues that consideration of the factors does not justify the $4,500 attorney fee. Because SAIF has now advanced arguments specifically addressing the factors, we provide the following supplementation of the ALJ's order.

SAIF contends that claimant's counsel solicited one report from claimant's physician, there were no depositions, the hearing lasted about two hours and one witness testified. SAIF argues that the record does not support the ALJ's assessment that this was a "complex medical case" warranting a $4,500 attorney fee. After our review, we do not agree that the attorney fee awarded by the ALJ was excessive.

The record contains no statement of services documenting the time claimant's attorney spent on the case. The transcript is 31 pages long and the hearing lasted 2 hours and 20 minutes. The record contains 29 exhibits, one of which was submitted by claimant's counsel.

The issue at hearing was whether claimant's hypertension was compensably related to a May 9, 1996 crush injury. Because of the medically complex nature of the case, we find that the compensability issue was of above average complexity. The value of the interest and the benefit secured for claimant were significant in that claimant will now receive treatment for his hypertension and its potential effects. Claimant's attorney skillfully conducted the litigation. No frivolous issues or defenses were raised. In addition, given the divided medical evidence and vigorous defense by SAIF, there was a significant risk that claimant's counsel might go uncompensated.

After our review of the record and application of the factors, we agree with the ALJ that the time and effort expended by claimant's counsel and the complexity of the case justify a fee of $4,500. Consequently, we affirm the ALJ's attorney fee award.

Claimant's attorney is also entitled to an assessed fee for services in defending against SAIF's request for review regarding the issue of compensability. *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 those services is $1,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue and the value of the interest involved. Claimant's attorney is not entitled to an assessed fee for defending the ALJ's fee award. *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated March 30, 1998 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
FOREST G. HULL, Claimant
WCB Case No. 97-05568
ORDER ON RECONSIDERATION
Martin L. Alvey, Claimant Attorney
VavRosky, et al, Defense Attorneys

The self-insured employer requests reconsideration of our July 6, 1998 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order that set aside its partial denial of claimant's current cervical-thoracic condition. Specifically, the employer contends that, by adopting and affirming the ALJ's order, we have not sufficiently considered or responded to its arguments.

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

Consequently, we withdraw our July 6, 1998 order. On reconsideration, as supplemented herein, we republish our July 6, 1998 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID D. SULLIVAN, Claimant
WCB Case No. 97-09292
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that awarded an assessed attorney fee of $5,119.10. In its brief, SAIF requests that the case by remanded to the ALJ and asks that claimant's attorney be required to provide an itemized statement of services. On review, the issues are remand and attorney fees. We deny the motion to remand and modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. We change the date in the second paragraph of the findings of fact to "January 29, 1997." We change the fourth paragraph to read:

"An MRI on March 24, 1997 showed degenerative disc disease associated with a moderate posterior and slightly right-sided disc herniation at L5-S1. There was no demonstrable nerve root compression. (Ex. 16)."

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside SAIF's denial of claimant's claim for a right-sided disc herniation at L5-S1. Claimant's attorney submitted a Statement of Services indicating he had spent 16 total hours on the case and requesting an attorney fee of $2,700. SAIF argued that the statement of services was inadequate to justify a finding that claimant's attorney had devoted 16 hours to prosecution of the claim. The ALJ awarded an attorney fee of $5,119.10.

Remand

On review, SAIF argues that the ALJ erred by awarding an attorney fee of $5,119.10. SAIF requests that the case by remanded to the ALJ and asks that claimant's attorney be required to provide an itemized statement of services. SAIF also requests an opportunity to respond to the itemization and asks that the award be explained as required by *Schoch v. Leupold & Stevens*, 325 Or 112 (1997).

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).

We are not persuaded that the additional evidence is reasonably likely to affect the outcome of the case. Under ORS 656.295(6), we have *de novo* review authority and may reverse or modify the ALJ's order or make any disposition of the case that we deem appropriate. *See Destael v. Nicolai Co.*, 80 Or App 596, 600 (1986). Therefore, we are statutorily authorized to modify the ALJ's attorney fee award. *See Phyllis M. Hays*, 50 Van Natta 867 (1998) (although the carrier did not object to the claimant's counsel's statement of services at hearing, the Board was statutorily authorized to modify the attorney fee award). Under these circumstances, we decline to remand the case to the ALJ for additional proceedings.

Attorney Fee at Hearing

SAIF contends that the ALJ erred in awarding an attorney fee award greater than that requested by claimant's attorney. Claimant agrees that the ALJ should not have awarded an attorney fee greater than the $2,700 fee requested.

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

The issue in dispute was compensability of claimant's right-sided disc herniation at L5-S1. Twenty-four exhibits were received into evidence, two of which were generated or submitted by claimant's counsel. There were no depositions. The transcript consists of eleven pages. There were no witnesses. In his statement of services, claimant's counsel indicated that he spent 15.5 hours on this case at hearing, plus .5 estimated additional hours.

Turning to the factors under OAR 438-015-0010(4), we find that the compensability issue was of average complexity when compared to other claims generally presented to this forum for resolution and that the proceedings were limited, with no depositions or witnesses. Prior to hearing, however, claimant's attorney expended additional time and effort seeking medical evidence to support claimant's claim. In addition to the time devoted to this case, there was the significant value of claimant's interest in obtaining acceptance of the right-sided disc herniation at L5-S1. The parties' attorneys were skilled and presented their positions in a thorough, well-reasoned manner. No frivolous issues or defenses were presented. Finally, considering the conflicting medical evidence, there was a risk that claimant's counsel's services might go uncompensated. Considering all these factors, we find that $2,700 is a reasonable fee for claimant's counsel's services at hearing concerning compensability of the right-sided disc herniation at L5-S1. The ALJ's order is modified accordingly.

Attorney Fee on Review

Claimant's attorney submitted a Statement of Services on review, requesting an assessed attorney fee of $600 for his services before the Board. The only issue on review was attorney fees and claimant's brief did not address any other issue. Claimant's attorney is not entitled to an attorney fee for services concerning the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986) ("compensation" in ORS 656.382(2) does not include attorney fees).

ORDER

The ALJ's order dated March 5, 1998 is affirmed in part and modified in part. That portion of the order that awarded a $5,119.10 assessed fee for claimant's attorney's services at hearing regarding the compensability issue is modified to reduce the fee to $2,700, payable by SAIF. The remainder of the order is affirmed.

In the Matter of the Compensation of
MURIEL E. DEXTER, Claimant
Own Motion No. 97-0409M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Employers Ins. of Wausau, Insurance Carrier

Claimant requests review of the insurer's March 27, 1998 Notice of Closure which closed her claim with an award of temporary disability compensation from October 22, 1997 through February 6, 1998. The insurer declared claimant medically stationary as of February 6, 1998. Claimant contends that she is entitled to additional benefits as she was not medically stationary when her claim was closed.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that she was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the March 27, 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 an April 10, 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 April 16, 1998. Claimant responded by letters dated May 2 and May 22, 1998, wherein she requested an extension of time to allow her to obtain additional medical documentation in support of her position. An extension of time to file her response was granted. Claimant then submitted two additional letters dated June 21 and June 24, 1998 and attached some medical documentation. No further extensions were requested and none were granted. Therefore, we will proceed with our review.

Claimant was referred to Northwest Occupational Medicine Center to participate in a diagnostic evaluation and multidisciplinary treatment for chronic complaints of pain following her October 22, 1997 low back surgery. She participated in a four week injury management program and was discharged on February 6, 1998. Dr. Lammers, the injury management program team leader, opined, in his discharge summary, that claimant was "medically stationary with regard to her industrial injury. No further diagnostic studies or curative treatments will be necessary in her case." Dr. Silver, claimant's attending physician, concurred with Dr. Lammers' report on March 24, 1998. These opinions are unrebutted.[1]

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 March 27, 1998 Notice of Closure in its entirety.

IT IS SO ORDERED.

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[1] With her multiple submissions, claimant attached copies of medical reports that date prior to her surgery and some more recent reports dated after the March 27, 1998 Notice of Closure issued. None of the reports submitted by claimant reference her medically stationary status at the time of the claim closure nor do they imply that she was not medically stationary on March 27, 1998. Claimant eloquently and in great detail listed her reasons to support her contention that she was not medically stationary when the closure was issued. She further contended that she is still not medically stationary. However, as stated above, 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 has not met her burden of proof by providing a medical opinion that would support her contention that she was not medically stationary when her claim was closed on March 27, 1998.

In the Matter of the Compensation of
JOHNNY L. HART, Claimant
WCB Case Nos. 96-08710 & 96-08709
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Employers Defense Counsel, Defense Attorneys
Thomas A. Andersen, Defense Attorney

Reviewed by Board Members Moller and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Black's order that: (1) set aside Employers Insurance of Wausau's (Wausau's) partial denial of responsibility for his current low back condition; and (2) upheld Liberty Northwest Insurance Corporation's (Liberty's) partial denial of responsibility for the same condition. On review, the issue is responsibility.

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

We begin with a brief summary of the relevant facts. Claimant sustained successive injuries to his low back, the first injury occurring in December 1987 while employed by Wausau's insured, and the second occurring in January 1994 while employed by Liberty's insured. Each of those claims was accepted for a disabling low back strain. The 1994 claim was closed by Determination Order in October 1994 with no award of permanent disability.

In May 1996, claimant sought treatment from Dr. Hacker, neurosurgeon, for low back pain that had worsened during the previous year or so, with radiation of pain into the left hip area and the left leg. (Ex. 16). Dr. Hacker suspected pseudarthrosis (failed fusion) at L5-S1 resulting from unsuccessful fusion surgeries in 1988 and 1989 following the 1987 injury. (Exs. 16, 21). His suspicion was later confirmed by CT scan and follow-up treatment was provided by Dr. Kitchel, who referred claimant to Dr. Gallo for neurosurgical evaluation. (Ex. 18). On claimant's behalf, Dr. Gallo filed claims for the current low back condition against Wausau and Liberty. Each carrier denied responsibility for the current condition, (Exs. 23, 27A), and the Department issued an order under ORS 656.307, which designated Wausau as the paying agent for benefits pending resolution of the responsibility issue, (Ex. 29).

The ALJ applied the last injury rule and the rebuttable presumption in *Industrial Indemnity Co. v. Kearns*, 70 Or App 583 (1984), to assign responsibility for claimant's current low back condition to Wausau, the first carrier. The ALJ reasoned that, although Liberty was presumptively responsible because it was the last carrier with an accepted claim involving the same body part (low back), Liberty successfully rebutted the *Kearns* presumption by proving that its accepted injury in 1994 is not a contributing factor in the current condition.

On review, claimant and Wausau challenge the ALJ's conclusion that the *Kearns* presumption was rebutted. They point to Dr. Hacker's November 4, 1996 letter which stated, in pertinent part:

> "[Claimant] may well have suffered an injury in January of 1994 resulting in lumbar strain which is a significant contributing factor to his need for additional treatment. However, if his present need for treatment revolves around pseudarthrosis and failed fusion, then his original [1987] injury and surgical treatment are the culprits here." (Ex. 25-2).

Based on our review of the quoted passage, we conclude that Dr. Hacker's opinion that the 1994 injury was a contributing factor, was contingent on whether or not claimant's current treatment involved the pseudarthrosis. That is, if the current treatment actually "revolved around" the pseudarthrosis, then it would be Dr. Hacker's opinion that the 1987 injury and resultant surgeries were the "culprits." Therefore, the dispositive question, at least with regard to understanding Dr. Hacker's causation opinion, is whether claimant's current treatment revolves around the pseudarthrosis; if we conclude it does, then we must interpret Dr. Hacker's opinion as supporting the absence of causal connection between the 1994 injury and the current condition.

Dr. Hacker clarified his opinion in the June 1997 deposition. He stated that claimant has an L5-S1 pseudarthrosis consisting of a thickened fibrous tissue between L5 and S1, which had been present since at least 1992. (Ex. 30, pp. 8-12, 24). He stated that the 1994 lifting incident with Liberty's insured probably resulted in an injury to the fibrous union, causing low back pain. (Ex. 30, pp. 19-20). He

opined that the 1994 injury was the major cause of the three or four months of disability that followed the injury. (Ex. 30, pp. 31-32). However, he also agreed with the statement that, based on the eventual resolution of pain and disability following the 1994 injury, the 1994 injury to the fibrous union has "resolved." (Ex. 30-33). He ultimately opined that the 1987 injury and resultant surgeries were the major contributing cause of the current disability and need for treatment. (Ex. 30, pp. 24-25).

Based on our review of Dr. Hacker's reports and testimony as a whole, particularly his statement that the 1994 injury had "resolved," we conclude that Dr. Hacker's opinion supports the ALJ's finding that there is no causal connection between the 1994 injury and the current condition. Dr. Hacker's opinion is supported by that of Dr. Gallo. In September 1996, based on her review of the mechanism of the 1994 lifting incident, Dr. Gallo wrote that claimant's current condition was likely due to the 1987 injury rather than the 1994 injury. (Ex. 22). While we recognize that Dr. Gallo later concurred, without comment, with Dr. Hacker's November 4, 1996 letter, (Ex. 26), to the extent that her concurrence could be interpreted as supporting a causal connection between the 1994 injury and the current condition, we discount its probative value because it is entirely unexplained.

For the forgoing reasons, we agree with the ALJ's application of the *Kearns* presumption and his conclusion that Liberty successfully rebutted the presumption by proving there is no causal connection between the 1994 injury and claimant's current condition. Accordingly, responsibility for the current condition was properly assigned to Wausau.

ORDER

The ALJ's order dated November 28, 1997, as reconsidered on February 3, 1998, is affirmed.

August 4, 1998 Cite as 50 Van Natta 1535 (1998)

In the Matter of the Compensation of
BETTY L. MARTINEZ, Claimant
WCB Case Nos. 96-01346, 96-00819 & 95-02012
ORDER ON REMAND
Malagon, Moore, et al, Claimant Attorneys
Reinisch, McKenzie, et al, Defense Attorneys
Alice M. Bartelt (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *Wal-Mart Stores, Inc. v. Martinez,* 152 Or App 152 (1998). The court has reversed a Board order that adopted and affirmed an Administrative Law Judge's (ALJ's) order that found Wal-Mart responsible for claimant's occupational disease claim for a right carpal tunnel syndrome (CTS) condition. Citing *Strametz v. Spectrum Motorwerks,* 325 Or 439 (1997), and *Roseburg Forest Products v. Long,* 325 Or 313 (1997), the court has remanded for reconsideration.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant worked for various employers as a hair stylist and as an apartment manager from 1969 until 1994. In June 1986, she injured her neck. In 1988, she had a diskectomy and fusion for a C5-6 disk herniation.

Claimant worked for SAIF's insured as a hair stylist from March 10, 1994 until May 1995. She began working for Wal-Mart in May 1995, first as a shelf-stocker, later as a sales clerk.

In October 1995, Dr. Pollard performed bilateral carpal tunnel release and excision of a left wrist ganglion cyst.

Claimant filed claims for bilateral arm conditions with Wal-Mart and SAIF. The claims were denied. Claimant requested a hearing.

The ALJ found claimant's bilateral CTS conditions compensable, based on claimant's years of repetitive hand work activities and high hand usage at work. The ALJ also determined that SAIF was responsible for the left CTS condition. The ALJ's decisions regarding the compensability of the bilateral conditions and responsibility for the left CTS condition were not challenged on appeal.

The ALJ initially assigned responsibility for claimant's right CTS condition with Wal-Mart, because claimant first sought treatment for, and was disabled by, that condition while she worked for Wal-Mart and the Wal-Mart employment could have contributed to claimant's right CTS. Finally, the ALJ determined that Wal-Mart could not avoid responsibility for claimant's right CTS condition, because it failed to prove that it was impossible for its employment to have contributed to claimant's condition. Therefore, the ALJ concluded that Wal-Mart remained responsible for claimant's right CTS condition.

On review, we adopted and affirmed the ALJ's order. Wal-Mart petitioned the court for judicial review of our decision. The court reversed our order and remanded for reconsideration in light of *Long* and *Strametz*.

Wal-Mart argues that we erred in finding it responsible for claimant's right CTS because we made inconsistent findings regarding whether it was possible for its employment to have caused claimant's particular condition. Specifically, Wal-Mart contends that our recognition of evidence that claimant's Wal-Mart work could have worsened claimant's right CTS symptoms is inconsistent with our conclusion that claimant did not have right CTS before she worked for Wal-Mart. We disagree with this reasoning. We did not *find* that claimant's Wal-Mart employment worsened her CTS symptoms, we merely acknowledged the existence of evidence to that effect. (*See* Ex. 128). Moreover, on remand, we continue to find that claimant did not have right CTS before she worked for Wal-Mart.[1] (*See* Ex. 132-8).

Wal-Mart also argues that we applied incorrect law, because the Supreme Court "added a step" to the last injurious exposure rule of assignment of responsibility in the *Long* and *Strametz* cases, and overruled portions of *Fossum v. SAIF*, 293 Or 252 (1982), and *Meyer v. SAIF*, 71 Or App 371 (1984). We disagree.

In *Long*, the Supreme Court considered aspects of the last injurious exposure rule when a claimant has a compensable occupational disease that is caused by working conditions at a single employer who has had a series of carriers. Citing to its earlier decision in *Boise Cascade Corp. v. Starbuck*, 296 Or 238 (1984), the Court held that:

> "[U]nder this court's prior precedents, once compensability is established, an employer that otherwise would be responsible under the last injurious exposure rule may avoid responsibility if it proves either: (1) that it was impossible for conditions at it workplace to have caused the disease in this particular case or (2) that the disease was caused solely by conditions at one or more previous employments." 325 Or at 313.

Shortly thereafter, in *Strametz*, the Court considered the application of the last injurious exposure rule in an initial claim context. In reversing the decision of the Court of Appeals,[2] the Court held that the last injurious exposure rule cannot impose responsibility on an employer who has proved that it could not have been the cause of a claimant's occupational disease. Citing the "either/or" test it articulated in *Long*, the Court concluded:

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[1] Wal-Mart and claimant argue that claimant's right CTS preexisted her employment with Wal-mart, relying on medical evidence of symptoms arguably compatible with right CTS before May 1995. However, we decline to infer that claimant had right CTS before it was diagnosed in 1995, in the absence of persuasive medical evidence to that effect. In this regard, we acknowledge that claimant did have right arm problems (including mention of a right CTS diagnosis) in the 1980's. (Exs. 1, 3, 9, 11-3, 27, 47-1, 55, 56). However, she had *normal* right arm nerve conduction studies in 1989 (Exs. 57, 58), she did not seek treatment for right arm or wrist symptoms for over 3 1/2 years before she began working for Wal-Mart, and her prior right arm problems were generally contemporaneously considered related to her *cervical* condition. (*See* Exs. 28, 31, 36, 39, 54-3; *see also* Ex. 41). Under these circumstances, we agree with SAIF and the ALJ that claimant's current right CTS was not the same condition she had before 1989 and, therefore, it did not preexist her Wal-Mart employment. (*See* Ex. 132-8).

[2] In *Beneficiaries of Strametz v. Spectrum Motorwerks*, 135 Or App 67, *adhered to as modified*, 138 Or App 9 (1995), the court held that under the last injurious exposure rule the employer on the risk at the time the claimant first sought treatment would be liable if the evidence established that the conditions of that employment were of the type that could have caused the claimant's occupational disease, even though that employment could not have been the actual cause of the disease.

> "Under the last injurious exposure rule, the employer that would otherwise be held responsible for a claimant's occupational disease may avoid responsibility by proving that conditions of its employment could not have caused the disease or that a previous employment was the sole cause of the disease." 325 Or at 445.

Reading these two decisions together, we have concluded that, in order for an employer that would otherwise be held responsible under the last injurious exposure rule (*i.e.* Wal-Mart, because claimant first sought treatment for his right CTS condition while working for Wal-mart) to shift responsibility to a prior employer, the employer that would otherwise be held responsible must *still* establish that it is impossible for that particular employment exposure to have caused or contributed to the claimant's condition or that the disease was caused solely by conditions that preexisted the employment at issue.[3] *See Larry W. Burke*, 49 Van Natta 1877, 1879 (1997).

Wal-Mart argues that it is not responsible for claimant's right CTS, because claimant's work for Wal-Mart did not *in fact* cause the condition. This is not the required hurdle for successful defensive use of the last injurious exposure rule. *See* n. 3, *supra.*

Accordingly, we apply the rule to assign initial or presumptive responsibility, then we apply it again to determine whether responsibility shifts from the initial assignee: 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[4] for the purpose of assigning initial responsibility for the claim (unless the subsequent employment contributes independently to the cause or worsening of the condition). *Timm v. Maley*, 125 Or App 396, 401 (1993).

On this record, we find that claimant first sought treatment for symptoms of right CTS during her Wal-Mart employment. *See* note 1, *supra.* (*See* Exs. 108, 114). Consequently, presumptive responsibility is assigned with Wal-Mart under LIER.

There is some evidence that claimant's work for Wal-Mart would not be expected to cause or worsen her right CTS. (*See* Ex. 132-10). However, there is no evidence that it was *impossible* for claimant's work for Wal-Mart to have caused her right CTS or that a prior employment was the *sole* cause of that condition. Consequently, Wal-Mart may not avoid responsibility for claimant's right CTS condition on this record. *See FMC Corporation v. Mutual Ins. Co.*, 70 Or App 370 (1984).

Accordingly, on reconsideration, as modified and supplemented herein, we republish our April 11, 1997 Order on Review that affirmed the ALJ's November 8, 1996 order.

IT IS SO ORDERED.

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[3] Evidence that the employment conditions probably did not cause or contribute to the claimant's condition is not enough. *See Burke*, 49 Van Natta at 1879. The carrier that would otherwise be held responsible must show that an earlier employment was the *sole* cause of the claimant's disability or that it was *impossible* for the later employment to have contributed to the claimant's condition. *Long*, 325 Or at 313.

[4] 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). We do not find *evidence* to that effect in this case. *See* note 1, *supra.*

In the Matter of the Compensation of
MARLO D. THOMAS, Claimant
WCB Case No. 97-09538
ORDER ON REVIEW
Bettis & Penz, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that awarded a $5,038.70 attorney fee under ORS 656.386(1). On review, the issue is attorney fees. We modify.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact."[1]

CONCLUSIONS OF LAW AND OPINION

The ALJ awarded a $5,038.70 assessed attorney fee under ORS 656.386(1), considering the factors set forth in OAR 438-015-0010(4), particularly the time and effort devoted to the case, the value and nature of the results obtained, and the risk that claimant's attorney may go uncompensated. He applied "a factor of 2.5 as a multiplier" and a factor for travel costs. (Opinion and Order, p. 4).

The employer argues that the attorney fee is excessive, considering the factors set forth in the rule. In addition, the employer contends that the ALJ erred in reimbursing claimant for his attorney's travel expenses and in applying a "risk related" multiplier. Claimant contends that the fee was reasonable. After considering the parties' respective positions, we modify the ALJ's attorney fee award.

"Costs," which are monies expended by an attorney for things and services reasonably necessary to pursue a matter on behalf of a party, are *not* included in amounts that the Board can authorize an opposing party to pay. OAR 438-015-0005(4), (6); *Marilyn M. Keener*, 49 Van Natta 110, 114 (1997)[2]; *Tom Goodpastor*, 46 Van Natta 936 (1994). Accordingly, we only consider time expended in providing legal services (as reflected by the record[3]), which do not include claimant's attorney's travel costs.

We have previously declined to apply a contingency factor or "multiplier" in a strict mathematical sense. *See, e.g., Lois J. Schoch*, 49 Van Natta 788, 790, n.1 (1997); *Lois J. Schoch*, 49 Van Natta 170, 173, n.1 (1997). We decline to do so in this case as well. Instead, in conjunction with the other relevant factors discussed below, the risk that claimant's counsel might go uncompensated for services rendered in this proceeding is considered in our ultimate determination of a reasonable attorney fee.

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[1] The employer contends that the ALJ erred in taking administrative notice of the Director's records regarding compensability hearings' results (which the ALJ relied on in evaluating the risk that claimant's counsel might go uncompensated). (Opinion and Order, pp. 2, 4). We need not address this contention because we neither adopt nor rely on the ALJ's "Notice Facts."

[2] In *Keener*, we noted that reimbursement for "costs" is not allowed within a fee payable to an attorney under the above cited rule. However, we also stated:

> "[A] attorney's preparation for, travel to and attendance at depositions and correspondence with attending physicians represent hours of legal services rendered on behalf of a party; those hours are considered in awarding a reasonable attorney fee." 49 Van Natta at 113.

The distinction is this: *Time* spent providing legal services is considered in awarding an attorney fee, but travel expenses (*e.g.*, mileage) is not reimbursable *via* an assessed fee. *See Rollin R. Bradford*, 50 Van Natta 33 (1998).

[3] We note that claimant's attorney did not submit a statement of services.

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

Our review of the record reveals the following information. The relevant issue in dispute was the compensability of claimant's low back condition. Approximately 12 exhibits were received into evidence. The hearing lasted about 3 1/2 hours, with a transcript of approximately 130 pages. Claimant and three witnesses testified on claimant's behalf. One witness testified for the employer. No expert witnesses testified and there were no depositions. The case involved issues of average medical and legal complexity, as compared to compensability issues generally presented to this forum for resolution. The claim's value and the benefits secured are less substantial than those routinely evaluated.[4] The parties' respective counsels presented their positions in a thorough manner. No frivolous issues or defenses were presented. Finally, there was a risk that claimant's counsel's efforts might have gone uncompensated, considering the employer's vigorous defense.

Based upon our application of each of the previously enumerated factors and considering the parties' arguments, we conclude that $3,000 is a reasonable and appropriate attorney fee for services at the hearings level in this case. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the record), the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Claimant's attorney is not entitled to an attorney fee for services devoted to the attorney fee issue on review. *See Saxton v. SAIF*, 80 Or App 631 (1986); *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated March 16, 1998 is modified in part and affirmed in part. That portion of the order that awarded a $5,038.70 assessed attorney fee is modified. In lieu of the ALJ's attorney fee award, claimant is awarded a $3,000 attorney fee, payable by the self-insured employer. The remainder of the order is affirmed.

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[4] In reaching this conclusion, we note that claimant lost very little work time because of her injury and she apparently sought treatment only three times before her symptoms subsided.

August 4, 1998 Cite as 50 Van Natta 1539 (1998)

In the Matter of the Compensation of
RICHARD G. MIRES, Claimant
WCB Case No. 97-03969
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Saif Legal Department, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

John Zigler, doing business as John Zigler Automotive Repair, the alleged noncomplying employer (NCE), requests review of Administrative Law Judge (ALJ) Howell's order that: (1) found that claimant was a subject worker; and (2) set aside the SAIF Corporation's denial of claimant's face and left wrist injury claim. On review, the issue is subjectivity. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

We adopt the ALJ's "Conclusions," with the exception of the ALJ's discussion of the evidentiary presumption (and footnotes 8 and 9) on page 7 of the Opinion and Order. We substitute the following analysis.

We conclude that, whether or not there is an inference from the absence of the employer's business records, the preponderance of the evidence supports a conclusion that claimant received more than $500 in earnings in a 30-day period.

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

ORDER

The ALJ's order dated January 30, 1998 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, to be paid by the SAIF Corporation on behalf of the noncomplying employer.

In the Matter of the Compensation of
BRAD WINSLOW, Claimant
WCB Case No. C8-01448
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Daniel E. Hitchcock, Claimant Attorney
VavRosky, et al, Defense Attorney

Reviewed by Board Member Hall and Moller.

On June 25, 1998, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We disapprove the proposed disposition.

On June 30, 1998, the Board wrote the parties noting that the CDA failed to provide the order paragraph in prominent or bold-face type, lines for the date of approval and signatures of the Board members at the conclusion of the agreement. *See* OAR 438-009-0020(3). Consequently, the Board requested that the parties correct this deficiency.

Pursuant to OAR 438-009-0020(4)(b), the Board may disapprove the agreement as unreasonable as a matter of law if the deficiency noted in the Board's addendum letter is not corrected within 21 days. To date, the parties have not submitted the addendum as requested on June 30, 1998. Under the circumstances, we disapprove the proposed disposition as unreasonable as a matter of law. *See* OAR 438-009-0020(4)(b).[1]

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of any benefits that were stayed by submission of the proposed disposition. *See* OAR 436-060-0150(4)(i) and (6)(e).

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[1] Although we received a "faxed" copy of a request from claimant for disapproval of the CDA within the 30 day period specified by ORS 656.236(1)(a)(C), a facsimile transmission does not constitute "filing" under the Board's rules. *See* OAR 438-005-0046(1)(d). Thus, because a request for disapproval has not been "filed" with the Board prior to the expiration of the 30 day period, we are not authorized to disapprove the CDA on that basis. *See* ORS 656.236(1)(a)(C).

Should the parties disagree with our interpretation of the CDA, or wish to comply with our prior request to supplement the agreement, 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
MICHAEL D. CESSNUN, Claimant
WCB Case No. 97-09918
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

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

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for the ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has worked for SAIF's insured since 1989 as a log truck driver. His work requires frequent and forceful overhead use of his arms in order to throw and tighten chain and cable binders over the logs on the truck. Claimant testified that he began having left shoulder problems about two years before the March 1998 hearing. (Tr. 4). He first sought medical treatment in April 1997. (Ex. 1). He was later diagnosed with a large rotator cuff tear in the left shoulder. (Exs. 5, 6). On November 11, 1997, Dr. Boughal surgically repaired the rotator cuff tear. (Ex. 9A). SAIF denied claimant's shoulder condition on the ground that his "injury" was not the major cause of his need for treatment and disability. (Ex. 12). Claimant requested a hearing.

The ALJ relied on Dr. Boughal's opinion and concluded that claimant's work activities were the major contributing cause of the combined condition, as well as the major contributing cause of a pathological worsening of his preexisting disease.

SAIF argues the ALJ erred in concluding that Dr. Boughal's opinions satisfied claimant's burden of establishing his left rotator cuff tear condition. We disagree.

To establish an occupational disease, claimant must prove that his employment conditions were the major contributing cause of his left shoulder condition. ORS 656.802(2)(a). If the occupational disease claim is based on the worsening of a preexisting disease or condition, claimant must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease. ORS 656.802(2)(b).

We first determine whether claimant has a preexisting disease or condition. A "preexisting condition" is defined as "any injury, disease, congenital abnormality, personality disorder or similar condition that contributes or predisposes a worker to disability or need for treatment and that precedes the onset of an initial claim for an * * * occupational disease[.]" ORS 656.005(24). Here, claimant contends that his left shoulder rotator cuff tear was caused in major part by his employment activities at SAIF's insured. This is an initial occupational disease claim for that condition. Therefore, the onset of this occupational disease claim is 1989, when claimant began working for SAIF's insured. *See The New Portland Meadows v. Dieringer*, 153 Or App 383, 387-88 (1998); *Douglas G. Andrews*, 50 Van Natta 919 (1998). Thus, we examine whether claimant had any left shoulder disease or condition that preexisted the beginning of his employment in 1989.

At the time of claimant's left shoulder surgery, Dr. Boughal found that he had an anterior acromial spur in the left shoulder. (Exs. 11, 14-1). He reported that the anterior acromial spur predisposed claimant to developing the left rotator cuff tear and he felt that the acromial spur should be considered a preexisting condition. (Ex. 14-1). Although Dr. Boughal characterized the spur as "preexisting," he did not indicate whether or not the spur preexisted the beginning of claimant's employment in 1989. Moreover, there are no other medical reports that establish that claimant's acromial spur preexisted his 1989 employment. Therefore, we are not persuaded that claimant's acromial spur preexisted the initial onset of this claim. Because claimant's occupational disease claim is not based on the worsening or combining of a preexisting disease or condition, ORS 656.802(2)(b) does not apply.

Under ORS 656.802(2)(a), claimant must prove that his work activities for SAIF's insured were the major contributing cause of his left rotator cuff tear. We generally defer to the conclusions of a treating physician, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810, 814 (1983). Here, we find no persuasive reason not to rely on the opinion of Dr. Boughal.

On November 19, 1997, Dr. Boughal indicated that claimant's work exposure and the anterior acromial spur had contributed to his need for treatment. (Ex. 11-1). At that time, he could not determine the major contributing cause of claimant's left rotator cuff tear. (*Id.*) Claimant's attorney subsequently provided Dr. Boughal with detailed information about claimant's work activities as a log truck driver. (Ex. 13). Claimant's attorney explained that the work included a good deal of overhead work related to the loading process. (Ex. 13-1). Among other things, Dr. Boughal was informed that, after the truck trailer is loaded with logs, the driver has to throw a series of chain-and-cable binders over the stacked logs. (*Id.*) The binders must be fastened down using a "swede" pry bar, which required considerable force. (*Id.*) At hearing, claimant reviewed the information about his work activities provided to Dr. Boughal and testified that it was an accurate description. (Tr. 8).

After receiving additional information about claimant's job duties, Dr. Boughal opined that vigorous overhead activities, by themselves, were unlikely to result in a rotator cuff tear. (Ex. 14-1). However, he said that those activities could predispose a patient with a shoulder injury or an anterior acromial spur to "develop a degenerative rotator cuff tear or worsen a tear which had already been present." (*Id.*) Dr. Boughal concluded that claimant's work activities resulted in a degenerative tear of the left rotator cuff. (Ex. 14-2). He noted that claimant's occasional off-work activities of golf, hunting and camping would be unlikely to result in a significant tear of the rotator cuff in the presence of a subacromial spur. (*Id.*) Dr. Boughal felt that claimant's work activities, which required repetitive throwing and overhead work, were "a major contributing cause" of his need for treatment in 1997. (*Id.*) In a later report, he clarified that claimant's work activities were "the major contributing cause" of his need for treatment and resulting disability in 1997. (Ex. 15).

Based on Dr. Boughal's opinion, we agree with the ALJ that claimant's work activities were the major contributing cause of his left rotator cuff tear. There is no contrary medical evidence. We conclude that claimant has established compensability of his left rotator cuff tear pursuant to ORS 656.802(2)(a).

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

ORDER

The ALJ's order dated March 31, 1998 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by the SAIF Corporation.

In the Matter of the Compensation of
LINDA K. FISTER, Claimant
WCB Case No. 95-05569
SECOND ORDER ON REMAND
Max Rae, Claimant Attorney
David L. Runner (Saif), Defense Attorney

Claimant requests reconsideration of our July 24, 1998 Order on Remand that increased her unscheduled permanent disability award for a back injury from 31 percent (99.2 degrees) to 45 percent (144 degrees). While agreeing with the amount of unscheduled permanent disability awarded by our order, claimant disagrees with footnote 6. In footnote 6, we listed several reasons why we found distinguishable *Consuela Trujillo*, 49 Van Natta 1555 (1997), a case relied on by the SAIF Corporation in its supplemental brief. Claimant argues that our decision in *Fister* compels that we disavow our prior decision in *Trujillo*, rather than simply distinguishing that case on the facts.

We withdraw our order for reconsideration. After conducting our reconsideration and reviewing claimant's arguments, we continue to hold that *Trujillo* is distinguishable on its facts. However, to clarify our reasoning, we replace footnote 6 in our prior order with the following.

In *Trujillo*, the evidence was in dispute regarding whether the claimant's at-injury job required "medium" strength or "heavy" strength. The claimant argued that his at-injury job should fall under Lumber Handler, DOT 922.687-070, which had a strength category of heavy. Because the description of Lumber Handler pertained essentially to manually stacking lumber, a duty that the claimant's at-injury job did not entail, we rejected the claimant's argument that "Lumber Handler" accurately described his at-injury job. We found more persuasive a job analysis of the at-injury job that provided that workers "[r]arely lift maximum of 40 pounds * * *; continually lift barricade boards weighing up to 5 pounds and occasionally assembled barricades weighing up to 15 pounds." *Trujillo*, 49 Van Natta 1556. Thus, relying on that job analysis, we found that the claimant's BFC was medium. While we discussed the claimant's failure to establish the required frequency of lifting, the primary focus of our decision was on whether the claimant's at-injury job involved lifting the amount of weight required to meet a BFC of "heavy." Finding the job analysis, which established that claimant rarely lifted a maximum of 40 pounds, most persuasive, we found that the at-injury job was "medium."

Here, in contrast, we have found that claimant lifted patients weighing from 100 to 150 pounds. Thus, contrary to the claimant in *Trujillo*, claimant has established that her at-injury job involved lifting the amount of weight required to meet a BFC of "heavy." The question, as posed by SAIF and addressed in our prior order, was whether claimant had established the required frequency of lifting. Based on our analysis of the rules and the DOT, we found that claimant had met her burden of proof. In reaching this conclusion, we analyzed the definitions of the strength classifications as defined in the DOT and the rules. In contrast, *Trujillo* did not analyze those definitions.

Because of the different factual records and the different focus involved in *Trujillo* and the present case, we do not find it appropriate or necessary to disavow *Trujillo*.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our July 24, 1998 order effective this date. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ERIC S. GUNN, Claimant
WCB Case No. 97-00901
ORDER ON RECONSIDERATION
Black, Chapman, et al, Claimant Attorneys
Charles L. Lisle, Defense Attorney

On June 12, 1998, we abated our May 15, 1998 Order on Review to consider the self-insured employer's request for reconsideration. In our May 15, 1998 order, we upheld the self-insured employer's partial denial of claimant's injury claim for left shoulder rotator cuff tendinitis and subacromial bursitis, reduced an Administrative Law Judge's (ALJ's) attorney fee award from $3,600 to $1,800, and affirmed the ALJ's award of interim compensation between November 12, 1996 and February 6, 1997. The employer seeks reconsideration of our interim compensation award, contending that claimant is not entitled to these benefits because he voluntarily left modified work with the employer for reasons unrelated to his compensable injury. Having received claimant's response, we proceed with our reconsideration.

Interim compensation and other temporary disability benefits are intended to provide replacement for wages lost due to a compensable injury. *Cutright v. Weyerhaeuser Co.*, 299 Or 290 (1985); *Roseburg Forest Products v. Wilson*, 110 Or App 72, 75 (1991). Where a worker leaves work for reasons other than an inability to work as a result of a compensable injury, the worker is not entitled to temporary disability benefits. *Noffsinger v. Yoncalla Timber Products*, 88 Or App 118, 121 (1987); *Bruce Conklin*, 44 Van Natta 134 (1992). *Compare Peggy J. Baker*, 49 Van Natta 40 (1997) (claimant entitled to temporary disability when terminated, at least in part, because of inability to perform regular work due to compensable injury).

Here, claimant went on lay-off status on November 13, 1996. At that time, he was restricted to light duty work as a result of his compensable injury. The employer contends that claimant voluntarily went on lay-off status for reasons unrelated to his injury. In support of that contention, the employer relies on the testimony of Mary Ann Gerst, who works in the employer's occupational health department. Ms. Gerst gave the following testimony regarding a conversation she had with claimant after he went on lay-off status:

> "[O]ne day he came into our office, and I asked him where he had been -- you know, what was going on. And he said that he -- he was working with -- you know, he -- you know, he had -- he had laid himself off, that he was working with the employment center to get a new -- another job[.] I said, '[y]ou know, that's, you know, a bit odd, what happened.' And he -- he -- my recollection of what he told me was that he was not -- was having problems getting along with people that he worked with, and he didn't feel that they were very intelligent, and that he wanted to work in another department."

We evaluate Ms. Gerst's testimony in the context of the record as a whole. While claimant did return to light duty work for the employer the day after the compensable injury, there is no evidence that further light duty work was available after that date. To the contrary, Dr. Naugle's November 15, 1996 chart note states that claimant was waiting for a department change and was not currently working for the employer because there was no light duty in his current department. Whereas Dr. Naugle's chart note was prepared shortly after claimant went on lay-off status, Ms. Gerst's testimony is less reliable because it reflects her recollection of a conversation that occurred more than a year before the hearing. Furthermore, Ms. Gerst acknowledged that she really did not know what claimant meant by his remark that he had laid himself off. Moreover, because the context and timing of claimant's alleged remark is unclear, we are not persuaded that he was explaining why he initially went on lay-off status. Claimant could have been discussing the reason he wished to work in a different department once he was released to return to regular work.

In summary, after reconsidering the record, we continue to find that further, suitable light duty work was not available to claimant when he commenced lay-off status on November 13, 1996.[1]

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[1] Given this finding, the employer's obligation to pay interim compensation is not dependent on the applicability of ORS 656.325(5). Thus, we need not address the employer's argument that this provision has no application in the present case.

Finally, claimant's attorney is entitled to an assessed fee for services on review and reconsideration concerning the interim compensation 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 and reconsideration is $1,200, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record, claimant's respondent's brief, and claimant's response to the employer's motion for reconsideration), the complexity of the issue, and the value of the interest involved.

Accordingly, as supplemented and modified herein, we republish our May 15, 1998 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

August 5, 1998 Cite as 50 Van Natta 1545 (1998)

In the Matter of the Compensation of
STEFAN SWIERCZEK, Claimant
WCB Case No. C8-01705
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Steven Schoenfeld, Claimant Attorney
Michael G. Fetrow (Saif), Defense Attorney

Reviewed by Board Member Hall and Moller.

On July 27, 1998, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for his compensable injury. We approve the proposed disposition.

The first page of the proposed CDA provides that the total consideration due claimant is $4,000 and the total due claimant's attorney is *$1,000*, which equals a total consideration of $5,000. However, the body of the CDA, (page 4, line 2), provides a total due claimant's attorney as "*$1,00.*" (emphasis added). The reference on page four of the document to an attorney fee of "$1,00" appears to be a typographical error. Accordingly, we interpret the agreement as providing for a total consideration of $5,000, minus a $1,000 attorney fee.

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. See ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved. An attorney fee of $1,000, payable to claimant's counsel, is also approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
MINH Q. HAN, Claimant
WCB Case No. 97-00584
ORDER ON REVIEW
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant, *pro se*,[1] requests review of Administrative Law Judge (ALJ) Herman's order that upheld the SAIF Corporation's "de facto" denial of claimant's injury claim for a post-traumatic inner ear concussion syndrome condition. With his brief, claimant submits copies of several documents. We treat such a submission as a motion to remand. On review, the issues are remand and compensability.

We deny the motion for remand and, on the merits, adopt and affirm the ALJ's order with the following correction. The last sentence of the eighth paragraph of the ALJ's findings of fact should read: "A December 24, 1996 Order on Review reversed ALJ Poland's May 8, 1996 decision in part, reinstating the denial of claimant's aggravation claim." (Exs. 14, 22).

Claimant submits copies of several documents with his brief. We treat this submission as a motion for remand to the ALJ for further development of the hearings record. *Judy A. Britton*, 37 Van Natta 1262 (1985). Our review is limited to the record developed at hearing. ORS 656.295(5). However, we may remand to the ALJ should we find that the hearings record has been "improperly, incompletely or otherwise insufficiently developed." *Id.* Remand is appropriate upon a showing of good cause or other compelling basis. *Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988); *Bernard L. Osborn*, 37 Van Natta 1054, 1055 (1985), *aff'd mem*, 80 Or App 152 (1986).

The evidence claimant submits consists of copies of: (1) 1993 and 1994 chart notes from Dr. Tse, claimant's treating chiropractor; (2) a letter from Dr. O'Neill, M.D., dated December 31, 1996; (3) a letter from Dr. Wilson, M.D., dated February 3, 1997; (4) a telephone message from Ms. Landstrom, RN, dated September 20, 1994; (5) a memo from Mr. Russell, a co-worker of claimant, dated February 4, 1997; (6) a light duty job description from Ms. Jepsen, the employer's Human Resource Manager, dated March 15, 1996; (7) ticket stubs from an OMSI exhibit dated April 24, 1994; and (8) various handwritten notes from claimant. With the exception of the handwritten notes from claimant, all of these materials were dated well before the February 26, 1998 hearing. Therefore, we find that these materials were obtainable with due diligence at the time of hearing. In addition, although it is not clear when claimant's handwritten notes were authored, because the source is claimant himself, any information presented in those notes was also obtainable with due diligence at the time of hearing. In this regard, we note that claimant testified at hearing and, thus, had the opportunity to present this information at hearing.

Moreover, these additional materials are not reasonably likely to effect the outcome of the case. As the ALJ found, the issue of causation of the claimed condition of a post-traumatic inner ear concussion syndrome presents a complex medical issue, the resolution of which requires expert medical evidence. *Uris v. Compensation Department*, 247 Or 420 (1967); *Kassahn v. Publishers Paper Co.*, 76 Or App 105, 109 (1985). Although claimant submits additional medical evidence in the form of several chart notes and medical reports, none of this evidence addresses the cause of the claimed inner ear condition. Instead, it simply lists various symptoms and treatment modalities. Thus, because the additional evidence does not address the causation issue at hand, it is not reasonably likely to effect the outcome of the case.

Accordingly, for all of these reasons, we deny claimant's motion for remand.

ORDER

The ALJ's order dated April 15, 1998 is affirmed.

[1] Although represented at hearing, claimant is unrepresented on review.

In the Matter of the Compensation of
DEBORAH D. HOUSTON, Claimant
WCB Case No. 97-06182
ORDER ON REVIEW
Bennett, Hartman, 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) Hazelett's order that upheld the SAIF Corporation's denial of her occupational disease claim for a hepatitis C condition. On review, the issue is compensability.

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

On November 6, 1995, claimant began working for the employer as a lab technician. This was claimant's first job after completing her training as a lab technician. On October 7, 1996, claimant sustained a needle stick with a dirty needle. The needle source was negative for hepatitis B, C, and HIV. (Ex. 1). As a result of this needle stick, claimant underwent blood tests that revealed hepatitis C antibodies, which confirmed the diagnosis of hepatitis C. Because it takes at least several months for the body to develop hepatitis C antibodies after being exposed to the virus, all the physicians agreed that the October 7, 1996 needle stick could not be the cause of claimant's hepatitis C infection. (Exs. 4, 11-21-23, -28).

Claimant had no other history of any needle stick or direct exposure to blood. (Ex. 11-28). Thus, the question presented is whether claimant proved that her hepatitis C was caused by some unknown exposure at work through her latex gloves.

Claimant urges us to apply the principle stated in *Fenn v. Charles T. Parker Construction Co.*, 6 Or App 412, 416 (1971) (*citing In Livingston v. State Ind. Acc. Comm.*, 200 Or 468, 472-73 (1954)), that provisions of the Workers' Compensation Act should be interpreted liberally in favor of the worker and all reasonable doubts should be resolved in favor of the worker. However, as SAIF points out, *Fenn* was decided prior to the adoption of ORS 656.012(3),[1] which requires that the provisions of the Act be interpreted in an impartial and balanced manner.

Claimant contends that the deposition of Dr. Coodley, claimant's attending physician, establishes compensability of her claim.[2] Claimant cites *Bronco Cleaners v. Velazquez*, 141 Or App 295 (1996), in support of this contention. However, we find *Bronco Cleaners* distinguishable.

In *Bronco Cleaners*, the court held that ORS 656.266[3] "plainly requires that there be some affirmative evidence that the condition is caused by the claimant's work exposure." 141 Or App 298.

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[1] ORS 656.012(3) Provides:

"In Recognition That The Goals And Objectives Of This Workers' Compensation Law Are Intended To Benefit All Citizens, It Is Declared That The Provisions Of This Law Shall Be Interpreted In An Impartial And Balanced Manner."

[2] We note that Dr. Coodley initially agreed that, given the fact that many hepatitis C carriers have no identified exposure risks and claimant denies any occupational exposures to blood prior to her October 7, 1996 needle stick, though it may be theoretically possible, it is not medically probable that claimant's hepatitis C condition is the result of an unidentified exposure to an unidentified individual At work on an unspecified date between November 6, 1995 (the date claimant began working for the employer) and October 7, 1996. (Ex. 8). In her deposition, Dr. Coodley stated she changed her opinion. (Ex. 11-37). Because we find Dr. Coodley's opinion as a whole does not meet claimant's burden of proof, we need not determine whether Dr. Coodley persuasively explained her change of opinion. *See Kelso v. City of Salem*, 87 Or App 630 (1987) (unexplained change of opinion renders physician's opinion unpersuasive).

[3] ORS 656.266 provides:

"The burden of proving that an injury or occupational disease is compensable and of proving the nature and extent of any disability resulting therefrom is upon the worker. The worker cannot carry the burden of proving that an injury or occupational disease is compensable merely by disproving other possible explanations of how the injury or disease occurred."

There, the court found that nothing in ORS 656.266 precluded the Board from relying on a physician's observations that a claimant's rash appeared after the claimant had been working at a dry cleaning establishment where she was exposed to chemicals and steam and subsided when she was away from work. The court explained that, among other things, ORS 656.266 "provides that a claimant may not solely rely on the deductive reasoning that, because the condition did not occur until after the exposure to the work environment and cannot be proven to have been caused by another causative agent, it must have been caused by the work environment." Id. at 299; *Tamara D. Hergert*, 45 Van Natta 1707 (1993), *aff'd mem* 130 Or App 678 (1994).

The circumstances in *Bronco Cleaners*, *i.e.*, the disappearance and reappearance of symptoms depending on whether the claimant was at work, are not present in the current case. Instead, the only evidence that might support claimant's claim relies on the type of deductive reasoning that the court has held is forbidden by ORS 656.266.

Dr. Coodley, claimant's attending physician, acknowledged that: (1) claimant had no known direct exposure to blood at work outside of the October 7, 1996 needle stick which all the physicians agreed could not be the cause of claimant's hepatitis C infection; (2) hepatitis C is frequently not diagnosed until it has been present for months or years; (3) up to 40 percent of persons testing positive for hepatitis C do not know the source of the infection; and (4) she did not know that claimant was not infected during her schooling as a lab technician, but it seemed statistically more likely that claimant's exposure occurred at work, since claimant worked longer for the employer. (Ex. 11-9-10, 11-24, 11-25 11-28). However, based on her reasoning that claimant was at a higher risk for hepatitis C due to her work as a lab technician dealing with a high risk population and her opinion that viruses are known to travel through latex gloves, Dr. Coodley variously opined that claimant's work "might reasonably have been expected" to cause the hepatitis C infection, work was a "likely" cause, and it was "reasonably medically probable" that claimant's hepatitis C infection was caused by her work. (Ex. 11-17, -20, -22, -30). This is the type of deductive reasoning that is prohibited by ORS 656.266. For this reason, in addition to those presented by the ALJ, we find Dr. Coodley's opinion unpersuasive. Therefore, we agree with the ALJ that claimant failed to prove a compensable occupational disease claim.

ORDER

The ALJ's order dated April 9, 1998 is affirmed.

In the Matter of the Compensation of
MICHAEL L. INMAN, Claimant
WCB Case No. 97-02513
ORDER ON REVIEW
Rasmussen & Tyler, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that upheld the insurer's "backup" denial of his accepted overuse syndrome in the left wrist and its denial of Preiser's disease. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following changes and supplementation. In the second paragraph on page 2, we change the date in the first sentence to "November 1996." In the fourth paragraph of the "Discussion of Findings" on page 3, we change the citation to "(Ex. 28)." In the first paragraph on page 4, we change the citation in the last sentence to "(Exs. 24-9, 24-15, 24-21 and 29-4)."

On review, claimant argues that the ALJ erred by concluding that the insurer's denial was a not a "backup" denial. We need not address claimant's argument because, even if we assume, without deciding, that the insurer issued a "backup" denial, we find that the insurer has sustained its burden on proof and we uphold the denial.

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

Here, we adopt and affirm the ALJ's reasoning and conclusion that the insurer has met its burden of proving that the overuse syndrome of the left wrist is not compensable. We also adopt and affirm the ALJ's reasoning and conclusion that claimant's employment activities were not the major contributing cause of Preiser's disease or a pathological worsening of that condition.

ORDER

The ALJ's order dated February 26, 1998 is affirmed.

In the Matter of the Compensation of
KENNETH R. JOHNSON, Claimant
WCB Case Nos. 97-05488 & 97-04735
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Michael O. Whitty (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Liberty Northwest Insurance Corporation requests review of Administrative Law Judge (ALJ) Mongrain's order that: (1) set aside its responsibility denial of claimant's claim for his current L5 condition; and (2) upheld the SAIF Corporation's denial of claimant's claim for the same condition. Claimant cross-requests review, seeking an increased fee for his counsel's services at hearing, in addition to a fee for services on review. On review, the issues are responsibility and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Responsibility

We adopt and affirm the ALJ's order with respect to the issue of responsibility.

Attorney fees/hearings level

On review, claimant seeks an increased fee beyond the $1,000 attorney fee awarded at hearing by the ALJ pursuant to ORS 656.308(2)(d). Claimant argues that, because this case involved a "307" proceeding, the statutory limitations set forth in ORS 656.308(2)(d) do not apply. Although claimant's attorney has not submitted a statement of services, claimant requests a fee of $4,500.

We agree with claimant that ORS 656.308(2)(d) is not applicable. *See Dean Warren Plumbing v. Brenner*, 150 Or App 422 (1997) (Limitations of ORS 656.308(2)(d) are not applicable in a "307" proceeding); *Dan J. Anderson*, 47 Van Natta 1929). Accordingly, we address claimant's request for an increased attorney fee. *See Russell L. Martin*, 50 Van Natta 313 (1998).

Turning to the factors under OAR 438-015-0010(4), our review of the record reveals the following. We note that claimant's counsel did not submit a statement of services. Nevertheless, claimant's counsel estimates that approximately 17 hours was spent representing claimant. The insurer has not opposed claimant's request for an increased fee.

We further find that the hearing in this matter lasted approximately one hour (transcript of 45 pages) and one deposition (41 pages) was taken. Additionally, we conclude that the medical evidence in this case was of above average complexity when compared to claims normally presented to this forum for resolution. Finally, the record included 83 exhibits.

With respect to the value of the interest involved and the benefit secured, we find that, although this was a responsibility case, claimant's SAIF claim was in Own Motion status. Consequently, because claimant was required to establish a "new injury" against Liberty in order to secure additional benefits, vocational assistance and new aggravation rights, the interest involved and benefit secured was significant.

Finally, we note that all attorneys involved in this matter are skilled litigators with substantial experience in workers' compensation law. No frivolous issues or defenses were raised. However, due to the nature of the proceeding, we find it unlikely that claimant's counsel would go uncompensated for her services.[1]

Based on our consideration of the factors in OAR 438-015-0010(4), particularly the aforementioned factors of complexity, value, and benefit, we conclude that $4,500 is a reasonable fee for claimant's counsel's services at hearing. We modify the ALJ's order accordingly.

Attorney fee/Board level

Claimant's attorney is also entitled to an assessed fee for services on review.[2] ORS 656.382(2); *Gary L. Brenner*, 48 Van Natta 361 (1996). After considering the factors set forth in OAR 438-015-0010(4) and applying them in this case, we find that a reasonable fee for claimant's attorney's services on review 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. We further note that claimant is not entitled to an attorney fee on review for services devoted to the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated April 30, 1998 is modified in part and affirmed in part. The ALJ's attorney fee award is modified. In lieu of the ALJ's award, claimant's counsel is awarded an assessed attorney fee of $4,500, for services at hearing, payable by Liberty Northwest Insurance Corporation. 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, to be paid by Liberty.

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[1] There has been no contention by Liberty that claimant's counsel did not "actively and meaningfully" participate in the responsibility proceedings. *See* ORS 656.307(5); *Darrel W. Vinson*, 47 Van Natta 356 (1995).

[2] Claimant's compensation was at risk for a reduction due to the fact that the SAIF claim was in Own Motion status. It follows that, had we reversed the ALJ's responsibility finding and found SAIF responsible, claimant's benefits would have been limited.

In the Matter of the Compensation of
DAVID R. LEGORE, Claimant
WCB Case No. 97-09760
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) Michael Johnson's order that set aside its denial of claimant's aggravation claim for a low back condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the first paragraph of the findings of fact, we change the date in the second sentence to "April 20, 1995." In the first full paragraph on page 2, we change the first sentence to read: "Dr. Mitchell referred claimant to Dr. Miller, neurosurgeon." In the seventh full paragraph on page 3, we change the date in the first sentence to "February 19, 1998."

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his low back on April 20, 1995. The insurer accepted a lumbosacral strain/sprain. (Ex. 5). Claimant was later diagnosed with a herniated disc at L5-S1. On May 2, 1996, Dr. Miller performed a lumbar laminectomy. (Ex. 16). The insurer amended the acceptance to include an L5-S1 herniated disc on the left. (Ex. 17). A Determination Order dated October 1, 1996 awarded claimant 30 percent unscheduled permanent disability for his low back condition and 4 percent scheduled permanent disability for the loss of use or function of his left leg. (Ex. 22).

Claimant testified that his low back and left leg condition worsened between June 1996 and mid-August 1997. (Tr. 9-10). He began having problems performing his work and he had problems with balance and bending. (Tr. 10). He sought treatment from Dr. James on August 13, 1997. (Ex. 24). On the following day, Dr. James signed a notice of claim of aggravation. (Ex. 25). On November 13, 1997, the insurer denied the claim on the basis that claimant's condition had not worsened since the claim was closed. (Ex. 37). Claimant requested a hearing.

The ALJ relied on the opinions of Drs. Mitchell and Grewe and concluded that claimant had sustained a pathological worsening of his accepted condition.

The insurer argues that claimant did not suffer a pathological worsening of his accepted disc condition and it asserts that any increase in symptoms represented a waxing and waning of symptoms contemplated by the previous permanent disability award.

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, 305 (1996), *rev allowed* 325 Or 367 (1997), the court determined that the term "actual worsening" was not intended to include a symptomatic worsening. Rather, the court concluded that, 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.* The court held that proof of a pathological worsening was required. *Id.*

On review, claimant relies on the ALJ's order, which found that the opinions of Dr. Mitchell and Dr. Grewe established a pathological worsening. For the following reasons, we are not persuaded by their opinions.

Dr. Mitchell treated claimant in June and July 1995 and on November 14, 1997. (Ex. 38). On February 23, 1998, Dr. Mitchell said that he had last seen claimant in November 1997 and claimant had "persistent low back pain with a left radiculopathy: 'chronic lumbar strain[.]'" (Ex. 48-1). Dr. Mitchell explained:

> "[Claimant] was apparently declared medically stationary in Oct 1996. I am unaware of the precise details of physical status at that time. However Dr. Miller's letter of 17 Oct 1997 implies that in the subsequent 12 months [claimant] had deteriorated. In my opinion such worsening would be more than mere waxing and waning, and should be considered permanent, not amenable to surgery or therapy." (Ex. 48-2).

Although Dr. Mitchell said that claimant's symptoms were "more than mere waxing and waning," he acknowledged that he was not aware of claimant's condition at the time of claim closure. Under these circumstances, Dr. Mitchell's opinion is entitled to little probative weight. Dr. Mitchell's conclusory opinion is insufficient to establish that claimant's has sustained an "actual worsening" of the compensable condition.

Dr. Grewe examined claimant on one occasion, in December 1997. He reported that the August 15, 1997 MRI showed spondylosis at L5-S1 and "fairly significant" left-sided L5-S1 scar tissue. (Ex. 44-3). He diagnosed "[c]hronic low back and primarily left lower extremity pain (improving)" and L5-S1 spondylosis. (*Id.*) Dr. Grewe indicated he had discussed the degenerative changes at L5-S1 with claimant, as well as the possibility that was contributing to his symptoms. (*Id.*) He noted, however, that proving the degenerative changes as a source of pain could be difficult. (*Id.*)

In a later report, Dr. Grewe indicated his diagnosis was L5-S1 spondylosis and improved low back/left lower extremity pain. (Ex. 49-2). He was asked if the "accepted claim" had pathologically worsened since claim closure. (*Id.*) He responded: "Comparing MRI scans from 7/3/95 to 8/15/97 - yes. Otherwise, subjective symptomatic worsening." (*Id.*) He said that the MRI changes were permanent. Dr. Grewe was asked if the worsened condition was more than what he would expect from the waxing and waning of the accepted condition. (*Id.*) He responded: "I think his L5-S1 degenerative changes were accelerated by the disc herniation and surgery." (*Id.*)

We are not persuaded by Dr. Grewe's opinion because it lacks adequate explanation. Although Dr. Grewe said that the MRI scans between 1995 and 1997 indicated the "accepted claim" had pathologically worsened, he did not explain how the MRI scans were different or how claimant's condition had pathologically worsened. There is no indication that Dr. Grewe was aware of claimant's condition at the time of claim closure. Furthermore, he did not explain how or why claimant's "worsened" condition was more than waxing and waning of symptoms of the condition contemplated by the previous permanent disability award. *See* ORS 656.273(8). Rather, he simply responded that claimant's degenerative changes were accelerated. We conclude that Dr. Grewe's conclusory opinion is not persuasive.

We generally defer to the treating physician, unless there are persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810, 814 (1983). Here, the opinions of claimant's treating physicians, Drs. Miller and James, do not support compensability. Dr. Miller performed claimant's May 1996 back surgery and later examined him for recurrent low back pain in September 1997. (Ex. 28). He diagnosed degenerative disc disease at L5-S1 and said that claimant's symptoms were due to the degenerative condition. (Ex. 50-1, -2). He did not know if there had been a pathologic worsening of claimant's "degenerative disc" since claim closure (Ex. 50-1). He said that claimant had experienced a "waxing and waning of his symptoms[.]" (Ex. 50-2). Dr. Miller's opinion does not support claimant's aggravation claim.

Dr. Frank James treated claimant in August 1997 and filed an aggravation claim. (Exs. 24, 25). He also treated claimant in October and December 1997. (Exs. 31, 43). In a concurrence letter from the insurer, Dr. James agreed that claimant's increased symptoms in August 1997 represented a waxing and waning of symptoms contemplated by the previous permanent disability award. (Ex. 45-2). ORS 656.273(8) requires that the worsening must be *more than* waxing and waning of symptoms of the condition contemplated by the previous permanent disability award. Dr. James indicated in a later report that claimant's condition was "most likely an aggravation of his previous injury which has subsequently resolved." (Ex. 46a-1). To the extent Dr. James' second opinion represents a change from his previous concurrence with the insurer, it is not persuasive because it lacks explanation for the change. *See Kelso v. City of Salem*, 87 Or App 630 (1987). In any event, his conclusory opinion is not sufficient to establish that claimant had an "actual worsening" of his compensable condition.

Dr. Robinson, chiropractor, treated claimant from October through December 1997. In a concurrence letter from the insurer, Dr. Robinson agreed that claimant had not sustained a pathological worsening, but only a symptomatic worsening of his low back condition. (Ex. 46-2). In a later opinion,

Dr. Robinson said he needed a more accurate definition of a pathological worsening. (Ex. 47-1). He felt that claimant was "symptomatically and objectively worsened as a result of activities in 1997[,]" but he found "little objective evidence of any permanent additional worsening" as a result of the 1997 "aggravation." (Ex. 47-1, -2). Although Dr. Robinson said that claimant's 1997 condition was "certainly more severe than a mere waxing and waning of symptoms" (Ex. 47-2), he did not explain the factors that led to his conclusion. Dr. Robinson's conclusory opinion is not sufficient to establish that claimant sustained an "actual worsening" of his compensable condition.

Drs. Platt and Stanley James examined claimant on behalf of the insurer and reported that the objective findings were relatively meager and did not entirely substantiate subjective complaints. (Ex. 30-7). They noted inconsistencies in measurement of range of motion and sensory findings that were nonanatomic. (Ex. 30-8). They felt it was difficult to say if claimant was objectively worse and they said his pain may represent a waxing and waning of symptoms. (Ex. 30-9).

On this record, we conclude that claimant has not met his burden of proving an "actual worsening" pursuant to ORS 656.273(1).

ORDER

The ALJ's order dated March 30, 1998 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

August 6, 1998 Cite as 50 Van Natta 1553 (1998)

In the Matter of the Compensation of
KENNETH R. JOHNSON, Claimant
Own Motion No. 97-0277M
OWN MOTION ORDER
Malagon, Moore, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation initially submitted claimant's request for temporary disability compensation for his compensable acute lumbosacral strain. Claimant's aggravation rights on that claim expired on August 16, 1996.

On May 30, 1997, SAIF denied medical benefits and the responsibility for claimant's current low back condition. Claimant requested a hearing. (WCB Case No. 97-04735). We issued an interim order consenting to the designation of a paying agent (ORS 656.307) and postponed action on the own motion matter pending resolution of that litigation.

By Opinion and Order dated April 30, 1998, Administrative Law Judge (ALJ) Mongrain upheld SAIF's May 30, 1997 denial, and found a subsequent insurer (Liberty Northwest Insurance Company) responsible. Liberty Northwest requested Board review of ALJ Mongrain's order, and in an order issued on today's date, the Board affirmed ALJ Mongrain's order.

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

Here, the current condition and ensuing medical treatment for which claimant requests own motion relief, remains in denied status, and is the responsibility of a subsequent insurer (Liberty Northwest). As a result, we are not authorized to grant claimant's request for own motion relief. *See Id.*[1]

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[1] As previously notes, we issued an interim order consenting to the designation of a paying agent pursuant to ORS 656.307. SAIF, the own motion carrier, was designated as the paying agent.

As a result of the ALJ's order and our affirmance of that decision, Liberty Northwest is responsible for the processing of the claim. Consequently, if SAIF issued a Notice of Closure pursuant to OAR 438-012-0055, that closure would be null and void as a result of this order.

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

IT IS SO ORDERED.

August 6, 1998 Cite as 50 Van Natta 1554 (1998)

In the Matter of the Compensation of
DANA M. PETERSON, Claimant
WCB Case No. 97-04856
ORDER ON REVIEW
Roger Wallingford, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Peterson's order that: (1) upheld the insurer's partial denial of claimant's L5-S1 disc herniation/bulge injury claim; and (2) reduced claimant's unscheduled permanent disability award for a low back injury from 15 percent (48 degrees), as awarded by the Order on Reconsideration, to zero. In addition, the insurer seeks "acknowledgment of the overpayment documented in the record." On review, the issues are compensability, extent of unscheduled permanent disability, and alternatively, offset.[1]

We adopt and affirm the ALJ's order with the following supplementation regarding the extent of unscheduled permanent disability issue.

Disability standards adopted by the Director pursuant to ORS 656.726 are used to evaluate disability. ORS 656.283(7), 656.295(5). The standards adopted by the Director that are in effect at the time of claim closure are used in determining claimant's permanent disability. ORS 656.283(7), ORS 656.726(3)(f)(A). Claimant's claim was closed by Notice of Closure dated February 28, 1997. (Ex. 48). Therefore, as the ALJ found, the standards at Workers' Compensation Department Administrative Order 96-072, effective February 15, 1997, apply to determine claimant's disability. OAR 436-035-0003(2) and (3).

Findings concerning a worker's impairment may be considered only if they come from one of three sources: (1) the attending physician at the time of claim closure; (2) findings with which the attending physician has concurred; or (3) a medical arbiter appointed pursuant to ORS 656.268(7). *See* ORS 656.245(2)(b)(B); ORS 656.268(7); *Koitzsch v. Liberty Northwest Insurance Corporation*, 125 Or App 666 (1994); *Tektronix, Inc. v. Watson*, 132 Or App 483 (1995). Moreover, we have previously held that, to be consistent with ORS 656.245(2)(b)(B) and ORS 656.268(7), the "preponderance of medical evidence" standard prescribed by the disability standards to determine a worker's level of impairment is limited to the above three medical sources. *Former* OAR 436-035-0007(12) and (13); *Adam J. Delfel*, 50 Van Natta 1041 (1998). Thus, consideration of an examining physician's opinion regarding a worker's impairment is not appropriate, unless that opinion has been concurred with by the worker's attending physician.

Here, the sole issue regarding impairment is whether claimant has established a valid loss of lumbar range of motion. Dr. Flemming, M.D., served as claimant's attending physician at the time of claim closure. Dr. Rosenbaum, M.D., examined claimant on the insurer's behalf and opined that claimant had "no objective abnormalities" and her "marked limitation on range of motion of the lumbar spine is out of proportion to her diagnosis." (Ex. 44-4). In addition, Dr. Rosenbaum found claimant to have "very prominent functional overlay." (Ex. 44-5). Dr. Flemming concurred with Dr. Rosenbaum's report, noting explicit disagreement only with Dr. Rosenbaum's opinion that claimant could return to her at-injury job. (Ex. 47). In addition, Dr. Flemming also separately stated that claimant had a "lot of psychologic overlay into her pain management." (Ex. 31). The ALJ noted that a prior examining physician, Dr. Farris, M.D., also concurred with Dr. Rosenbaum's report. However, as explained above, because Dr. Farris' concurrence is not one of the three medical sources upon which we may rely to determine impairment, we do not consider it in deciding claimant's impairment.

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[1] The insurer requested that "[t]o the extent necessary, employer seeks acknowledgment of the overpayment documented in the record against any benefits awarded." Respondent's Brief, page 1. Because we are not awarding any benefits, we do not address the offset request.

Finally, claimant was examined by Dr. Gripekoven, M.D., who served as the medical arbiter. (Ex. 51). Claimant argues that we should rely on Dr. Gripekoven's reduced ranges of motion measurements to rate her impairment. However, we agree with the ALJ that, given Dr. Gripekoven's comments regarding the invalidity of those measurements, they do not support a finding that claimant has valid losses of ranges of motion. Specifically, Dr. Gripekoven stated that "measurements of range of motion are felt to be valid and reproducible individually, but do not meet the criteria for validity based on the straight leg raising [SLR] validity test." (Ex. 51-5).

We have previously held that the validity of range of motion testing must be determined by the medical examiner performing the tests. *Harvey Clark*, 47 Van Natta 136 (1995); *Michael D. Walker*, 46 Van Natta 1914 (1994). Thus, regardless of whether the ranges of motion might satisfy a portion of the Director's validity criteria in that, over three consecutive measurements of mobility, the individual measurements are within plus or minus five degrees of each other, Dr. Gripekoven expressly questioned the validity of the findings and, therefore, those findings are not sufficient to establish permanent disability. *See Bulletin 242*; *Teri S. Callahan*, 49 Van Natta 548 (1998) (where the attending physician noted that the range of motion data did not contribute significant information about the claimant's level of disability, the Board found that the claimant failed to prove impairment); *Harvey Clark*, 47 Van Natta 136 (1995) (where the medical arbiter found the claimant's range of motion findings invalid, the Board found that the claimant failed to prove impairment); *Benjamin G. Santos*, 46 Van Natta 1912 (1994) (where the medical arbiter found the claimant's lumbar flexion measurement invalid based on the SLR validity test, the Board found the measurement properly excluded from calculation of the claimant's impairment).

To hold otherwise would require us to independently determine the validity of the range of motion measurements in the face of a specific finding from Dr. Gripekoven that the measurements are not valid. Given the fact that impairment must be measured by the medical arbiter or attending physician, we are not qualified to independently apply validity testing and determine that the medical arbiter's impairment findings are valid. Accordingly, inasmuch as we find that the medical arbiter questions the validity of claimant's range of motion measurements and the attending physician concurred with a report that also questions the validity of range of motion measurements, we agree with the ALJ that the record presents no valid range of motion measurements upon which to rate impairment. *Compare Robert E. Roy*, 46 Van Natta 1909 (1994) (where the medical arbiter did not note any range of motion measurements as being invalid, there was no basis for the ALJ to independently apply Bulletin 242 to find the measurements invalid); *Michael D. Walker*, 46 Van Natta at 1915 (same).

ORDER

The ALJ's order dated March 5, 1998 is affirmed.

August 6, 1998 Cite as 50 Van Natta 1555 (1998)

In the Matter of the Compensation of
JOHN A. RODDEN, Claimant
WCB Case No. 97-06717
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Moller and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Menashe's order that set aside its denial of claimant's aggravation claim for an L5-S1 herniated disc. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

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

Claimant, who worked as a heavy equipment operator for the employer, had been experiencing low back pain for about a month when his back "went out" on October 28, 1993. Dr. Nicholson reported right-sided sciatic pain and bilateral positive straight leg testing. SAIF accepted a disabling lumbar strain.

On November 2, 1993, Dr. Nicholson declared claimant medically stationary and released him to light duty work. On March 16, 1994, claimant sought chiropractic treatment for low back and posterior bilateral leg pain, left greater than right. Claimant's claim was closed by an April 15, 1994 Determination Order that awarded no permanent disability. As of April 18, 1994, claimant was performing regular work.

Claimant continued chiropractic treatment for his low back symptoms through August 1994, and he had one treatment in March 1995 and again in February 1996. (Exs. 15-2, 20-1). Claimant was seen on July 24, 1996 for an acute flare up. He was seen three times a week for two weeks through July 31, 1996, then once in August, twice in October, once in November, and twice in December 1996. On February 27, 1997, claimant again sought treatment and improvement was reported on March 8, 1997.

On about March 15 or 16, 1997, claimant was playing basketball with his son and his friends. He felt stiff and sore afterward, and, on the next morning, he was unable to work. On March 17, 1997, he sought chiropractic treatment and was seen twice. A supportive belt was prescribed. Claimant's condition continued to worsen and, on March 22, 1997, he sought emergency room treatment for low back and bilateral leg symptoms that extended into the ankles. Dr. Brenner ordered an MRI, which revealed an L5-S1 herniated disc midline and to the left and degenerative disc disease. On March 27, 1997, Dr. Ordonez performed a laminectomy and diskectomy at L5-S1.

CONCLUSIONS OF LAW AND OPINION

On review, SAIF challenges the ALJ's conclusion that claimant has established a compensable aggravation of his accepted 1993 lumbar strain. SAIF argues that the persuasive medical evidence establishes that claimant's L5-S1 herniated disc was the result of his preexisting degenerative disc disease. Thus, SAIF contends that claimant has not proven that the work injury was the major contributing cause of his recent need for surgery.

Claimant relies on the opinion of the ALJ, and contends that his herniated disc arose directly from his 1993 low back injury and that the condition materially worsened. The ALJ's conclusion was based on the opinion of the treating surgeon, Dr. Ordonez. We agree with SAIF and reverse the ALJ's aggravation ruling.

Under ORS 656.273(1), a worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings. Two elements are necessary to establish a compensable aggravation: (1) a compensable condition; and (2) an "actual worsening." *Gloria T. Olson*, 47 Van Natta 2348, 2350 (1995). If the allegedly worsened condition is not a compensable condition, compensability must first be established under ORS 656.005(7)(a). *Id.*

Claimant has the burden of proving compensability. ORS 656.266. Considering the passage of time since the 1993 injury, and the number of 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. which requires expert evidence for its resolution. *Barnett v. SAIF*, 122 Or App 279 (1993); *Uris v. Compensation Dept.*, 247 Or 420 (1967). Although we generally rely on the opinion of a worker's treating physician, absent persuasive reasons to do otherwise, we find persuasive reasons not to do so in this case. *See Weiland v. SAIF*, 64 Or App 810 (1983); *Argonaut Insurance Company v. Mageske*, 93 Or App 698 (1988).

Three doctors offered causation opinions regarding claimant's L5-S1 disc herniation.

Dr. Strum, orthopedist, performed a records review in June 1997, and noted that claimant had intermittent chiropractic treatments following the 1993 injury. Based on his review of the March 1994 and March 1997 x-rays, Dr. Strum concluded that claimant had already developed moderate degenerative disc disease at L5-S1, which, he opined, would be the major contributing cause of claimant's persistent symptomatology from the time of the 1993 injury. Dr. Strum explained that the persistence of claimant's symptoms, which required intermittent treatment until the substantial worsening in March 1997, was entirely consistent with the natural history of degenerative disc disease. Dr. Strum concluded that claimant's October 1993 work injury did not produce a material pathological worsening of the preexisting degenerative condition, nor was that injury the major contributing cause of "the resultant combined condition."

Dr. Duff, orthopedist, who examined claimant on July 18, 1997, obtained a detailed history and reviewed claimant's diagnostic and treatment records. Dr. Duff concluded that claimant had a degenerative lumbar disc that spontaneously herniated sometime in February or March 1997. He also indicated that claimant's persisting symptoms after October 1993 resulted from the progressive degeneration of the L5-S1 disc. Dr. Duff concluded that claimant's preexisting condition was the major contributing cause of his current need for treatment. Dr. Duff explained that the gap of three-and-one-half years between the work injury and the need for surgery did not support a disc rupture at the time of the 1993 injury.

Dr. Ordonez, who performed claimant's March 27, 1997 disc surgery, first examined claimant on March 26, 1997. He agreed that claimant had degenerative disc disease at L5-S1, and that it was a preexisting condition. He also found an acute posterior disc herniation at L5-S1 on the left at surgery, which, he concluded, was not degenerative in nature, but would in all medical probability arise after trauma or strenuous physical activity. He opined that claimant's low back and leg symptoms after the 1993 injury were an indication that it was likely that claimant had suffered a disc rupture in 1993. He also stated that the size of the 1993 disc herniation may have increased over time, which might account for the fact that he was able to continue to perform heavy work since the original injury. Finally, he stated that, lacking documentation of claimant's condition in 1993, he could "only assume that the injury in 1993 was more extensive than the simple strain that is mentioned in relation to [claimant's] case."

First, although Dr. Ordonez performed claimant's disc surgery, he did not see claimant until the day prior to the surgery. Therefore, he did not have the advantage of attending claimant over time. Second, we find his conclusory opinion less persuasive than that of the two other physicians. *Somers v. SAIF*, 77 Or App 259 (1986). His opinion is based on speculation that claimant sustained an actual disc herniation at the time of the October 1993 lumbar strain. There are no objective findings to support his conclusion, nor did he supply any reasoning for concluding that claimant's supposed 1993 disc injury was the reason that claimant's symptoms did not resolve. Moreover, he did not address Dr. Strum's opinion that claimant's course of intermittent treatment during the three-and-one-half year period since the 1993 injury was consistent with the progression of degenerative disc disease, eventually leading to claimant's need for surgery in 1997. Finally, even though Dr. Ordonez was aware of claimant's basketball activities, he did not discuss their effect on the development of claimant's herniated disc and need for treatment, in contrast to the opinion of Dr. Duff.

Since we have concluded that Dr. Ordonez's opinion is not persuasive, and because the remaining medical opinions do not support the compensability of claimant's herniated disc condition, we uphold SAIF's aggravation denial.

ORDER

The ALJ's order dated March 27, 1998 is reversed. The SAIF Corporation's denial is reinstated and upheld. The attorney fee award is reversed.

August 6, 1998 Cite as 50 Van Natta 1557 (1998)

In the Matter of the Compensation of
SHEILA K. WENTZ, Claimant
WCB Case No. 96-05659
ORDER ON REVIEW
Gary L. Tyler, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Lipton's order that awarded temporary disability benefits for the period of March 14, 1996 through October 25, 1996.[1] On review, the issue is interim compensation. We reverse.

[1] The parties do not challenge that portion of the ALJ's order that upheld the employer's denial of claimant's aggravation claim.

FINDINGS OF FACT

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

In January 1995, while employed as a bus driver for the employer, claimant made a claim for right arm and hand pain. She sought treatment from Dr. Richardson, an osteopath, who ultimately diagnosed carpal tunnel syndrome. The employer accepted bilateral carpal tunnel syndrome on April 7, 1995. On July 11, 1995, Dr. Silver performed a right carpal tunnel release surgery.

On October 17, 1997, claimant began treating with Dr. Layman. She completed a form 829 (Change of Attending Physician form), which Dr. Layman signed and forwarded to the employer.

Claimant's claim was closed pursuant to a November 13, 1995 Notice of Closure, which awarded temporary disability and 9 percent scheduled permanent disability for the right forearm. Claimant requested reconsideration and a medical arbiter examination. She was examined by Dr. Vessely on February 24, 1996. A March 7, 1996 Order on Reconsideration awarded claimant 7 percent (10.5 degrees) scheduled permanent disability of the right forearm and 2 percent (3 degrees) scheduled permanent disability of the left forearm.

Claimant returned to Dr. Richardson on March 13, 1996 complaining of increased pain in her right wrist and tingling in her fingertips after her bus driving work the day prior. Dr. Richardson placed claimant on modified work until March 18, 1996, with no repetitive gripping of the right wrist. Dr. Richardson also completed a form 2837 (Notice of Claim for Aggravation), authorizing time loss through March 17, 1996. This form was sent to the employer, but was not accompanied by a medical report.[2]

Claimant returned to Dr. Richardson for follow up treatments on March 18 and 21, 1996. He diagnosed tenosynovitis and released claimant for modified work. Dr. Richardson also referred claimant back to Dr. Layman, who saw her again on April 3, 1996. Dr. Layman noted swelling of the right wrist and a positive Finkelstein's test. He recommended a splint and continued light duty work.

During April and May 1996, claimant saw both Dr. Richardson and Dr. Layman. A repeat nerve conduction study on April 15, 1996 was within normal limits. Dr. Richardson continued to authorize modified duty.

On May 17, 1996, claimant wrote to Dr. Layman stating that she considered Dr. Richardson to be her attending physician, and rescinding any prior change of attending physician form she may have signed. This letter was copied to the employer's claims processor and Dr. Richardson.

On May 20, 1996, Dr. Richardson wrote to the employer's claims processor to elaborate on his report of March 13, 1996. He indicated that, at that time, he believed that claimant had suffered an aggravation of her prior right carpal tunnel syndrome secondary to her work activity. Objective findings included mild swelling of the right wrist. He further reported that subsequent EMG testing showed no evidence of a worsening of her carpal tunnel syndrome, but rather tenosynovitis. Dr. Richardson continued to authorize modified duty.

Claimant's light duty job was eliminated on May 24, 1996.[3] Thereafter, she did not receive wage or temporary disability benefits. In July 1996, claimant was referred to occupational therapy. Both the occupational therapist and Dr. Bonafede, who treated claimant in June and July 1996, expressed concern that claimant was over-focusing on her pain.

On October 7, 1996, claimant completed a Change of Attending Physician form with Dr. Richardson. Dr. Richardson also completed another aggravation claim form, indicating that claimant was restricted from driving commercial vehicles.

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[2] When the employer received the 2837 form, it sent the form back to Dr. Richardson highlighting the language stating that the form must be accompanied by a written medical report and requesting the required information.

[3] Between March 25, 1996 and May 24, 1996, claimant had been working in a light duty position on a modified schedule. (Tr. 32-33).

The employer denied claimant's "recently received" aggravation claim on October 25, 1996. The employer did not pay any interim compensation between March 13, 1996 and October 25, 1996.

CONCLUSIONS OF LAW AND OPINION

Noting that claimant was restricted to light duty work on and after March 13, 1996 through the time of the employer's October 25, 1996 denial, the ALJ concluded that claimant was entitled to interim compensation. In so finding, the ALJ determined that the employer had a duty to investigate the claim and clarify claimant's work status with her attending physician.

On review, the employer argues that it had no duty to clarify claimant's time loss status. The employer further asserts that claimant is not entitled to interim compensation for the period in dispute because she did not perfect her aggravation claim pursuant to ORS 656.273(3) until October 1996. For the reasons set forth below, we agree that claimant has not established an entitlement to interim compensation.

Under the aggravation statute, a claimant's entitlement to interim compensation in the form of temporary disability benefits depends on when the carrier received notice or knowledge of a medically verified inability to work in a medical report that satisfies the requirements of ORS 656.273(3). *See Russell D. Parker*, 49 Van Natta 83 (1997); *see also Ronda G. Prewitt*, 49 Van Natta 831 (1997). ORS 656.273(3) requires that the claim for aggravation be in writing in a form and format prescribed by the Director and signed by the worker or the worker's representative. The statute further requires that the aggravation claim "*be accompanied by the attending physician's report* establishing by written medical evidence supported by objective findings that the claimant has suffered a *worsened condition attributable to the compensable injury.*" (emphasis added). Furthermore, although ORS 656.273(6) obligates the carrier to begin paying interim compensation benefits within 14 days after the subject employer has notice of the claimant's medically verified inability to work resulting from a compensable worsening, the carrier has no affirmative duty to request or obtain such verification from the attending physician. *See Jim R. Reed*, 49 Van Natta 753 (1997); *see also Mark V. Moser*, 50 Van Natta 221 (1998).

Here, although Dr. Richardson submitted an aggravation claim form on March 13, 1996, he was not claimant's attending physician at the time,[4] nor was the 2837 form accompanied by a medical report indicating that claimant had suffered a worsened condition attributable to her accepted carpal tunnel syndrome. Indeed, upon receipt of the claim form, the employer's claims processor wrote to Dr. Richardson requesting a report with the "required information." (Ex. 62a). Because Dr. Richardson was not claimant's attending physician and the aggravation claim form was not accompanied by any medical report, the employer's receipt of the March 13, 1996 aggravation claim form did not satisfy the requirements of ORS 656.273(3) and did not trigger the employer's claims processing obligations under ORS 656.273(6).[5] *See Laura D. Girard*, 49 Van Natta 1417 (1997) (aggravation claim form that was not

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[4] An "attending physician" is the physician who is primarily responsible for the treatment of a worker's compensable injury. ORS 656.005(12)(b); *David A. Matthews*, 47 Van Natta 257 (1995). Whether a physician qualifies as an "attending physician" is a question of fact. *See Debbie I. Jensen*, 48 Van Natta 1235, 1236 (1996).

Here, according to the record, Dr. Richardson referred claimant to Dr. Layman in early October 1995 following her carpal tunnel release surgery. Claimant saw Dr. Layman on October 17, 1995 and signed a Change of Attending Physician form (829 form) naming Dr. Layman as her attending physician. (Exs. 48, 49). Although she returned to Dr. Richardson on March 13, 1996, she did not complete another 829 form at that time. Dr. Richardson referred claimant back to Dr. Layman on March 21, 1996, and both doctors treated her in April and May 1996. (*See* Exs. 60, 61, 62, 64, 66, 67, 68, 69). The confusion as to who was her "attending physician" apparently prompted claimant's May 17, 1996 letter confirming her desire to have Dr. Richardson as her attending physician. (Ex. 69A). Thereafter, she treated with Dr. Richardson as well as Dr. Bonafede. (*See, e.g.* Exs. 72, 74, 75, 77, 78). Claimant did not sign an 829 form identifying Dr. Richardson as her attending physician until October 7, 1996. (Ex. 93). Under these circumstances, we conclude that Dr. Layman was claimant's attending physician from October 17, 1995 until May 17, 1996, when she affirmatively expressed her desire to return to Dr. Richardson.

[5] The employer apparently received Dr. Richardson's March 13, 1996 chart note (which documented mild swelling of the right wrist) on March 29, 1996 (*see* Ex. 54), but that note also indicated that claimant should be able to return to her regular job by March 18, 1996. The record does not indicate when the employer received Dr. Richardson's March 18 and 21, 1996 chart notes, which continued claimant's light duty restriction. Further, although the employer also received Dr. Layman's April 3, 1996 report on April 9, 1996, that report does not document an inability to work due to a worsened condition attributable to her accepted carpal tunnel syndrome. (Ex. 60).

accompanied by a medical report satisfying ORS 656.273(3) did not give rise to an entitlement to interim compensation); *see also Melvin L. Shroy*, 48 Van Natta 561 (1996) (aggravation claim that was not accompanied by an attending physician's report is not a claim for aggravation under ORS 656.273(3)).

On May 17, 1996, claimant indicated in writing that she considered Dr. Richardson to be her attending physician, and rescinded her consent to Dr. Layman as attending physician. Around the same time, Dr. Richardson reported to the employer that, although he had initially believed in March 1996 that claimant had suffered an aggravation of her accepted carpal tunnel syndrome, repeat electrical studies showed no evidence of a worsening. (Ex. 70). In this report, which the employer received on June 3, 1996, Dr. Richardson related claimant's ongoing symptoms to a different condition, tenosynovitis.[6] *Id.* Therefore, although Dr. Richardson became claimant's attending physician in mid-May 1996, his medical reports at that time did not operate to perfect claimant's aggravation claim because the reports received by the employer did not indicate that claimant suffered a worsened condition attributable to her compensable injury.[7] *Compare Ronda G. Prewitt*, 49 Van Natta at 834 (where the employer did not challenge the validity of the aggravation claim on the ground that the claim form was not "accompanied by" a attending physician's report, the employer's claim processing obligations under ORS 656.273(6) were triggered upon the belated receipt of the attending physician's report providing medical verification of the claimant's inability to work resulting from a prima facie compensable worsening under ORS 656.273(1)).

In summary, claimant has not established an entitlement to interim compensation under ORS 656.273(3) and (6). In other words, on this record, we are not persuaded that, at any time prior to the employer's October 1996 denial, the employer received a completed aggravation claim form accompanied by a medical report from claimant's attending physician verifying her inability to work due to a worsening of her original injury under ORS 656.273(1).

ORDER

The ALJ's order dated April 2, 1998 is reversed in part and affirmed in part. That part of the order that directed the employer to pay interim compensation from March 14, 1996 through October 25, 1996 is reversed. The ALJ's "out-of-compensation" attorney fee award is likewise reversed. The remainder of the order is affirmed.

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[6] There is no evidence in this record that claimant made a "new medical condition" claim for this condition. *See* ORS 656.262(7)(a).

[7] Dr. Richardson also did not submit these supplemental reports with a completed aggravation claim form.

In the Matter of the Compensation of
ROSE M. WAKEFIELD, Claimant
WCB Case No. 97-07394
ORDER OF ABATEMENT
Pozzi, Wilson, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

On July 23, 1998, we affirmed an Administrative Law Judge's (ALJ's) order that affirmed an Order on Reconsideration awarding no scheduled permanent disability for loss of use or function of the left foot. The parties have now submitted a proposed "Disputed Claim Settlement," which is designed to resolve all issues raised or raisable between them. We treat the parties' submission as a motion for reconsideration.

The Board has no objection to that portion of the proposed settlement that seeks to resolve the compensability of the enumerated conditions recited in the agreement because the settlement establishes the existence of a bona fide dispute regarding the compensability of those conditions. *See* ORS 656.289(4); OAR 438-009-0010(2). However, because another portion of the agreement does not comply with Board rules, the settlement as currently proposed cannot receive our approval.

Specifically, the settlement neglects to include a provision stating that claimant retains her entitlement to future benefits arising under ORS 656.245, 656.273, 656.278, and 656.340 insofar as those rights may be related to her original, accepted left ankle strain.[1] *See* OAR 438-009-0010(4)(b). Lacking such a provision, the settlement is presently unapprovable. Consequently, the proposed settlement is being returned to the self-insured employer's counsel for supplementation.[2]

In order to retain jurisdiction to consider the parties' revised agreement, we withdraw our July 23, 1998 order. On receipt of a revised, fully-executed settlement which is drafted in compliance with our rules and the matters discussed in this order, we will proceed with our review.

IT IS SO ORDERED.

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[1] Contained within the settlement is a denial in which the employer states that claimant retains the aforementioned rights to the extent that those rights are related to the original, accepted claim. Nevertheless, the agreement later provides that "[c]laimant shall have no further entitlement to compensation, or any other legal right under Oregon workers' compensation law relating to her left ankle/foot/leg conditions, however diagnosed." In light of such circumstances and to remove any potential confusion, we conclude that the parties' agreement must be supplemented to confirm that claimant retains her rights to benefits to the extent that those rights are related to her original, accepted left ankle strain. *See* OAR 438-009-0010(4)(b).

[2] The proposed settlement also contains a signature line for an ALJ. Because the agreement is designed to resolve the parties' pending dispute before the Board, the parties should replace the ALJ signature line with two signature lines for Board Members.

In the Matter of the Compensation of
WILLIAM J. BARABASH, Claimant
WCB Case Nos. 97-07363 & 97-07362
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Podnar's order that: (1) upheld the insurer's denial of his ulnar neuropathy, cervical strain and lumbar strain conditions; and (2) reduced claimant's scheduled permanent disability for loss of use or function of the left hand from 5 percent (7.5 degrees), as awarded by an Order on Reconsideration, to zero. On review, the issues are compensability and extent of scheduled permanent disability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the third full paragraph on page 2, we change the date in the last sentence to "April 23, 1997." We do not adopt the last 3 sentences of the findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant was compensably injured on February 28, 1996 when he experienced an electrical shock and fell off a ladder. On February 17, 1997, the insurer accepted a "[l]ow voltage electrical injury." (Ex. 21). A Notice of Closure issued on June 9, 1997 awarding no permanent disability. (Ex. 37).

Claimant continued to have problems with his left upper extremity, neck and low back. On August 4, 1997, the insurer issued an "updated notice of acceptance at closure," referring to the accepted conditions as low voltage electrical injury to the chest and upper extremities, fracture of 11th rib and chip fracture, C6. (Ex. 52). On September 4, 1997, an Order on Reconsideration awarded claimant 5 percent scheduled permanent disability for a sensory loss of the left ring and little finger. (Ex. 59).

On September 15, 1997, a claim was made for claimant's ulnar neuropathy and cervical and lumbar strain conditions. (Ex. 61). The insurer denied the claim for ulnar neuropathy, cervical and lumbar strain on September 22, 1997. (Ex. 63).

Compensability - Ulnar Neuropathy

The ALJ analyzed the claim for ulnar neuropathy under ORS 656.005(7)(a)(A) and concluded that claimant failed to establish that his ulnar problems were related to, or resulted from, his compensable injury.

Claimant contends that he suffered ulnar neuropathy as a direct and immediate result of his electrical shock and the ALJ erred by applying a "consequential condition" analysis. Claimant argues that he sustained an immediate injury to his left hand, although a more clear diagnosis (ulnar neuropathy) was not made until a later time. He relies on the opinion of Dr. Kemple to establish compensability.

Claimant is correct that, if his left ulnar neuropathy arose directly from the February 1996 injury, that 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); *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992). However, we need not resolve this particular issue, because we conclude that claimant's ulnar neuropathy condition is compensable under either a material or major causation standard.

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 Dr. Kemple's opinion regarding claimant's ulnar neuropathy condition persuasive.

The insurer contends that claimant's ulnar neuropathy arose long after the injury. The medical evidence, however, indicates that claimant has been having left ulnar problems since the compensable injury. On February 29, 1996, one day after the accident, Dr. Olmscheid reported that claimant had "[w]eakness and numbness of both hands, possibly representative of an electrical injury." (Ex. 3-2). On March 5, 1996, Dr. Olmscheid reported that claimant had noticed some paresthesias in the left ulnar distribution periodically and claimant had said he struck his left elbow when he fell. (Ex. 8). Dr. Olmscheid noted claimant had a prominent Tinel's sign over the left median nerve and modest tenderness over the left ulnar nerve at the notch. (*Id.*) He diagnosed, among other things, "[e]lectrical injury upper extremity without definite residual." (*Id.*) He recommended EMG and nerve conduction studies of the left ulnar nerve.

Dr. Olmscheid referred claimant to Dr. Weller because he had a question of whether claimant had cervical radiculopathy versus ulnar neuropathy. (Ex. 9). Dr. Weller's exam on April 16, 1996 revealed a clear reduction in pin prick in the left ulnar hand, largely limited to the most distal portion of the left ulnar forearm and he noted that claimant had a Tinel's sign in the left ulnar groove. (Ex. 9-1). Nerve conduction studies done primarily in the left ulnar nerve were normal. (*Id.*) EMG studies were also performed and Dr. Weller found acute denervation changes in the first dorsal interosseous, abductor digiti quinti and triceps. (Ex. 9-2). He noted that claimant appeared to have "either C8 or ulnar numbness in the left hand." (*Id.*) Dr. Weller felt the findings were suggestive of a left C8 radiculopathy. (*Id.*)

Dr. Kemple examined claimant on September 23, 1996 and diagnosed, among other things, left upper extremity paresthesias, stating that claimant's symptoms were currently modest and did not seem to represent fixed neurologic injury. (Ex. 14-3). He noted that ulnar neuropathy had apparently been ruled out. (*Id.*) On March 12, 1997, Dr. Kemple reported that claimant continued to have low grade paresthesias that occured on an intermittent basis in the ulnar aspect of his forearm and left hand. (Ex. 26-1).

On July 1, 1997, Dr. Kemple reported that claimant had more frequent and persistent numbness in his left forearm and hand in an ulnar distribution, with some associated aching in the forearm. (Ex. 43). He recommended updated nerve conduction and EMG studies. On July 9, 1997, Dr. Denekas reported that claimant had left cubital tunnel syndrome by electrical criteria. (Ex. 44). He also noted that claimant had decreased sensation in the ulnar aspect of the left hand. (*Id.*)

On July 24, 1997, Dr. Kemple diagnosed posttraumatic cervical brachial pain with a significant element of ulnar neuropathy. (Ex. 48-1). Dr. Mason examined claimant on August 18, 1997 and found evidence of a tardy ulnar palsy on the left. (Ex. 55-2). He recommended surgery for transposition of the nerve. (*Id.*) On September 15, 1997, Dr. Kemple commented that claimant's ulnar neuropathy appeared to be directly related to his cervical injury and probably also involved the compression - traction injury at the elbow in his fall. (Ex. 60-1).

On December 22, 1997, Dr. Kemple diagnosed ulnar neuropathy at the left elbow and explained:

> "The evaluation results suggest that there is a combined ('double crunch') component of cervical root irritation and peripheral ulnar nerve injury - reaction at the cubital tunnel. This has resulted in progressive-symptomatic disturbance in sensation and pain modulation into the forearm and hand, which has been clearly documented. The injury of 2-28-96 is clearly the major contributing cause of these left upper extremity neurologic problems." (Ex. 70-2).

Dr. Kemple continued to recommend surgical decompression of the left ulnar nerve at the cubital tunnel. (Ex. 70-3).

The insurer argues that Dr. Kemple's report is not persuasive because it was based on a cervical root irritation and no other physician diagnosed radiculopathy or even had clinical findings to suggest it. We disagree.

A March 1, 1996 radiology study showed claimant had a mild compression fracture to the anterior aspect of C6. (Ex. 6). The insurer accepted a C6 chip fracture. (Ex. 52). As we discussed earlier, on April 16, 1996, Dr. Weller performed nerve conduction and EMG studies and concluded that the findings were suggestive of a left C8 radiculopathy. (Ex. 9-2). Drs. Brooks and Strum concluded that the C8 radicular changes on the initial EMG studies were "considered to be secondary to his on-the-job injury." (Ex. 69-9). Based on these reports, we find support for Dr. Kemple's conclusion that claimant's condition involved cervical nerve root irritation.

The insurer contends that Dr. Kemple's opinion is not persuasive because it is based on an incorrect assumption that claimant struck his elbow when he fell from the ladder on February 28, 1996. Claimant testified that he could not remember where he struck his elbow during the fall, but he knew he hit his elbow "somewhere along the line[.]" (Tr. 18-19). Dr. Olmscheid reported approximately one week after the injury that claimant had said he struck his left elbow when he fell. (Ex. 8). Based on claimant's testimony and Dr. Olmscheid's report, we are not persuaded that Dr. Kemple had an incorrect history.

Dr. Brooks concluded that, because the initial nerve conduction study in April 1996 was normal, he did not believe an association could be made between the February 28, 1996 injury and cubital tunnel neuropathy. (Ex. 62). The medical evidence, however, establishes that claimant had ulnar problems arising immediately after the injury. In the initial study in April 1996, Dr. Weller noted that claimant had acute denervation changes and felt claimant appeared to have "either C8 or ulnar numbness in the left hand." (Ex. 9-2). In a later report, Drs. Brooks and Strum said they could not rule out the possibility that claimant's ulnar neuropathy resulted from the February 1996 accident. They said that if claimant injured his elbow at the time of the fall, it was possible that some changes had taken place that resulted in an ulnar neuropathy at the elbow. (Ex. 69-10).

We find that Dr. Kemple's opinion concerning claimant's ulnar neuropathy condition is persuasive because it is well-reasoned and based on complete information. We conclude that claimant has established that the work injury was the major contributing cause of the ulnar neuropathy condition.

Lumbar Strain

The ALJ found that claimant had a preexisting condition in the lumbar spine and he had to establish compensability of the lumbar strain under a "major contributing cause" standard pursuant to ORS 656.005(7)(a)(B).

Claimant argues that there is no evidence of a "combined" condition and the "material" cause standard applies. He relies on Dr. Kemple's opinion to establish compensability of a lumbar strain.

For the following reasons, we agree with the ALJ that the major contributing cause standard applies to claimant's lumbar strain. The medical evidence establishes that claimant had preexisting degenerative disc disease in the lumbar spine. X-rays on February 29, 1996 showed claimant had degenerative disc disease at L5-S1. (Ex. 4). Dr. Kemple's reports referred to "preexisting" degenerative disc disease in the lumbar spine, as did the reports of Drs. Brooks, Strum and Peterson. (Exs. 54-10, 60, 69-8, -9, 70).

The medical evidence also establishes that claimant's preexisting degenerative disc disease in the lumbar spine combined with the February 1996 injury to cause disability and need for treatment. On September 15, 1997, Dr. Kemple reported that claimant's injury-related diagnosis continued to be lumbar strain "superimposed on preexisting degenerative disease" at L5-S1. (Ex. 60-2). On December 22, 1997, Dr. Kemple reported that claimant's low back problems had been "significant and clearly reflect a chronic strain pattern injury superimposed on previous degenerative changes." (Ex. 70-2). We interpret Dr. Kemple's reports to indicate that claimant's preexisting degenerative lumbar changes "combined" with the work injury to cause his disability and/or need for treatment. We agree with the ALJ that ORS 656.005(7)(a)(B) applies to the lumbar strain and claimant must prove that the February 1996 injury was the major contributing cause of the disability or the need for treatment of the lumbar strain.

Claimant was not diagnosed with a lumbar strain at the time of the February 28, 1996 injury. One day after the injury, Dr. Olmscheid reported that claimant complained of right hip pain, but Dr. Olmscheid did not diagnose a hip or back condition. (Ex. 3-1). X-rays on that date showed degenerative disc disease at L5-S1. (Ex. 4). On March 5, 1996, Dr. Olmscheid reported that claimant had no lower extremity symptoms and the lower extremities were "entirely normal." (Ex. 8).

Dr. Kemple first examined claimant on September 23, 1996, almost seven months after the work injury. (Ex. 14). He indicated claimant continued to have low back and hip pain. (Ex. 14-1). He diagnosed "[l]ow back, hip girdle pain" and noted that degenerative disc disease had been documented. (Ex. 14-3). The first diagnosis of a lumbar strain was on March 12, 1997. (Ex. 25). Dr. Kemple said claimant had persistent low back pain and he diagnosed a lumbar strain with chronic reactive features. (Ex. 25-2). On July 24, 1997, Dr. Kemple commented that the clinical presentation of low back pain "continues to include features of some underlying degenerative disease and a moderate reactive-myofascial component." (Ex. 48-1).

On December 22, 1997, Dr. Kemple reported that claimant's low back problems had been "significant and clearly reflect a chronic strain pattern injury superimposed on previous degenerative changes." (Ex. 70-2).

In contrast, Dr. Peterson concluded that claimant's lumbar complaints were related to preexisting underlying degenerative disease and were not related to the accepted condition. (Exs. 54-10, 57). Drs. Brooks and Strum opined that if claimant had a lumbar strain from the work injury, that type of injury would have been expected to resolve long ago. (Ex. 69-8).

We are not persuaded by Dr. Kemple's opinion. He did not explain why, if claimant had a lumbar strain resulting from the February 1996 injury, there was no diagnosis of a lumbar strain until March 1997. Furthermore, Dr. Kemple did not comment on Dr. Olmscheid's finding on March 5, 1996 that claimant had no lower extremity symptoms and the lower extremities were "entirely normal." (Ex. 8). Moreover, we are not persuaded by Dr. Kemple's opinion because he did not provide an explanation as to why claimant's low back symptoms were due to a lumbar strain, rather than the preexisting degenerative disc disease. We conclude that claimant has not established that the work injury was the major contributing cause of the disability or the need for treatment of the lumbar strain.

Cervical Strain

The ALJ found that claimant had a preexisting condition in the cervical spine and he had to establish compensability of the cervical strain under a "major contributing cause" standard pursuant to ORS 656.005(7)(a)(B).

Claimant argues that there is no evidence of a "combined" condition and the "material" cause standard applies. He relies on Dr. Kemple's opinion to establish compensability of a cervical strain.

Some of the medical evidence indicates that claimant had degenerative disc disease in the cervical spine. (Exs. 8, 14, 32). On the other hand, Dr. Peterson found no evidence of degenerative disease in the cervical spine. (Ex. 54-9). In any event, we find no medical evidence that establishes that any cervical disc disease preexisted the February 1996 injury. Moreover, we find no medical evidence that persuasively establishes that any such degenerative disc disease in the cervical spine "combined" with the work injury to cause the disability or need for treatment. Absent evidence that a preexisting condition combined with the February 1996 work injury, claimant need only establish that his work injury was a material contributing cause of his disability and need for treatment. *See* ORS 656.005(7)(a); *Beverly Enterprises v. Michl*, 150 Or App 357 (1997).

On the day after claimant was injured, Dr. Olmscheid reported that claimant had restricted cervical range of motion and tenderness in the C5-6 midline. (Ex. 3-2). He diagnosed neck pain with possible cervical upper dorsal compressive injury to the vertebral bodies. (*Id.*) A study on March 1, 1996 showed a mild compression fracture to the anterior aspect of the body of C6. (Ex. 6). The insurer subsequently accepted a chip fracture at C6. (Ex. 52). On March 5, 1996, Dr. Olmscheid reported that claimant had minimal cervical discomfort and modest restricted cervical range of motion. (Ex. 8).

On April 16, 1996, Dr. Weller performed EMG studies that he felt were suggestive of a left C8 radiculopathy. (Ex. 9-2). He reported that he was unable to obtain reliable findings in the paraspinalis muscles. (*Id.*) He commented that there was "so much activity due to cervical muscle spasm and inability to relax that it was largely futile to pursue a search for acute denervation changes." (*Id.*)

Dr. Kemple examined claimant on September 23, 1996 and reported that claimant continued to have neck and shoulder girdle pain. (Ex. 14-1). He diagnosed "[c]hronic evolving cervical - shoulder girdle pain syndrome" and noted that a significant component of cervical strain with associated disc disease seemed likely. (*Id.*)

Claimant continued to have complaints of neck pain. (Exs. 16, 20, 25). In April 1997, Dr. Kemple diagnosed a chronic cervicothoracic strain with reactive upper extremity pain and degenerative cervical spondylosis. (Ex. 32). On September 15, 1997, Dr. Kemple diagnosed a chronic cervical strain with chronic regional myofascial pain with radiation into his upper extremity. (Ex. 60-1).

On December 22, 1997, Dr. Kemple reported there was clear evidence of a cervical soft tissue injury, as well as anticipated degenerative problems. (Ex. 70-2). He also felt residual cervical radicular irritation was also likely. (*Id.*)

Based on Dr. Kemple's reports, as well as the medical reports shortly after the injury that referred to reduced cervical range of motion and cervical muscle spasm, we conclude that claimant's February 1996 work injury was a material contributing cause of a cervical strain. In addition, we rely on the report from Drs. Brooks and Strum that acknowledged that claimant may well have suffered a cervical strain as a result of his work injury. (Ex. 69-8).

Extent of Scheduled Permanent Disability

A September 4, 1997 Order on Reconsideration awarded claimant 5 percent scheduled permanent disability for a sensory loss of the left ring and little finger. (Ex. 59). The ALJ reduced claimant's scheduled permanent disability to zero. The ALJ was not persuaded by the medical arbiter's opinion that claimant's ulnar nerve problems were related to the accepted condition.

Claimant contends that if the ulnar neuropathy condition is found compensable, he will be evaluated for disability related to that condition at closure. He argues that because the insurer has not accepted all the conditions related to the February 1996 work injury, the closure is premature and should be set aside.

In this order, we have determined that claimant's ulnar neuropathy and cervical strain conditions are compensable. Neither of those conditions was an accepted condition at the time of claim closure. For the following reasons, we reject claimant's argument that the closure was "premature" because the insurer had not accepted all the conditions related to the February 1996 work injury.

In *Anthony J. Telesmanich*, 49 Van Natta 49, 51 (1997), *on recon* 49 Van Natta 166 (1997), we held that, where the carrier has accepted additional conditions after issuance of an Order on Reconsideration, the proper procedure at hearing on the Order on Reconsideration is to rate the conditions accepted at the time of the Order on Reconsideration and remand the later accepted conditions to the carrier for processing according to law. *See also* ORS 656.262(7)(c)[1]; *Bernard G. Hunt*, 49 Van Natta 223 (1997). Therefore, in rating permanent disability under the current statutory scheme, the focus is on accepted conditions at the time of claim closure and reconsideration. *See Janet R. Christensen*, 50 Van Natta 1152 (1998) (evaluation of conditions ordered accepted after claim closure must await the reopening and processing of the claim for that new condition); *James Mack*, 50 Van Natta 338 (1998). Here, the evaluation of claimant's ulnar neuropathy and cervical strain must await the reopening and processing of those claims.

We proceed to review claimant's extent of disability based on the accepted conditions at claim closure. Here, the insurer initially accepted a "[l]ow voltage electrical injury." (Ex. 21). On August 4, 1997, the insurer issued an "updated notice of acceptance at closure," referring to the accepted conditions as low voltage electrical injury to the chest and upper extremities, fracture of 11th rib and chip fracture, C6. (Ex. 52). A September 4, 1997 Order on Reconsideration awarded claimant 5 percent scheduled permanent disability for a sensory loss of the left ring and little finger (Ex. 59), which was reduced to zero by the ALJ.

The insurer argues that, without its acceptance of the ulnar neuropathy condition, either voluntarily or via litigation, the Department did not have authority to award disability related to that condition. The insurer ignores ORS 656.268(16), which provides that "[c]onditions that are direct medical sequelae to the original accepted condition shall be included in rating permanent disability of the claim unless they have been specifically denied."

Under ORS 656.266, claimant has the burden of proving the nature and extent of any disability resulting from a compensable injury. In *Julio C. Garcia-Caro*, 50 Van Natta 160 (1998), we considered whether the claimant's unaccepted cervical and thoracic conditions were "direct medical sequela" under ORS 656.268(16) of the accepted right shoulder tendonitis condition. Based on the language of ORS 656.268(16), as well as ORS 656.262(7) and 656.283(7), we concluded that, in the absence of evidence that the unaccepted conditions were "direct medical sequela" of the *accepted condition* (as opposed to the accidental injury from which the accepted condition arose), the claimant was not entitled to permanent disability based on the unaccepted conditions. *See also Donald D. Davis*, 50 Van Natta 357, *on recon* 50 Van Natta 682 (1998) (the claimant failed to show that claimant's epicondylitis condition was a "direct medical sequela" of the accepted left elbow contusion).

After reviewing the record, we are not persuaded that claimant's impairment constituted a "direct medical sequela" to the accepted conditions.

Claimant was found medically stationary on March 12; 1997, based on reports from Dr. Kemple. (Exs. 25, 26). Dr. Duff examined claimant on May 9, 1997 and reported that the examination was characterized by a lot of nonorganic, functional findings, with range of motion and strength testing clearly invalid and with no indication there was any residual impairment. (Ex. 35-5). A Notice of Closure issued on June 9, 1997 awarding no permanent disability. (Ex. 37).

Claimant requested reconsideration. (Ex. 40). Dr. Peterson, neurologist, performed a medical arbiter examination. (Ex. 54). Dr. Peterson reported that two point discrimination was impaired in the left ring and index fingers, which corresponded to the ulnar nerve distribution. (Ex. 54-8). She explained:

> "[Claimant] does have slight limitation in ability to repetitively use the ring and little fingers of the left hand because of sensory loss. No weakness was encountered. This is felt to be attributable to the ulnar nerve condition. *If this is considered one of the accepted conditions*, then there is limited ability to repetitively use the hand on the basis of this injury. *It is not clear to this examiner, however, whether this is to be considered an accepted condition.*" (*Id*; emphasis added).

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[1] ORS 656.262(7)(c) provides that "[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."

The Department subsequently asked for clarification from Dr. Peterson and she responded that claimant's "sensory loss on the left is attributable to ulnar nerve condition. I have difficulty excluding 'ulnar nerve' from 'low voltage electrical injury to upper extremity.'" (Ex. 57-2).

The September 4, 1997 Order on Reconsideration concluded that claimant's sensory loss in the fingers was a "direct sequela of the accepted electrical injury to the left upper extremity" and awarded 5 percent scheduled permanent disability. (Ex. 59-2).

The accepted conditions at the time of closure were a low voltage electrical injury to the chest and upper extremities, fracture of the 11 rib and a chip fracture at C6. (Exs. 21, 52). We find no persuasive medical evidence that claimant's impairment was a "direct medical sequela" of any of the accepted conditions at claim closure. Dr. Peterson reported that claimant's sensory loss was "attributable to the ulnar nerve condition." (Ex. 54-8). In her first report, she said it was not clear whether that was to be considered an accepted condition. (*Id.*) In a later report, however, Dr. Peterson indicated that she had "difficulty excluding" the ulnar nerve condition from the electrical injury. (Ex. 57-2). We conclude that Dr. Peterson's conclusory statement in her later report is insufficient to establish that claimant's sensory loss constituted a "direct medical sequela" to the accepted conditions.

Based on this record, we conclude that claimant is not entitled to a permanent disability award for sensory loss in his left hand. In reaching this conclusion, we note that, by virtue of this order, claimant's ulnar neuropathy and cervical strain conditions will be remanded to the insurer for processing acording to law. If claimant is dissatisfied with the processing and rating of those conditions, he may request reconsideration and/or a hearing at the appropriate time. *See Janet R. Christensen*, 50 Van Natta at 1152.

Claimant also argues that he is entitled to a 5 percent chronic condition award for his limitations on "fingering and feeling." (Appellant's brief at 10). The September 4, 1997 Order on Reconsideration noted that a "chronic and permanent medical condition which would *significantly* limit repetitive use of either hand, wrist/forearm or elbow/arm was not identified." (Ex. 59-2; emphasis in original).

Former OAR 436-035-0010(5) (WCD Admin Order 96-072) provides, in part:

"A worker is entitled to a 5% scheduled chronic condition impairment value for each applicable body part, stated in this section, when a preponderance of medical opinion establishes that, due to a chronic and permanent medical condition, the worker is *significantly* limited in the repetitive use of one or more of the following four body parts:

"* * * * *

"(c) Forearm (below elbow/hand/wrist); and/or

"(d) Arm (elbow and above)." (Emphasis added).

Dr. Peterson reported that claimant had a "slight limitation in ability to repetitively use the ring and little fingers of the left hand because of sensory loss." (Ex. 54-8). Dr. Peterson concluded that there may be "some limitation in fingering and feeling with the ring and little fingers of the left hand on the basis of the ulnar neuropathy if it is to be considered an accepted condition." (Ex. 54-11). However, Dr. Peterson's report does not establish that claimant is *significantly* limited in the repetitive use of his hand. We conclude that claimant is not entitled to a 5 percent chronic condition award.

Attorney Fees

Claimant's attorney is entitled to an assessed fee for services at hearing and on review regarding compensability of the ulnar neuropathy and cervical strain 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 regarding compensability of the ulnar neuropathy and cervical strain conditions is $4,500, 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 briefs), the complexity of the issues, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated March 23, 1998 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 ulnar neuropathy and cervical strain conditions are reversed. Those denials are set aside and the claims are remanded to the insurer for processing in accordance with law. The remainder of the ALJ's order is affirmed. For services at hearing and on review regarding compensability of the ulnar neuropathy and cervical strain conditions, claimant's attorney is awarded $4,500, payable by the insurer.

In the Matter of the Compensation of
JENNIFER BRADLEY, Claimant
WCB Case Nos. 95-10232 & 95-09669
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Nichols' order that: (1) upheld the self-insured employer's denial of her injury claim for a right shoulder condition; and (2) declined to award a penalty for allegedly unreasonable claims processing. Claimant also moves for remand to the ALJ for the consideration of additional evidence. The employer cross-requests review of that part of the ALJ's order that set aside its denial of claimant's left shoulder injury. On review, the issues are remand, compensability and penalties.

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

In conjunction with her opening brief, claimant moved for remand contending that the record was inadequately developed. Claimant also submitted two pieces of additional evidence which, she asserts, undermines the testimony of one of the employer's witnesses.

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). 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); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

Here, we find no compelling reason to remand, as we are not persuaded that the proffered evidence (pictures of "u-racks" allegedly similar to the one on which claimant was assigned to cut on May 18, 1995, and claimant's "daily production ticket" for that day) would likely affect the outcome of this case. In other words, even if we were to consider the proffered evidence (and accept as accurate claimant's testimony that she cut five boards rather than three and that this was the last task she completed prior to leaving work on May 18, 1995), we would continue to agree with the ALJ that claimant has failed to prove by a preponderance of the evidence that her right shoulder condition was caused by her work exposure on May 18, 1995.

Insofar as we have not reduced the compensation awarded to claimant with regard to her compensable left shoulder injury 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 left shoulder issue is $500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to this compensability issue (as represented by claimant's cross-respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated March 12, 1998 is affirmed. For services on review with regard to the compensability of claimant's left shoulder injury, claimant's counsel is awarded $500, payable by the employer.

In the Matter of the Compensation of
STEPHEN L. DOKEY, Claimant
WCB Case No. 97-08888
ORDER ON REVIEW
Linerud Law Firm, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Myzak's order that upheld the SAIF Corporation's denial of claimant's current low back condition. On review, the issues are whether claimant is precluded from litigating compensability of his current condition and, if not, compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for lumbar strain and L4-5 herniated disc as a result of a 1983 work injury. In November 1995, SAIF issued a denial of claimant's then-current treatment for his low back, right buttock and leg. Claimant did not contest the denial.

The ALJ decided that the uncontested November 1995 denial precluded claimant from litigating compensability of his current low back condition. In particular, the ALJ found that, although worse, claimant's condition in November 1995 was the same one for which he was currently seeking benefits and, in the absence of evidence that subsequent work exposure caused the worsening, claim preclusion applied.

Claimant challenges this conclusion, arguing that, because his current low back condition worsened following the November 1995 denial, he is not precluded from litigating compensability. Claimant further contends that he proved the major contributing cause of his current need for treatment and disability is his 1983 injury.

Claimant's current diagnosis is degenerative disc disease at L4-5. (Exs. 25-1, 27-2). Dr. Keenen, claimant's treating physician, reported that "the November, 1995 chronic low back pain, right buttock and leg pain continue to date, and represent an overall material worsening of the original degenerative disc process that began with the L4-5 disc herniation in 1983." (Ex. 27A-1). Dr. Brett, neurosurgeon, stated that claimant's "on-going low back difficulties and current discomfort, disability, and need for treatment and investigation are a direct result of his original work injury of 1983 in all medical probability; and this remains a major contributing factor." (Ex. 31-2).

We find such evidence shows that claimant's current need for treatment is for the same condition that was treated in 1995 and the subject of the November 1995 denial. We disagree with claimant, however, that the record establishes that claimant's condition has worsened since November 1995. Although indicating that claimant's condition began in 1983 and worsened since that date, neither Dr. Keenen nor Dr. Brett distinguish between claimant's condition in 1995 and 1997. That is, neither physician affirmatively indicates that claimant's condition has worsened since 1995.

Thus, we do not find a preponderance of evidence establishing that claimant's condition has worsened since November 1995. For that reason, we agree with the ALJ that claimant is precluded by the uncontested November 1995 denial from litigating compensability of his current condition. *See, e.g., Liberty Northwest Ins. Corp. v. Bird*, 99 Or App 560 (1989, *rev den* 309 Or 645 (1990).

Alternatively, even if claimant was not precluded, we find the medical evidence inadequate to carry his burden of proving compensability. When Dr. Keenen and Dr. Brett provided their reports, both had seen claimant on a single occasion. Thus, we find that neither physician is entitled to the deference normally given to a treating physician's opinion. *See Weiland v. SAIF*, 64 Or App 810 (1983). Moreover, neither physician provides any reasoning explaining how the 1983 injury caused claimant's degenerative disc disease and why that incident continues to be the cause of any worsening. Consequently, we do not find their opinions to be well-reasoned. *See Somers v. SAIF*, 77 Or App 259 (1986).

ORDER

The ALJ's order dated March 27, 1998 is affirmed.

In the Matter of the Compensation of
GRACIELA KASPRZYK, Claimant
WCB Case No. 97-07598
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Mannix, Nielsen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Livesley's order that: (1) directed it to recalculate claimant's temporary disability compensation based on a full-time work week; and (2) assessed a penalty based upon the insurer's allegedly unreasonable claim processing. On review, the issues are rate of temporary disability and penalties. We reverse.

FINDINGS OF FACT

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

Claimant worked for the employer, a fast-food restaurant, for five months in 1995. She was rehired to work at a new location in November 1996, and began working on November 11, 1996.

Claimant was compensably injured on November 13, 1996, when she slipped and fell. She did not miss work, however, until after she sought treatment on November 18, 1996, at which time she was released for part-time light duty work.

At the time claimant was rehired by the employer, she was looking for full-time employment. She advised the employer that she was available to work the 5:00 a.m. to 1:00 p.m. or 6:00 a.m. to 2:00 p.m. shift, Monday through Friday.

The employer posts the employees' weekly work schedules at the work place. The work schedules change from week to week for a majority of the employees, and are dependent upon the restaurant's needs, the time of year, the employee's skill and training, and the employee's availability for certain (higher volume) days and hours.

In her first week, beginning on November 11, 1996, claimant was scheduled to work for three hours on Monday, three hours on Tuesday, four hours on Wednesday, five hours on Thursday and seven and a half hours on Friday, for a total of 22-1/2 hours, less scheduled breaks. (Ex. A).

The employer's payroll records indicate that, during her first week, claimant actually worked 3.17 hours on Monday, 3.0 hours on Tuesday, 4.05 hours on Wednesday, 5.12 hours on Thursday and 7.03 hours on Friday for a total of 22.37 hours. (Ex. 8).

Mr. Beaulaurier completed the "Employer" section of claimant's 801 form on November 20, 1996. He indicated in box 43 that claimant's working shift was from 5:00 a.m. to 1:00 p.m. and in box 49 that she worked "approx. 3" days per week. In completing the total weekly wage section (box 47), Beaulaurier noted "we do variable hours scheduling. Worker only recently started work -- worked only 6 days." In box 48, he placed an "X" indicating that Saturdays and Sundays were claimant's scheduled days off.[1] (Ex 2).

The insurer calculated the rate of claimant's temporary disability compensation based on the assumption that claimant worked 4.75 hours a day, 5 days per week for a total of 23.75 hours per week. (Ex. 8).

CONCLUSIONS OF LAW AND OPINION

Finding that the parties intended at the time of her hire that claimant would be employed full-time (35 hours per week) over a five-day work week, the ALJ remanded the claim to the insurer for recalculation based upon that weekly schedule. On review, the insurer asserts that claimant failed to prove by a preponderance of the evidence that she was hired to work on a regular, full-time basis. We agree.

This dispute is governed by OAR 436-060-0025(5)(a) (WCB Admin. Order 96-053), which provides, in pertinent part, as follows:

> "(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 four weeks, insurers shall use the intent of the most recent wage earning agreement as confirmed by the employer and the worker."

We determine the parties' intent of the most recent wage earning agreement by reviewing the information provided by the employer on the "801" form and the testimony at hearing. *See Qualified Contractors v. Smith*, 126 Or App 131 (1994); *Dean A. Stubbs*, 49 Van Natta 1068, *on recon* 49 Van Natta 1481 (1997); *Ralph L. Keller*, 48 Van Natta 146 (1996).

As set forth above, the 801 form indicated that claimant was scheduled to work "variable hours," that she worked "approx[imately] 3 days per week" and that her shift was from 5:00 a.m. to 1:00 p.m. The employer provided no legible response in box 44 (the number of hours worked per shift) and indicated that claimant's scheduled days off were Saturday and Sunday (although Monday and Tuesday were also "x"ed, but then crossed out). (Ex. 2).

Claimant testified at hearing that she was looking for full-time work (35 hours a week) when she accepted employment with the employer. She further testified that she advised Ms. Beaulaurier, a co-owner of the employer, that she was available to work Monday through Friday, on the 5:00 a.m. to 1:00 p.m. or 6:00 a.m. to 2:00 p.m. shift. (Tr. 8-10). She also understood that, because she would be training her first week, her hours would be less than her regular full-time schedule. (Tr. 10).

On the other hand, Mrs. Beaulaurier testified that because claimant was only available during the early shift on weekdays, had no seniority and was only qualified for certain positions (*i.e.*, grilling and cleaning, but not the front counter), she was not hired as a full-time employee. (Tr. 19-1, 21-23). Mrs. Beaulaurier also testified that she did not know claimant wanted full-time work, but that even if she did know, she would not have offered claimant such work because the restaurant did not have any full-time positions available for someone of claimant's skill level and stated availability. (Tr. 26-26). She

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[1] "X"'s were also placed in the Monday and Tuesday boxes, and then crossed out. (Ex. 2).

further explained that because the restaurant was relatively new, the employer did not know what its staffing needs would be for the upcoming months and therefore could not promise claimant any regular schedule or fixed hours every week. (Tr. 22-24). Finally, Mrs. Beaulaurier testified that claimant was scheduled for more hours in her first week than what she would have ordinarily worked because she had an additional training day and she filled in for another employee who was out sick. (Tr. 24).

Mr. Beaulaurier, the other owner, testified that he understood claimant was hired to work part-time, three days a week and three to four hours a day. (Tr. 36). He also testified that, given claimant's stated availability (the early shift on weekdays only), her limited experience and the particular needs of the restaurant at the time she was hired, she would not have been offered full-time employment. (Tr. 35-36).

After considering the information provided on the 801 form and the testimony at hearing, we are not persuaded that claimant was hired under an agreement to work on a full-time, regular basis. Although the evidence establishes claimant desired full-time work, she has not shown that the employer agreed or intended that she work a regular schedule of five days a week, seven and a half hours a day. Indeed, the indication on the 801 that claimant worked "approximately three" days per week with "variable hours scheduling," is consistent with the employer's position that claimant was hired to work on a part-time, as needed basis.[2] Under these circumstances, it was appropriate for the insurer to base claimant's time loss rate on an average of 23.75 hours per week.

Finally, because we have found no error in the insurer's calculation of claimant's temporary disability compensation based on a part-time, 23.75 hour work week, no penalty is warranted under ORS 656.262(11).

ORDER

The ALJ's order dated February 23, 1998 is reversed. The insurer's calculation of claimant's temporary disability compensation based on a 23.75 hour work week is reinstated and affirmed. The ALJ's penalty-based attorney fee is also reversed.

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[2] The notation in boxes 43 and 48 that claimant's shift was from 5:00 a.m. to 1:00 p.m., and that her scheduled days off were Saturday and Sunday is consistent with claimant's stated availability for work. Unlike the ALJ, however, we do not construe this information as persuasive evidence of an agreement that claimant would be regularly scheduled for this 8 hour shift five days a week, especially in light of other indications and comments in the 801 to the contrary.

In the Matter of the Compensation of
JOHN W. HOLLEY, Claimant
WCB Case No. 97-10447
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Neil W. Jones, Defense Attorney

Reviewed by Board Members Moller and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) determined that its denial was a procedurally invalid "pre-closure" denial; and (2) awarded an assessed fee of $3,600. On review, the issues are the propriety of the insurer's denial and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Preclosure Denial

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

The ALJ set aside the insurer's denial, finding that it was an impermissible "pre-closure" partial denial. On review, the insurer contends that, when the denial was issued, the claim was in nondisabling status. Thus, the insurer asserts its denial was procedurally valid because there was no claim to close.

Subsequent to its denial, however, the insurer changed the claim status to "disabling" and issued a Notice of Closure. (Exs. 18, 19). Therefore, the insurer's denial preceded closure of the claim. Under such circumstances, the claim's nondisabling "status" when the denial issued does not make the denial procedurally valid. Furthermore, because the insurer does not dispute the ALJ's finding that ORS 656.262(7)(b) (allowing pre-closure denials of "combined" conditions) is inapplicable, we conclude that the ALJ properly set aside the insurer's denial as an invalid "pre-closure" denial.

Attorney Fees

The insurer contends that the ALJ's attorney fee award was excessive. For the following reasons, we modify the ALJ's award.

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

Here, claimant's counsel has not submitted a statement of services. With respect to the time devoted to the case, the hearing in this matter consisted of only brief oral closing arguments. No witnesses testified. Applying the first factor in this case, we consider the time devoted to the case to have been minimal.

Next, we find that the issue concerning the procedural propriety of the insurer's denial was of average complexity. The value of the interest involved has not been shown to be above average, as the condition at issue is claimant's ongoing disability and need for treatment for his current right wrist condition. The nature of the proceeding was relatively uncomplicated as it concerned the procedural validity of the insurer's denial, which entailed a brief hearing without witnesses.

Claimant did receive a benefit from her attorney's services in obtaining the reversal of the insurer's denial of his current wrist condition. Considering the insurer's defense to the claim, there was a risk that counsel's services would go uncompensated. There was no assertion of frivolous issues.

After considering these factors, we conclude that $1,500 is a more appropriate attorney fee award in this case. In reaching this conclusion, we particularly rely on our findings that the time devoted to the case was below average, the interest to claimant was of average value, and the issue and the nature of the proceeding were not complicated. *Compare Michael C. Leggett*, 50 Van Natta 151, *on recon* 50 Van Natta 754 (1998) (awarding $2,500 for services at hearing, on review, and on reconsideration concerning impermissible pre-closure denial issue). Consequently, the ALJ's attorney fee award of $3,600 is modified to $1,500.

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 $750, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant's attorney is not entitled to a fee for services pertaining to the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated April 28, 1998 is modified in part and affirmed in part. The ALJ's attorney fee award is modified. In lieu of the ALJ's award, claimant's counsel is an assessed fee of $1,500, to be paid by the insurer. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $750, payable by the insurer.

In the Matter of the Compensation of
NINA M. RICCI, Claimant
WCB Case No. C8-01555
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Reinisch, et al, Defense Attorneys

Reviewed by Board Member Hall and Haynes.

On July 8, 1998, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for her compensable injury. We approve the proposed disposition.

Parties may dispose of all matters concerning a claim, except for medical services, with a CDA "subject to such terms and conditions as the Workers' Compensation Board may prescribe." ORS 656.236(1). The worker, insurer or self-insured employer may request disapproval of the disposition within 30 days of its submission to the Board. ORS 656.236(1)(a)(C). Notwithstanding this provision, however, the CDA may provide for waiver of the 30-day period if the worker was represented by an attorney at the time the worker signed the disposition. ORS 656.236(1)(b). This rule requires that the first page of the CDA contain a "statement indicating whether or not the parties are waiving the "30-day" approval period of ORS 656.236(1)(a)(C) as permitted by ORS 656.236(1)(b)."

The first page of the agreement includes the required statement indicating that the parties do not wish to waive the "30-day" cooling off period. However, the body of the document on page 4, line number 4 - 6, provides that the parties request a waiver of the 30-day statutory period. Nonetheless, because claimant is unrepresented, the Board is without statutory authority to waive the "30-day" cooling off period. *See Kathleen McKay*, 49 Van Natta 2062 (1997). Thus, consistent with the first page of the document, we conclude that the "waiver" language was left in the body of the agreement inadvertently. Thus, we do not interpret the agreement as attempting to waive the 30-day period.

We conclude the agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
GREGORY C. NOBLE, Claimant
WCB Case No. 97-05971
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) Black's order that: (1) found that claimant was not entitled to temporary disability; and (2) declined to assess a penalty for the insurer's allegedly unreasonable failure to pay temporary disability. On review, the issues are temporary disability and penalties.

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

Claimant has previously injured his right knee and has preexisting degenerative conditions in that knee. On October 28, 1995, claimant injured his right knee at work. On February 2, 1996, the insurer denied claimant's right knee injury claim. That denial was upheld by an ALJ. However, by order dated June 16, 1997, the Board reversed that ALJ's decision, set aside the denial, and remanded the claim to the insurer for processing according to law. *Gregory C. Noble*, 49 Van Natta 764 (1997). The court has affirmed that decision. *Liberty Northwest Insurance Corporation v. Noble*, 153 Or App 125 (1998).

Pursuant to ORS 656.313(1)(a)(A), filing by the insurer of a court appeal stays payment of the compensation appealed, except for "[t]emporary disability benefits that accrue from the date of the order appealed from until closure under ORS 656.268, or until the order appealed from is itself reversed, whichever event first occurs."

Although our prior decision was appealed, claimant's claim remains in open status. "Procedural" temporary disability benefits are those benefits payable under ORS 656.268 while an accepted claim is in open status. *See SAIF v. Taylor*, 126 Or App 658 (1994). Entitlement to procedural temporary disability benefits is contingent upon authorization of temporary disability benefits by the attending physician. ORS 656.262(4)(g);[1] *Kenneth P. Bundy*, 48 Van Natta 2501 (1996); *Gerald A. Zeller*, 48 Van Natta 501, *on recon* 48 Van Natta 735 (1996). Because the issue of entitlement to temporary disability on an open claim necessarily involves satisfaction of the statutory requirement of ORS 656.262, it is claimant's burden to prove his entitlement to temporary disability benefits. ORS 656.266.

In support of his contention that he is entitled to procedural temporary disability benefits, claimant argues that he was not medically stationary during the period in question. Pursuant to ORS 656.262(4)(g), the determining factor in determining entitlement to procedural temporary disability is an attending physician's authorization for temporary disability for the period in question, not the worker's medically stationary status. Therefore, under the facts of this particular case, the issue before us is whether claimant's attending physician, Dr. Lange, authorized temporary disability benefits for any part of the period after June 16, 1997, the date of the appealed Board order. Any procedural temporary disability that would otherwise be due prior to that date is stayed pending appeal. ORS 656.313(1)(a)(A).

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[1] ORS 656.262(4)(g), renumbered from ORS 656.262(4)(f) in 1997, 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."

We agree with the ALJ that the record contains no time loss authorization from Dr. Lange for the period in question. In contrast, earlier in the claim, Dr. Lange issued specific time loss authorizations and was aware of the procedures for authorizing time loss.

In a January 31, 1996 response to a report by two examining physicians, Dr. Lange stated "[i]t is my opinion that [claimant] will not be able to return to work without having total knee replacement arthroplasty surgery performed." (Ex. 12-2). Claimant argues that Dr. Lange's statement provided an "open ended" time loss authorization. Claimant also argues that, pursuant to OAR 436-060-0020(11)[2] and Dr. Lange's "open ended" time loss authorization, the insurer was required to begin paying time loss as of the date of the Board order setting aside the insurer's denial. The insurer argues that: (1) Dr. Lange's statement is not an "open ended" time loss authorization; (2) OAR 436-060-0020(11) does not apply to this claim because the denied claim has not finally been determined compensable since it remains under appeal; and (3) the requirement in OAR 436-060-0020(11) that "retroactive" periods of time loss be paid is contrary to ORS 656.313, which only requires payment of prospective periods of time loss during the pendency of an appeal.

We need not address the insurer's arguments because assuming, without deciding, that OAR 436-060-0020(11) applies and Dr. Lange's statement represented an "open ended" time loss authorization, under the facts of this case, claimant has not established entitlement to time loss.

Dr. Lange stated that claimant was unable to work without undergoing a total knee replacement surgery. Dr. Lange's statement was "open ended" only in relationship to the recommended surgery. *See Larry D. Northey*, 49 Van Natta 875, 876 (1997) (where a physician's statement authorized time loss "until" a further medical appointment, time loss was authorized only until that time). However, claimant underwent that surgery on April 23, 1997, well before the June 16, 1997 Board order that set aside the insurer's denial. Therefore, any "open ended" time loss authorization ended before the relevant period began, *i.e.*, before June 16, 1997. Furthermore, Dr. Lange provided no subsequent time loss authorization.

Claimant argues that time loss was authorized for a reasonable period of recovery following the surgery. However, given the statutory mandate that procedural time loss must be authorized by the attending physician, we are not authorized to award time loss based on such an assumption. ORS 656.262(4)(g); *see Joann K. Russum*, 48 Van Natta 1289 (1996) (no evidence of attending physician authorization for temporary disability after low back surgery; therefore, pursuant to *former* ORS 656.262(4)(f), the claimant was not entitled to procedural temporary disability benefits).

Accordingly, on this record, we agree with the ALJ that claimant has failed to establish entitlement to procedural temporary disability benefits.

ORDER

The ALJ's order dated December 17, 1997, as reconsidered on January 29, 1998, is affirmed.

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[2] OAR 436-060-0020(11) provides:

"If a denied claim has been determined to be compensable, the insurer shall begin temporary disability payments pursuant to ORS 656.262, including retroactive periods, if the time loss authorization was open ended at the time of denial, and there are no other lawful bases to terminate temporary disability."

In the Matter of the Compensation of
AMELIA VILLANUEVA, Claimant
WCB Case No. 97-07789
ORDER ON REVIEW
Rodolfo A. Camacho, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order that set aside its denial of claimant's injury claim for a right knee condition. On review, the issue is whether claimant's injury arose out of and in the course of employment.

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

The ALJ set aside the insurer's denial of claimant's right knee injury claim, finding that claimant's injury arose out of and in the course of her employment. In reaching this conclusion, the ALJ found claimant's testimony credible based on observation of her conduct and demeanor. "Construe[ing] all ambiguities in the record in claimant's favor," the ALJ determined that, as she testified, claimant's right knee injury occurred when she slipped on water while stepping from the top step of a stairway onto a concrete floor at work.

Citing ORS 656.012(3), the insurer contends on review that the ALJ's decision to construe all ambiguities in claimant's favor is not consistent with the statutory directive to interpret workers' compensation law in an impartial and balanced manner. The insurer's contention notwithstanding, we do not find that the alleged statutory violation occurred.

Reading the order in its entirety, it appears that the ALJ was merely giving effect to his finding that claimant was a credible witness based on observation of her demeanor and conduct at hearing. Thus, the ALJ resolved ambiguities or conflicts in the evidence consistent with his determination that claimant was a credible witness. The ALJ's decision to accept claimant's credible testimony is consistent with the policy which underlies the well-settled precedent that holds that deference is given to demeanor-based credibility findings. *See e.g. International Paper Co. v. McElroy*, 101 Or App 61, 64 (1990).

Given the ALJ's credibility finding, we, like the ALJ, accept claimant's testimony as to how her injury occurred. Based on that credible testimony, we agree with the ALJ's finding that claimant satisfied her burden of proving that her right knee injury arose out of and in the course of employment, and, thus, is compensable. Accordingly, we affirm.

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

ORDER

The ALJ's order dated March 20, 1998 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
JANET F. BERHORST, Claimant
Own Motion No. 98-0129M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our June 29, 1998 Own Motion Order on Reconsideration, in which we declined to reopen her claim for the payment of temporary disability compensation because she failed to establish that she was in the work force at the time of disability.

On July 7, 1998, we abated our June 29, 1998 order, and allowed the SAIF Corporation 14 days in which to file a response to the motion. Inasmuch as that time has expired without a response, we proceed with our reconsideration.

In our prior order we found that the medical documentation contained in the record did not satisfy claimant's burden of proof regarding the "futility standard" of the third criterion expressed in *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989). On reconsideration, we continue to adhere to our previous findings.

Claimant submits two new medical reports and an unsworn statement in support of her contention that she was in the work force at the time of her current disability. The reports summarize Dr. Herrington's medical examinations of February 18 and March 26, 1997. As the medical reports contained already in the record, Dr. Herrington's reports outline claimant's deteriorating physical condition. They do not address how her deteriorating condition affected her ability to work and/or seek work.

Claimant argues that the doctors with whom she treated logically would not have addressed her work force status because she told them she was a housewife.[1] However, the fact remains that, regardless of why her physicians made no reference to her work status, we continue to find that the record still does not contain a competent medical opinion that claimant was unable to work and/or seek work due to her compensable condition.

Further, claimant continues to argue that we should "draw a logical conclusion" that claimant was unable to work and/or seek work due to her compensable condition from the medical documentation wherein the "objective findings and subjective symptoms support claimant's sworn affidavit that she was unable to work or look for work due to her condition." However, we are without the medical expertise to infer such an opinion, especially considering that none of the physicians render such an opinion or make any statements from which we can draw such an opinion. Again, we continue to find that, although her physicians thoroughly discuss her deteriorating condition, claimant fails to meet her burden of proof by providing a medical opinion that relates this deteriorating condition to her ability to work and/or seek work.

Finally, claimant cites *Bethel A. Lamping*, 50 Van Natta 883 (1998) and *Barbara M. Johnson*, 50 Van Natta 882 (1998) in support of her contention that Dr. Bailey's January 12, 1998 chart note, wherein he retroactively authorized time loss, is sufficient to support her burden of proof regarding the "futility standard." We disagree. We consider the "futility" standard on a case-by-case basis and determine if the record before us in each particular case supports the finding that it would have been futile for a claimant to work and/or seek work due to the compensable condition. In both *Lamping* and *Johnson*, we found the treating physicians' opinions clearly stated that the claimants were unable to work or seek

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[1] Claimant contends that had "she had an attorney at her side, or been carrying around a copy of Chapter 656 - she would have clarified in no uncertain terms to her physicians that the reason she was no longer gainfully employed or seeking gainful employment was because of her documented, deteriorating condition (due to her original work injury)." Whether it would be futile for claimant to seek work is not a subjective test viewed through the eyes of claimant; it is an objective test determined from the record as a whole. While claimant's own impressions of futility are probative, whether a work search is futile is determined objectively by evaluation of the totality of the record. The question is whether it is futile for claimant to make reasonable efforts, not whether claimant reasonably believes it to be futile.

work during the current period of disability due to the compensable condition. Here, Dr. Bailey simply authorizes time loss and his conclusory opinion is without explanation. Lacking a reasoned medical conclusion explaining why it would be futile for claimant to attempt to work and/or seek work, we are unable to find that it would be medically futile for claimant to work and/or seek work.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our April 15, 1998 and June 29, 1998 orders effective this date. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

August 12, 1998 Cite as 50 Van Natta 1579 (1998)

In the Matter of the Compensation of
FOREST G. HULL, Claimant
WCB Case No. 97-05568
SECOND ORDER ON RECONSIDERATION
Martin L. Alvey, Claimant Attorney
VavRosky, et al, Defense Attorneys

On August 3, 1998, we issued our Order on Reconsideration which withdrew and republished our July 6, 1998 order. In our initial Order on Review, we affirmed an Administrative Law Judge's (ALJ's) order that set aside the self-insured employer's partial denial of claimant's current cervical-thoracic condition.

On August 4, 1998, we received claimant's response to the employer's request for reconsideration. In addition to contending that we properly affirmed the ALJ's order, claimant requests an assessed attorney fee for services on reconsideration. We treat claimant's response as a request for reconsideration.

Inasmuch as we found that claimant's compensation should not be disallowed or reduced, we conclude that claimant's attorney is entitled to an assessed fee for services provided in responding to the employer's reconsideration request. 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 reconsideration is $262.50, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's response to the employer's arguments regarding the issue of compensability), the complexity of the issue, and the value of the interest involved.

Accordingly, we withdraw our prior orders. On reconsideration, as supplemented and modified herein, we adhere to and republish our July 6, 1998 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED

In the Matter of the Compensation of
NGA H. BURSON, Claimant
WCB Case Nos. 97-08998 & 97-02515
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The Hartford Insurance Company (Hartford) on behalf of its insured (Olsten Corporation) requests review of Administrative Law Judge (ALJ) Crumme's order that: (1) set aside its denial of compensability of and responsibility for claimant's occupational disease claim for a left elbow condition; (2) upheld Kemper Insurance Company's (Kemper's) denial of the same condition on behalf of Candice Burns Foods; and (3) awarded claimant an assessed fee of $2,500 pursuant to ORS 656.386(1) and $500 pursuant to ORS 656.308(2)(d). Hartford also contests the ALJ's admission of Exhibit 87. On review, the issues are compensability, responsibility, attorney fees and evidence.

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

The ALJ determined that claimant's left lateral epicondylitis condition was compensable, relying on the medical opinion of the only physician to comment on the causation issue, Dr. Kaye, a consulting physician. On review, Hartford contends that Dr. Kaye's opinion does not satisfy claimant's burden of proof because that opinion was phrased in terms of medical possibility, not probability. In addition, Hartford asserts that Dr. Kaye did not explain what he meant by the word "repetative" [sic] when he stated that there was a reasonable "chance" that such work activities were responsible for claimant's left arm condition. (Ex. 86). Hartford also contends that Dr. Kaye did not weigh the relative causes of claimant's condition as required by *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 321 Or 416 (1995) (determining major contributing cause involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause).

Hartford's contentions notwithstanding, we agree with the ALJ that Dr. Kaye's unrebutted opinion is sufficient to satisfy claimant's burden of proving a compensable occupational disease claim. While Dr. Kaye did use the word "chance" in his initial medical report on causation, he subsequently clarified that claimant's work activity was the primary cause of her left elbow condition to a reasonable degree of medical probability. (Ex. 87).[1] Moreover, we are persuaded that Dr. Kaye had an accurate understanding of claimant's work and off-the-job activities. (Exs. 84, 85A). Based on this history, Dr. Kaye concluded that work activities were the primary factor in her left arm condition. We find Dr. Kaye's unrebutted medical opinion persuasive. Therefore, we agree with the ALJ that claimant's left arm condition is compensable.

Hartford also argues that the record establishes that claimant had a left upper extremity condition that either preexisted her employment at Olsten or predisposed her to the left arm problems that she developed there. Specifically, Hartford points to Exhibit 73A, a report from Dr. Butters in 1994 that referred to bilateral forearm pain. Hartford also refers to Exhibit 74, a 1994 chart note that mentions swelling under claimant's left arm.

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[1] Hartford contends that the ALJ improperly admitted Exhibit 87, which is a "check-the-box" report that Hartford contended was not a medical report, and, further, was unintelligible and "grossly leading." (Tr. 4, 5). The ALJ overruled Hartford's objection, finding that the disputed exhibit was typical of exhibits presented in workers' compensation proceedings. (Tr. 6). Moreover, the ALJ afforded Hartford the opportunity to depose Dr. Kaye, which it declined to do. We review an ALJ's evidentiary ruling for abuse of discretion. *Mary J. Richards*, 48 Van Natta 390 (1996) (citing *James D. Brusseau II*, 43 Van Natta 541 (1991)). The ALJ is given broad discretion on determinations concerning the admissibility of evidence. *See, e.g., Brown v. SAIF*, 51 Or App 389, 394 (1991) (the ALJ's decision to admit or exclude evidence is limited only by the consideration that the hearing as a whole achieve substantial justice). Under these circumstances, we do not find that the ALJ abused his discretion in admitting the disputed exhibit. Moreover, we agree with the ALJ that any objection to the exhibit would more properly pertain to the evidentiary weight to be given to the document, rather than to its admissibility.

We are not persuaded that either report establishes the presence of a preexisting or predisposing left arm condition. First, we agree with the ALJ's reasons for discounting the significance of Exhibit 73A. (Opinion and Order p. 2 n. 3). Second, with respect to Exhibit 74, the condition apparently responsible for the swelling (adenopathy) resolved by the time of claimant's next office visit. (Ex. 81A). In addition, there is no evidence that suggests that the adenopathy is in any way related to the claimant's current left arm condition.

Hartford also contends that, because claimant attributed her left arm condition to her prior *right* arm claim for which Kemper was responsible, her current left arm condition is most likely related to her prior Kemper claim. There is no evidence, however, to support Hartford's contention. In addition, the medical causation issue is complex. Therefore, claimant's lay opinion as to the cause of her left epicondylitis condition is not persuasive. *See Uris v. Compensation Department*, 247 Or 420, 424 (1967); *Kassahn v. Publishers Paper Co.*, 76 Or App 105, 109 (1985).

Finally, Hartford asserts that the total assessed fee of $3,000 was excessive. We disagree.

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

The issues in dispute were compensability of and responsibility for claimant's left arm condition. Approximately 50 exhibits were received into evidence, two of which were generated by claimant's counsel. The transcript consists of 28 pages. Claimant was the only witness to testify. The compensability issue primarily involved an evaluation of medical evidence and was of a complexity level that is normally faced by the Board and its Hearings Division. Because claimant's current left elbow condition has been found compensable, she is entitled to further workers' compensation benefits. The parties' attorneys were skilled and presented their positions in a thorough, well-reasoned manner. No frivolous issues or defenses were presented. Finally, considering Hartford's contentions regarding the persuasiveness of the medical evidence, there was a risk that claimant's counsel's efforts might go uncompensated. Considering all these factors, we find that $2,500 is a reasonable fee for claimant's counsel's services at hearing concerning compensability of the left arm condition.

Under ORS 656.308(2)(d), claimant's counsel was entitled to an attorney fee for services at hearing for finally prevailing over Hartford's responsibility denial. Considering the above circumstances, and applying the factors in OAR 438-015-0010(4), we find that the ALJ's award of $500 was a reasonable fee for claimant's attorney's services at hearing in prevailing over the responsibility denial.[2]

Claimant's attorney is also entitled to an assessed fee for services on review regarding Hartford's appeal 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 issue, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by Hartford, on behalf of Olsten Corporation. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review concerning the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated March 16, 1998 is affirmed. For services on review regarding the compensability issue, claimant's attorney is awarded is $1,000, payable by Hartford.

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[2] We make no attorney fee award under ORS 656.308(2)(d) for Board review because claimant's counsel provided no services on review regarding the responsibility issue.

In the Matter of the Compensation of
ESTON JONES, Claimant
WCB Case No. 97-07515
ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Claimant requests reconsideration of our July 15, 1998 Order on Review, in which we: (1) reversed that portion of the ALJ's order that assessed a 25 percent penalty for SAIF's allegedly unreasonable failure to timely deny a "new medical condition" claim and (2) affirmed the portion of the ALJ's order which awarded a $3,600 assessed attorney fee. Claimant asserts that our prior order placed form over substance when we held that two letters written by the wife of an unrepresented claimant did not constitute a clear request for formal written acceptance of a "new medical condition" claim, thus triggering SAIF's duty to accept or deny the claim within 90 days as required by ORS 656.262(7)(a). Claimant again argues that the ALJ correctly found that claimant's substantial compliance with the statute was legally sufficient.

Having once more considered claimant's arguments, we continue to conclude that the letters that claimant's wife wrote to SAIF did not sufficiently comply with the requirements of ORS 656.262(7)(a) so as to constitute a "new medical condition" claim. Pursuant to ORS 656.262(7)(a), a claimant must have clearly requested formal written acceptance of the condition. *See Diane S. Hill*, 48 Van Natta 2351, 2352-53 (1996), *aff'd mem Hill v. Stuart Andersons*, 149 Or App 496 (1997). Although we appreciate the fact that claimant was not represented when the letters at issue were written, the statute does not distinguish between represented and unrepresented claimants. Therefore, in both instances, there must be a "clear" request for formal written acceptance of a "new medical condition." Because we continue to find that the letters did not constitute such a request, the statutory requirement to deny a new medical condition claim within 90 days was not triggered.[1]

Claimant's counsel also contends that the ALJ's $3,600 attorney fee award for legal services rendered at hearing in prevailing against SAIF's compensability denial provides inadequate compensation. Claimant's attorney requests a fee of $6,000. Upon further consideration of this matter, including a review of claimant's counsel's argument and attached affidavits, we continue to find, based on the factors listed in OAR 438-015-0010(4), that $3,600 is a reasonable attorney fee for claimant's counsel's services at hearing.

Accordingly, we withdraw our July 15, 1998 order. On reconsideration, as supplemented herein, we adhere to and republish our July 15, 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] We are not unsympathetic to claimant's argument that we have elevated form over substance. However, the express statutory language of ORS 656.262(7)(a) is clear: there must be a clear request for formal written acceptance of the new medical condition. Although claimant cites legislative history that arguably supports his contention that substantial compliance with the statute is sufficient, we need not resort to such sources where the statutory language is clear. Based on that statutory language, we continue to conclude that, to perfect a "new medical condition" claim, claimant must do more than send letters to a carrier that can be interpreted as a request for acceptance of a claim; rather, he must "clearly request formal written acceptance" of the new medical condition. Because the latter was not done in this case, we continue to conclude that SAIF's claim processing was not unreasonable.

In the Matter of the Compensation of
STEFEN S. WEBB, Claimant
WCB Case Nos. 96-03782, 96-02500 & 96-01855
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that: (1) found that claimant had not perfected a timely aggravation claim regarding his 1990 low back injury with the SAIF Corporation; and (2) upheld SAIF's denial of claimant's aggravation claim regarding his 1994 low back injury. On review, the issues are claims processing and aggravation. We affirm.

FINDINGS OF FACT

Claimant has accepted claims for low back injuries with SAIF's insured in May 1988, December 1990 and October 1994. Following the 1988 injury, claimant was diagnosed with an L5-S1 disc herniation which was surgically repaired in May 1989. Following the 1990 injury, claimant was diagnosed with a recurrent L5-S1 disc herniation which was surgically repaired in March 1991. Claimant's diagnosis following the 1994 injury was recurrent musculoskeletal pain/strain. SAIF formally accepted each injury claim as a lumbar strain.

In late 1995, claimant began experiencing an increase in low back symptoms. On January 29, 1996, he filed a Notice of Claim for Aggravation of his 1994 injury with supporting medical evidence. On February 22, 1996, SAIF issued a denial of that claim on the ground that the 1994 injury was not the major contributing cause of claimant's current low back pain.

A lumbar MRI performed on April 1, 1996 demonstrated a recurrent L5-S1 disc herniation.

In April and May 1996, SAIF received chart notes and letters from claimant's treating physician diagnosing a recurrent L5-S1 disc herniation, due in major part to the 1988 and 1990 injuries and related surgeries. Claimant then filed a May 24, 1996 Notice of Claim for Aggravation of the 1990 injury which was not signed by claimant's treating physician and did not physically attach or reference the supporting medical evidence. SAIF did not issue an acceptance or denial of that claim.

Claimant's aggravation rights under the 1990 claim expired on August 22, 1996.

On March 12, 1996, claimant requested a hearing from SAIF's February 22, 1996 denial of his claim for aggravation of the 1994 injury. On April 19, 1996, claimant requested a hearing from SAIF's *de facto* denial of his claim for aggravation of the 1990 injury.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that his current L5-S1 disc reherniation is compensable as an aggravation of his 1990 and 1994 injuries. Claimant has not filed a claim for aggravation of his 1988 injury.

A claim for aggravation must be filed within five years after the first determination or the first notice of closure made under ORS 656.268. ORS 656.273(3) and (4)(a). Once a timely aggravation claim has been filed, claimant must establish both a causal relationship if the claimed condition is not a compensable condition, and an "actual worsening" since claim closure. ORS 656.273(1); *Gloria T. Olson*, 47 Van Natta 2348 (1995). Here, claimant must establish that his current reherniation is a compensable condition, as SAIF formally accepted claimant's prior injuries as lumbar strains, and claimant has not previously established compensability of the reherniation. *Id.*

The ALJ upheld SAIF's denials of claimant's aggravation claims regarding both the 1990 and 1994 injuries. In so doing, the ALJ reasoned that claimant had not "perfected" a timely claim for aggravation of his 1990 injury, and had not established the requisite "actual worsening" of his 1994 injury.

On review, claimant contends that the ALJ erred in concluding that the claim for aggravation of the 1990 injury was untimely. Claimant further contends that SAIF is precluded from denying compensability of the recurrent herniation because the permanent disability award under the 1990 claim included a value for the surgical repair of the L5-S1 disc reherniation. Alternatively, claimant contends that the record otherwise establishes compensability of the reherniation and an "actual worsening" since closure of both the 1990 and 1994 claims.

We begin our analysis by rejecting claimant's argument that the permanent disability award under the 1990 claim for surgical repair of the L5-S1 disc herniation precludes SAIF from denying compensability of that condition. Pursuant to the express terms of *amended* ORS 656.262(10), a carrier's failure to appeal a prior Order on Reconsideration award of permanent disability for an unaccepted condition does not preclude the carrier from subsequently contesting the compensability of that condition. *See Keith Topits*, 49 Van Natta 1538 (1997).

We turn to claimant's alternative argument that the record otherwise establishes compensability of the reherniation. Because of the passage of time since claimant's initial disc herniation, resolution of this causation issue is a complex medical question that must be resolved with expert medical opinion. *Uris v. Compensation Department*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279, 283 (1993). As there is no medical evidence that claimant's prior accepted injuries with SAIF directly contributed to the current reherniation, claimant must establish compensability under either ORS 656.005(7)(a)(A) or (B). *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992).

We need not consider which provision of ORS 656.005(7)(a) is applicable, as we conclude that the record does not satisfy the major contributing cause standard required under both provisions.[1] In reaching this conclusion, we are persuaded by SAIF's argument that claimant has not proven that the recurrent herniation is a compensable condition because there is no medical evidence that the reherniation is due in major part to the 1990 and/or 1994 injuries, without regard to the residuals of the 1988 injury for which claimant has not filed an aggravation claim.

The record includes relevant medical opinions from Dr. Matteri, the current treating neurosurgeon, Dr. Panum, the former treating physician, and Dr. Hacker, the former treating neurosurgeon. Drs. Matteri and Panum opined that the 1988 and 1990 injuries and related surgeries were the major contributing cause of the reherniation. Dr. Hacker identified the 1988 and 1990 injuries and related surgeries as causes of the reherniation, but he did not expressly address the major contributing cause of the condition.

Because claimant has not filed a claim for aggravation of the 1988 injury, to establish compensability of his recurrent herniation as an aggravation, he must prove that the subsequent injuries in 1990 and 1994 are the major contributing cause of the recurrent herniation. As the medical record does not support such a finding, claimant has not established compensability of the reherniation as an aggravation under ORS 656.273 of either the 1990 or 1994 injury.

In reaching this decision, we reject claimant's argument that the current reherniation is compensable because, pursuant to ORS 656.308(1), SAIF's acceptance of the 1990 injury encompassed the residuals of the 1988 injury, and SAIF's acceptance of the 1994 injury encompassed the residuals of both the 1988 and 1990 injuries. SAIF's express acceptance of the 1990 and 1994 claims is limited to a lumbar strain. Accordingly, the current disc reherniation is not the same condition processed under the 1990 and 1994 claims, and ORS 656.308(1) has no application in this case. *See Conner v. B & S Logging*, 153 Or App 354 (1998) (ORS 656.308(1) has no application where the claimant has framed the issue as a claim for previously unaccepted conditions caused by earlier work-related injuries).

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[1] Pursuant to ORS 656.005(7)(a)(A), "[n]o 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."

Pursuant to ORS 656.005(7)(a)(B), "[i]f an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition."

In conclusion, based on this alternative rationale, we affirm the ALJ's ultimate decision to reject claimant's aggravation claims regarding his 1990 and 1994 injuries. Consequently, we need not address whether claimant submitted a timely claim for aggravation of the 1990 injury[2], or whether he established an actual worsening of his condition.

ORDER

The ALJ's order dated June 9, 1997 is affirmed.

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[2] We addressed a similar issue in *David L. Dylan*, 50 Van Natta 276 (1998), *on recon* 50 Van Natta 852 (1998). In that case, we concluded that the claimant's aggravation claim had not been "perfected" and was untimely where the claimant's Director-prescribed aggravation claim form was not accompanied by an attending physician's report, and such a report was not received by the carrier prior to the expiration of the claimant's aggravation rights.

In the Matter of the Compensation of
THOMAS A. ELEEN, Claimant
WCB Case No. 97-07791
ORDER ON RECONSIDERATION
Lawrence A. Castle, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

On July 15, 1998, we affirmed an Administrative Law Judge's (ALJ's) order that upheld the SAIF Corporation's denial of claimant's occupational disease and/or injury claims for cervical and lumbar disc disease, cervical strain, lumbar strain, left ulnar radiculopathy, left femoral radiculopathy, and left carpal tunnel syndrome conditions. Contending that we neither explained the basis for our decision nor addressed the arguments raised in his appellate briefs, claimant asserts that our order is inadequate to withstand judicial review and, as such, he seeks reconsideration of our decision and reversal of the ALJ's order.

To begin, we disagree with the fundamental premise of claimant's argument that our adoption of an ALJ's order, in the absence of our own findings of fact and conclusions, is insufficient for "substantial evidence" review. *George v. Richard's Food Center*, 90 Or App 639 (1988); *Jorge Pedraza*, 49 Van Natta 1019 (1997). In any event, after reviewing the record and reconsidering the parties' arguments, we continue to agree with the ALJ's findings and conclusions that, based on inconsistencies between claimant's testimony and other witnesses' testimony (as well as inconsistencies between claimant's testimony and his own prior statements), claimant's version of relevant events lacks credibility and, because the medical evidence is dependent on claimant's reliability as a historian, the record does not support a compensable, causal relatonship between claimant's conditions and his work.

Accordingly, we withdraw our July 15, 1998 order. On reconsideration, as supplemented herein, we adhere to and republish our prior order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES W. JORDAN, Claimant
WCB Case No. 95-02636
ORDER ON REMAND
Schneider, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *Jordan v. Brazier Forest Products*, 152 Or App 15 (1998). The court reversed our prior order that held that the Hearings Division lacked jurisdiction to consider claimant's hearing request from a Director's Order Denying Reconsideration or his request for reconsideration of a Notice of Closure. Finding that the statutory scheme established a schedule for the reconsideration and the conclusion of that process is an order on reconsideration, not an order denying reconsideration, the court has remanded for reconsideration. We now proceed with our review.[1]

FINDINGS OF FACT

We republish the "Findings of Fact" set forth in our December 31, 1996 Order on Review.

CONCLUSIONS OF LAW AND OPINION

It is first necessary to recount the factual and procedural background in some detail. Claimant suffered a work-related injury to both legs in 1986. SAIF accepted claimant's condition as bilateral knee arthralgia and ligamentous injury. Claimant filed an aggravation claim in 1992. Pursuant to a stipulation, SAIF reopened claimant's claim for processing the aggravation claim. On November 23, 1992, SAIF issued a Notice of Closure awarding claimant temporary disability benefits, but no additional permanent disability benefit.

Neither claimant nor his attorney received the November 23, 1992 Notice of Closure until June 24, 1994. On June 28, 1994, claimant requested reconsideration of the Notice of Closure. By order dated July 24, 1994, the Appellate Unit of the Department of Consumer and Business Services ("Department") denied claimant's request for reconsideration on the basis that claimant's request for reconsideration was untimely. Thereafter, claimant requested a hearing concerning the Department's order.

In a prior proceeding (WCB Case No. 94-09378) a hearing was held before Administrative Law Judge (ALJ) Davis of the Workers' Compensation Board's Hearings Division. By Opinion and Order dated November 24, 1994, ALJ Davis set aside the Department's July 20, 1994 Order Denying Request for Reconsideration and remanded claimant's request for reconsideration to the Appellate Unit for appointment of a medical arbiter and further processing of the request

In response to ALJ Davis' order, the Department, by letter dated February 24, 1995, indicated that it would conduct no further review of the July 20, 1994 Order Denying Reconsideration. The Department asserted that ALJ Davis lacked jurisdiction over the order and did not have the authority to remand the matter to the Department. Thereafter, claimant requested another hearing before the Board contesting the Department's failure to comply with ALJ Davis' order. This proceeding pertains to claimant's subsequent hearing request.

A hearing was held before ALJ Poland. In a February 23, 1996 Opinion and Order, ALJ Poland "enforced" ALJ Davis' order and remanded the matter to the Department for further reconsideration pursuant to ORS 656.268. Claimant requested Board review of ALJ Poland's order.

An Order on Review issued on December 31, 1996 wherein we reversed ALJ Poland's order concluding that inasmuch as ALJ Davis' order was invalid, based on a lack of statutory authority to consider the Order Denying Reconsideration, ALJ Davis' order could not be "enforced" Therefore, we denied claimant's request for enforcement or relief resulting from ALJ Davis' order. Claimant requested judicial review of our order.

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[1] The parties were advised that supplemental briefing would be permitted. Claimant waived his opening supplemental brief, however, SAIF's supplemental respondent's brief and claimant's supplemental reply brief have been received. In addition, the Director (the Workers' Compensation Division) announced that it wished to participate in the supplemental briefing process. However, no brief has been received from the Director has been received within the time prescribed in the supplemental briefing schedule.

The court reversed, concluding that the Hearings Division, and thus the Board, had jurisdiction over claimant's challenge to the Department's Order Denying Reconsideration as it was a matter concerning a claim. In reaching this conclusion, the court explained that claimant had initiated the reconsideration proceeding when he filed a request for reconsideration. *Jordan*, 152 Or App at 20. The court further reasoned that the Department terminated that reconsideration when it issued the Order Denying Reconsideration and regardless of whether or not the Department engaged in an evaluation of the merits of the request, the Hearings Division retained jurisdiction to review the merits of claimant's request. *Id.* Consequently, the court has remanded for reconsideration.

We now proceed with our review.

ALJ Poland concluded that ALJ Davis' order, which found that claimant's request for reconsideration of the Notice of Closure was timely and remanded the claim to the Department for processing, had become final by operation of law. Therefore, ALJ Poland, in effect, "enforced" ALJ Davis' order by remanding this matter to the Department for reconsideration. On remand, SAIF's sole contention is that the Notice of Closure should be upheld on the merits. Claimant contends that ALJ Poland's order should be affirmed and that the Department should proceed with its reconsideration of the Notice of Closure.[2]

It is apparent from the court's decision that the Department "Order Denying Reconsideration", regardless of how it was designated, terminated the reconsideration process. Moreover, it is clear that the Hearings Division (ALJ Davis) had jurisdiction over claimant's request for hearing concerning the Order Denying Reconsideration. Inasmuch as the Order Denying Reconsideration was properly in front of ALJ Davis, ALJ Poland likewise had the authority to "enforce" ALJ Davis' prior order.

Accordingly, we affirm ALJ Poland's February 23, 1996 order.[3]

IT IS SO ORDERED.

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[2] SAIF has moved to strike claimant's supplemental reply brief on the basis that it addresses issues not raised by SAIF's supplemental respondent's brief. Assuming *arguendo* that claimant's response was not considered, we would still be required to address the procedural context of this claim and jurisdictional issues raised in claimant's response. Consequently, we need not address SAIF's motion as it would not make a difference in our consideration of this matter.

[3] Inasmuch as ALJ Davis' order was not appealed, we are without authority to review that decision. Instead, the processing of the claim in accordance with ALJ Davis' directive is a matter between the parties and the Department.

In the Matter of the Compensation of
GEORGE SENITZ, Claimant
WCB Case No. 97-02650
ORDER OF ABATEMENT
James B. Northrop (Saif), Defense Attorney

The SAIF Corporation requests abatement and reconsideration of our July 16, 1998 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order that set aside its denial of claimant's hepatitis C infection claim. Specifically, SAIF contends that, at the time of hearing, claimant denied that he had ever used intravenous drugs. SAIF argues that it has now obtained evidence that shows that claimant did use such drugs. Citing *Tricia C. Wagner*, 48 Van Natta 2175 (1996)(Remand appropriate where, following the hearing, the claimant gave testimony that contradicted statements provided to an examining psychiatrist in the workers' compensation case), SAIF argues that this case should be remanded to the ALJ to admit records concerning claimant's alleged drug use.

In order to consider this matter, we withdraw our July 16, 1998 order. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 14 days from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
KATRINA KNEE, Claimant
WCB Case No. 97-08545
ORDER OF DISMISSAL
Reinisch, et al, Defense Attorneys

Claimant, *pro se*, has requested review of Administrative Law Judge (ALJ) Black's June 30, 1998 order. We have reviewed the request to determine whether we have jurisdiction to consider the matter. Because the record does not establish that either the Board or the self-insured employer received a timely request for review within 30 days of the ALJ's order, we dismiss.

FINDINGS OF FACT

On June 30, 1998, the ALJ issued an order upholding the employer's denial of claimant's right foot condition. A copy of the order was sent to claimant, claimant's attorney, the employer, the employer's claims service, and the employer's attorney. The order contained a statement explaining the parties' rights of appeal, including a notice that a request for review must be mailed to the Board within 30 days of the ALJ's order and that copies of the request for Board review must be mailed to the other parties within the 30-day appeal period.

On July 31, 1998, the Board received claimant's letter of the same date asking for Board review the case.[1] Claimant's request was not mailed by registered or certified mail; nor did the request indicate that copies had been mailed to the employer, the claims service, or the employer's attorney.

On August 6, 1998, the Board mailed its computer-generated letter to all parties acknowledging its receipt of claimant's request for Board review.

CONCLUSIONS OF LAW AND OPINION

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

Here, the 30th day after the ALJ's June 30, 1998 order was July 30, 1998. Therefore, July 30, 1998 was the final day to perfect a timely appeal of the ALJ's order. Because claimant's request was received by the Board on July 31, 1998, it is more than 30 days after the ALJ's June 30, 1998 order and, thus, was untimely filed. *See* ORS 656.289(3); 656.295(2); OAR 438-005-0046(1)(b).

Furthermore, the record fails to establish that the other parties to the proceeding before the ALJ were provided with a copy, or received actual knowledge, of claimant's request for review within the statutory 30-day period. In particular, claimant's letter contains no indication that she provided copies to the employer, the claims service, or the employer's attorney. Consequently, claimant failed to perfect her appeal on the additional basis that she did not provide copies of her request for Board review to the other parties.

Based on claimant's untimely request for Board review and her failure to provide copies of her request to the other parties, we lack jurisdiction to review the ALJ's order, which has become final by operation of law. *See* ORS 656.289(3); 656.295(2).

Finally, we are mindful that claimant has apparently requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. However, instructions for requesting review were clearly stated in the ALJ's order. Moreover, we are not free to relax a jurisdictional requirement. *Alfred F. Puglisi*, 39 Van Natta 310 (1987); *Julio P. Lopez*, 38 Van Natta 862 (1986).

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[1] Although the letter was addressed to ALJ Black, we consider it as having been "received" by the Board because it was delivered and accepted at a permanently staffed office of the Board.

Accordingly, claimant's request for review is dismissed.

IT IS SO ORDERED.

August 14, 1998 Cite as 50 Van Natta 1589 (1998)

In the Matter of the Compensation of
JASON L. WINNETT, Claimant
WCB Case No. 98-01940
ORDER OF DISMISSAL
Meyers, Radler, et al, Defense Attorneys

Claimant, *pro se*, has requested review of Administrative Law Judge (ALJ) Brazeau's June 5, 1998 order. The self-insured employer has moved to dismiss claimant's request, contending that he neglected to provide notice of his appeal to all parties to the proceeding within 30 days of the ALJ's order. *See* ORS 656.289(3); 656.295(2). Because the record does not establish that all parties received timely notice of claimant's request, we dismiss.

FINDINGS OF FACT

On June 5, 1998, the ALJ issued an order which upheld the employer's denial. The order contained a statement explaining the parties' rights of appeal, including a notice that a request for review must be mailed to the Board within 30 days of the ALJ's order and that copies of the request for Board review must be mailed to the other parties within the 30-day appeal period.

On July 1, 1998, the Board received a hand-written letter from claimant. In the letter, dated June 26, 1998, claimant requested review of the ALJ's order. Claimant's request did not indicate that copies had been provided to the other parties to the proceeding.

On July 6, 1998, the Board mailed a computer-generated letter to the parties, acknowledging claimant's request for Board review of the ALJ's June 5, 1998 order. Thereafter, the employer moved for dismissal of claimant's appeal, contending that its first notice of claimant's request occurred on its July 7, 1998 receipt of the Board's acknowledgment letter.

CONCLUSIONS OF LAW AND OPINION

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

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

Here, the 30th day after the ALJ's June 5, 1998 order was July 6, 1998.[1] Inasmuch as claimant's request for review was received by the Board on July 1, 1998, it was timely filed. *See* ORS 656.289(3); ORS 656.295(2); OAR 438-005-0046(1)(b).

However, the record fails to establish that the other parties to the proceeding before the ALJ were provided with a copy, or received actual knowledge, of claimant's request for review within the statutory 30-day period. Rather, the record indicates that the employer's first notice occurred on July 7,

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[1] Where the 30th day after the mailing of the ALJ's order falls on a Sunday or a federal holiday, the final day for perfecting the appeal is the next day in which mail is delivered. *See e.g., Robert K. Warren*, 47 Van Natta 84 (1995); *Anita L. Clifton*, 43 Van Natta 1921 (1991). Here, because the 30th day from the ALJ's June 5, 1998 order fell on Sunday, July 5, 1998, the final day to perfect an appeal of the ALJ's order was Monday, July 6, 1998.

1998 when it received a copy of the Board's July 6, 1998 letter acknowledging claimant's request for review. Because July 7, 1998 is more than 30 days after the ALJ's June 5, 1998 order, such notice is untimely. *Debra A. Hergert*, 48 Van Natta 1052 (1996); *John E. Bafford*, 48 Van Natta 513 (1996).

Under such circumstances, we conclude that notice of claimant's request was not provided to the other parties within 30 days after the ALJ's June 5, 1998 order.[2] Consequently, we lack jurisdiction to review the ALJ's order, which has become final by operation of law. *See* ORS 656.289(3); 656.295(2).

Finally, we are mindful that claimant has apparently requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. However, instructions for requesting review were clearly stated in the ALJ's order. Moreover, we are not free to relax a jurisdictional requirement. *Alfred F. Puglisi*, 39 Van Natta 310 (1987); *Julio P. Lopez*, 38 Van Natta 862 (1986).[3]

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

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[2] In the event that claimant can establish that he provided notice of his request for Board review to the employer within 30 days of the ALJ's June 5, 1998 order, he may submit written information for our consideration. However, we must receive such written information in sufficient time to permit us to reconsider this matter. Since our authority to consider this order expires within 30 days after the date of this order, claimant must file his written submission as soon as possible. Claimant is further admonished that any document he submits to the Board for its review, must be simultaneously served on all other parties to the claim.

[3] We acknowledge receipt of claimant's request for an extension of the briefing schedule to enable him to obtain additional evidence. Inasmuch as we lack authority to review claiman'ts appeal, it is unnecessary to further address his extension request.

August 14, 1998 Cite as 50 Van Natta 1590 (1998)

In the Matter of the Compensation of
JOHN BAGEANT, Claimant
WCB Case No. 97-09502
ORDER ON RECONSIDERATION
Robert G. Dolton, Claimant Attorney
Lundeen, et al, Defense Attorneys

On July 22, 1998, we affirmed an Administrative Law Judge's (ALJ's) order that set aside the insurer's denial of claimant's injury claim for a low back and right leg condition. The parties have submitted a proposed "Disputed Claim Settlement," which is designed to resolve all issues raised or raisable between them, in lieu of all prior orders. We treat this submission as a motion for reconsideration of our prior decision.[1]

Pursuant to the settlement, the parties agree that the insurer's denial, as supplemented in the agreement, "shall forever remain in full force and effect." The parties further stipulate that "the Request for Hearing shall be dismissed with prejudice," in full settlement of all issues raised or raisable.

By this order, we have approved the parties' settlement, thereby fully and finally resolving this dispute, in lieu of all prior orders. Accordingly, we withdraw our July 22, 1998 order. On reconsideration, this matter is dismissed with prejudice.

IT IS SO ORDERED.

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[1] We note that, on August 6, 1998, this settlement received approval by an Administrative Law Judge. Nonetheless, because the agreement pertains to the resolution of a dispute that was addressed in our July 22, 1998 order, the settlement requires our approval. See OAR 438-009-0015(5).

In the Matter of the Compensation of
FRANK D. BACON, Claimant
WCB Case No. 98-01053
ORDER ON REVIEW
Mitchell & Associates, Claimant Attorneys
Michael O. Whitty (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Garaventa's order that: (1) affirmed an Order on Reconsideration that awarded 27 percent (86.4 degrees) unscheduled permanent disability for a cervical condition; and (2) awarded a $2,000 attorney fee pursuant to ORS 656.382(2). On review, the issues are extent of unscheduled permanent disability and attorney fees.

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

SAIF argues that the $2,000 attorney fee awarded by the ALJ is excessive because there is no explanation as to how the ALJ arrived at the figure. In addition to the time devoted to the case, we note that the ALJ also considered the issue, the value of the case and the risk that the attorney's efforts might go uncompensated in awarding the fee.

In *Russell L. Martin*, 50 Van Natta 313 (1998), we found that an ALJ was not obligated to make specific findings regarding the rule-based factors in a case where there was no specific attorney fee request (or statement of services), and the parties had not submitted to the ALJ any argument as to how the rule-based factors should be weighed in determining a reasonable fee. Under such circumstances, we also concluded that *Schoch v. Leupold & Stevens*, 325 Or 112 (1997), was distinguishable. *Martin*, 50 Van Natta at 314.

On review, SAIF raises an argument concerning one of the factors contained in OAR 438-015-0010(4) and argues that the $2,000 attorney fee was excessive. Because SAIF has now advanced an argument addressing the factors, we provide the following supplementation of the ALJ's order.

In determining a reasonable attorney fee, we consider the factors listed in OAR 438-015-0010(4). Those factors are:(a) The time devoted to the case; (b) The complexity of the issue(s) involved; (c) The value of the interest involved; (d) The skill of the attorneys; (e) The nature of the proceedings; (f) The benefit secured for the represented party; (g) The risk in a particular case that an attorney's efforts may go uncompensated; and (h) The assertion of frivolous issues or defenses.

The record contains no statement of services documenting the time claimant's attorney spent on the case. The transcript is 4 pages long and the hearing lasted 15 minutes. No witnesses testified. The record contains approximately 18 exhibits, one of which was submitted by claimant's attorney.

The issue at hearing was limited to the extent of claimant's permanent disability arising from a compensable neck injury which involved a herniated disc at C5-6 and required cervical fusion surgery. SAIF requested the hearing on the Order on Reconsideration and sought reduction of claimant's permanent disability award. Based on other disputed extent of permanent disability claims presented for resolution to this forum, we find that the extent issue was of average complexity. The value of the interest and the benefit secured for claimant were significant in that the ALJ affirmed the Order on Reconsideration which awarded claimant 27 percent unscheduled permanent disability for the cervical injury (whereas SAIF's Notice of Closure had awarded 8 percent unscheduled permanent disability). Claimant's attorney skillfully conducted the litigation. No frivolous issues or defenses were raised. In addition, given the divided medical evidence and SAIF's challenge to claimant's permanent disability award, there was a significant risk that claimant's counsel might go uncompensated.

After our review of the record and application of the factors, we agree with the ALJ that the time and effort expended by claimant's counsel and the complexity of the case justify a fee of $2,000. Consequently, we affirm the ALJ's attorney fee award.

Claimant's attorney is also entitled to an assessed fee for services in defending against SAIF's request for review regarding the extent issue. *See* ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for those services is $1,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the

time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue and the value of the interest involved. Claimant's attorney is not entitled to an assessed fee for defending the ALJ's fee award. *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated April 28, 1998 is affirmed. For services on Board review, claimant's attorney is awarded $1,000, payable by SAIF.

In the Matter of the Compensation of
PATSY J. EVENSON, Claimant
WCB Case No. 97-07020
ORDER ON REVIEW
Robert E. Nelson, Claimant Attorney
Schwabe, Williamson & Wyatt, Defense Attorneys

Reviewed by Board Members Hall and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Mills' order that set aside its denial of claimant's injury claim for exposure to HIV and hepatitis. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant is a store manager for the employer. On May 25, 1997, during the course of her employment, claimant's hands were exposed to the bodily fluids of an individual who indicated that he was HIV-positive. Claimant had sores on her hands at the time of the exposure. After the incident, claimant was tested for HIV, hepatitis, liver, and other blood disorders. The tests were negative. She was set up for a four-week prophylactic treatment program for HIV and also a vaccine treatment for hepatitis. She was advised to obtain follow-up testing for HIV. Although claimant's medical bills were paid, the employer's claims processing agent denied her claim for workers' compensation benefits.

CONCLUSIONS OF LAW AND OPINION

The ALJ found claimant's claim for medical services compensable, because claimant was exposed to bodily fluids from an allegedly HIV-positive individual and the exposure required preventative and prophylactic medical services. On review, the employer argues that the claim is not compensable, because claimant has no disease or injury or symptoms of disease or injury. We disagree.

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[.]

Here, we find that it is undisputed that claimant *was* exposed at work to bodily fluids of another person infected with HIV. It is also undisputed that she *required* prophylactic and preventative medical services as a result of this exposure. Based on the undisputed medical evidence establishing that medical services were required as a result of the work incident, we agree with the ALJ that claimant suffered a compensable injury under the statute.

The employer argues that the ALJ erred in concluding that this case is distinguishable from *Brown v. SAIF*, 79 Or App 205, 208, *rev den* 301 Or 666 (1986), and from the Board's decision in *Daniel L. Hakes*, 45 Van Natta 2351 (1993). In *Brown*, the claimant had been exposed to asbestos at work and sought medical treatment when he became concerned that this exposure might have damaged his health. The doctors found that the claimant was healthy, but recommended regular testing. The court held that the claim was not compensable because the claimant failed to prove that he presently had a disease or had been injured.

We agree with the ALJ that *Brown* is distinguishable. In *Brown*, the court found that none of the medical services sought by the claimant were required. The court reasoned that the claimant had not proven that he had suffered actual physical or mental harm. Here, however, an incident occurred at work and claimant received treatment as a result of the work exposure. Additionally, claimant's treating doctor has opined that the work exposure was the major cause of her need for medical treatment.

We also find the *Hakes* case to be distinguishable. In *Hakes*, the claimant was a pilot who was exposed to blood while transporting a patient. Although we found that the claimant had been exposed to blood, we further concluded that there was no evidence that the claimant had been injured by the exposure, or that he had HIV or any other disease. Here, however, as stated above, we conclude that claimant was injured. Specifically, claimant was injured in this case when the sores on her skin were invaded by the bodily fluids of another individual.

Accordingly, we conclude that claimant has established a compensable claim. We, therefore, affirm the ALJ's order which set aside the employer's denial.

Claimant's counsel is entitled to an assessed attorney fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $900, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

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

In the Matter of the Compensation of
RANDY L. JACKSON, Claimant
Own Motion No. 98-0263M
OWN MOTION ORDER
Quintin Estell, Claimant Attorney
United Pacific Ins., Insurance Carrier

The insurer has submitted claimant's request for temporary disability compensation for claimant's compensable compression fracture T1 & T2 injury. Claimant's aggravation rights expired on October 25, 1984. The insurer expresses its "understanding" that claimant "is not currently in the work force." Nonetheless, the insurer recommends reopening claimant's claim for the provision of temporary disability compensation.

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

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).

Based on its "understanding," the insurer states that claimant "is not currently in the work force." Nonetheless, because these circumstances are "not due to his lack of effort, but to the above injury and the constant pain [claimant] suffers," the insurer does not contest the reopening of his claim.

In response, claimant submits an affidavit and a copy of his 1997 tax return in support of his position that, although he was not working at the time of his current disability, he was willing to work and seeking work.

During the 1996 and 1997 summer harvest seasons, claimant worked at Mallories Dairy, on an available basis. However, he was unable to sustain steady employment with Mallories due to increased back pain.

In his affidavit, claimant attests that he has tried to work despite of his continual pain. He asserts that he continues to seek work within his limitations. Claimant states that he worked in the summers of 1996 and 1997 and during the 1997 Christmas season. The tax return, as well as his sworn affidavit, demonstrate that he last worked in December of 1997.

On September 4, 1997, claimant underwent an insurer-arranged medical examination (IME) conducted by Dr. Thompson. Reporting that claimant "hasn't worked much in the past two years primarily because of back pain," Dr. Thompson further concurred with Dr. Olson's June 1997 assessment that claimant needed retraining in light duty jobs. Concluding that claimant was not medically stationary, Dr. Thompson referred claimant to a specialist to discuss a possible fusion.

During November and December 1997, claimant worked for Silver Bells Tree Farm during the 1997 Christmas tree harvest season. His duties included counting trees that were loaded onto trucks, as well as driving the trucks. In his affidavit, claimant attests that "Even though I did not do any heavy work I had great difficulty because of back problems, *** I took extra medication at that time and bore the pain for the period of time because I was so drastically in need of money."

In April and May of 1998, claimant consulted with Dr. Keenen. Noting that claimant had worked in the summer of 1997, Dr. Keenen reported that he was unable to continue that work because he "had a lot of trouble due to pain." Dr. Keenen recommended a anteroposterior release, fusion and instrumentation.

In June 1998, Dr. Sanford, claimant's long-standing treating physician, opined that "In spite of pain, [claimant] has continued to work the majority of time, but increased heavy physical activity has cause[d] aggravation of pain and therefore, I have recommended that he restrict heavy lifting and bending within tolerance of pain."

In order to satisfy the second *Dawkins* criterion, claimant must show that, although he is not working, he is willing to work and that he was seeking work. In claimant's affidavit, he attests that "I am not qualified for any type of sedentary or light work. To the best of my ability I have tried to work, but because of back pain I must frequently miss work, often for several days a week. " Based on claimant's unrebutted statements, we find that he has demonstrated his willingness to work. Moreover, based on claimant's documented work activities during 1996 and 1997, we also find that claimant has been seeking work.

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

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

IT IS SO ORDERED.

In the Matter of the Compensation of
MICHAEL L. McKINNEY, Claimant
WCB Case Nos. 98-00764 & 97-07435
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's occupational disease claim for a left knee degenerative condition. On review, the issue is compensability.

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

The ALJ concluded that claimant has established the compensability of his occupational disease claim for a left knee degenerative condition under ORS 656.802(2)(a), based on the finding that claimant's work activities as a mill worker over many years were the major contributing cause of the condition. In reaching that conclusion, the ALJ considered claimant's work activities in general rather than his work activities for this particular employer. It therefore appears that the ALJ applied the last injurious exposure rule (LIER) as a rule of proof, which allows claimants to prove compensability of a condition without having to prove the degree, if any, to which exposure to injurious conditions at a particular employment actually caused the condition. *See Willamette Industries v. Titus*, 151 Or App 76, 80 (1997) (discussing LIER rule of proof).

On review, citing *James H. Eisele*, 48 Van Natta 1740 (1996), SAIF contends that claimant is precluded from raising the LIER as a theory of compensability because he did not specifically invoke the rule at hearing. We disagree. Although *Eisele* supports SAIF's contention, we conclude that *Eisele* has been effectively overruled by the Court of Appeals in *Gosda v. J.B. Hunt Transportation*, 155 Or App 120 (1998). In *Gosda*, the claimant developed bilateral carpal tunnel syndrome after working many years as a long-haul truck driver for multiple employers. He filed an occupational disease claim against his current employer, which was denied on compensability grounds. The claimant requested a hearing on the denial and named only his current employer as the responsible party. The claimant did not raise the applicability of the LIER at any time during the hearing. The ALJ upheld the compensability denial, reasoning that the record did not establish that work for the current employer was the major contributing cause of the disease. The ALJ expressly declined to invoke the LIER because the claimant did not request reliance on the LIER. We affirmed the ALJ's decision.

The Court of Appeals reversed. Reasoning that the LIER rule of proof is not an issue in itself, the court ruled that "it need not be brought into a case by a claimant through a pleading or argument, but rather, is applicable in any case in which the evidence supports its application." *Gosda*, 155 Or App at 126 (citing *Bracke v. Baza'r*, 293 Or 239, 246 (1982)). The court stated that, if the record supports the predicate factual findings necessary to establish compensability under the LIER rule of proof, then the rule must be applied, irrespective of whether the claimant has uttered its name. *Id.* To hold otherwise, the court explained, would be inconsistent with the objective of Workers' Compensation Law to provide compensation benefits to Oregon workers who have been legitimately injured as a result of their employment, a goal that also influenced the adoption of the LIER in Oregon. *Id.* at 125-26.

Applying *Gosda* to the facts of this case, we conclude that claimant was not required to invoke the LIER rule of proof at hearing before arguing on review that the rule should be applied to find the claim compensable.[1] To the extent that *Eisele* holds otherwise, it is of no precedential value because it is contrary to *Gosda*.

Turning to SAIF's remaining contentions, we conclude that it is immaterial to the application of the LIER that claimant did not file claims against other employers. It appears that the claimant in *Gosda* also filed a claim against only one employer, yet the court did not view that fact as an impediment to applicability of the LIER. Furthermore, the fact that claimant elected to file a claim against only SAIF's

[1] SAIF appears to assue that the LIER was raised for the first time on Board review. However, as we stated earlier, it appears that the ALJ invoked and applied the LIER rule of proof to find the claim compensable under ORS 656.802(2)(a). As previously discussed, the ALJ's invocation of LIER rule of proof was in accordance with the *Gosda* holding.

insured, and relies on the LIER rule of proof to establish compensability, does not preclude SAIF from invoking defensively the LIER rule of assignment of responsibility to assert that it is not responsible for the claim. *See Titus*, 151 Or App at 81-82. Thus, the absence of claims against other employers does not result in any material prejudice to SAIF.

Finally, we reject SAIF's argument that the LIER is not applicable because SAIF has not raised a responsibility defense. As the court noted in *Garibay v. Barrett Business Services*, 148 Or App 496, 501 (1997), although a carrier may not have explicitly raised responsibility as a defense, its contention that the claimant has a condition that preexisted its particular employment and for which the carrier is not responsible, combined with a record showing that the condition was caused by his work in general, amounts to a responsibility defense. In this case, SAIF argued that claimant's left knee degenerative condition is based on the worsening of a preexisting degenerative condition for which SAIF is not responsible. Given the record, which supports the ALJ's finding that the degenerative condition is related in major part to work activities as a mill worker for multiple employers, we treat SAIF's "preexisting condition" argument as a responsibility defense. *See id.*

Claimant is entitled to an assessed attorney fee for services on review. *See* ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,400, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated April 30, 1998 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,400, payable by the SAIF Corporation.

August 17, 1998 Cite as 50 Van Natta 1596 (1998)

In the Matter of the Compensation of
MARY A. MINYARD, Claimant
WCB Case No. 97-07684
ORDER ON REVIEW
Jon C. Correll, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Hall and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Black's order that directed it to pay additional temporary total disability (TTD) benefits. On review, the issue is entitlement to temporary disability.

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

The employer began paying TTD benefits in September 1994 after claimant's August 1994 surgery. After claimant was released by her physician to modified employment following the 1994 surgery, the employer began identifying its temporary disability payments to claimant as temporary partial disability (TPD).[1] By letter dated September 10, 1997, the employer advised claimant that she had surpassed the maximum TPD benefits allowed by ORS 656.212(2)[2] and that the employer was stopping all temporary disability payments.

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[1] Although claimant had been released to modified work, the record does not reflect that she returned to regular or modified employment, was advised by the attending physician that she was released to return to regular employment, or was offered modified employment in writing by the employer and failed to begin such employment.

[2] ORS 656.212(2) limits payments of TPD to an aggregate period not exceeding two years.

The ALJ found that none of the events listed in ORS 656.268(3)[3] had ever occurred following claimant's 1994 surgery. On this basis, the ALJ found that the two year aggregate limitation on temporary partial disability contained in ORS 656.212(2) did not apply because claimant's temporary disability benefits following the 1994 surgery were properly characterized as TTD, rather than TPD.

On review, the employer relies on claimant's attending physician's release to modified employment to argue that the record establishes that claimant's disability is *partial* rather than total, and that the ALJ erred in finding that claimant's temporary disability benefits following the 1994 surgery were properly characterized as TTD. On the basis of this reasoning, the employer asserts that the two year aggregate limitation on TPD contained in ORS 656.212(2) applies and bars any further TPD payments. We disagree.

Claimant's claim is in open status. Thus, the issue is claimant's entitlement to *procedural* temporary disability under ORS 656.268, rather than claimant's substantive entitlement to benefits. *See Roberta F. Bieber*, 49 Van Natta 1541, 1542 (1997) (procedural temporary disability benefits are those benefits payable under ORS 656.268 while an accepted claim is in open status); *see also SAIF v. Taylor*, 126 Or App 658 (1994).

The employer's argument that the record establishes that claimant's temporary disability is only partial may be relevant to a determination of claimant's substantive entitlement to temporary disability when the claim is eventually closed. *See Lebanon Plywood v. Seiber*, 113 Or App 651, 654 (1992) (a claimant's substantive entitlement to temporary disability benefits, which is set forth in ORS 656.210 and 656.212, is determined on claim closure and is proven by a preponderance of the evidence in the entire record showing that the claimant was disabled due to the compensable injury before being declared medically stationary). However, the fact that claimant was released to modified work is not helpful in determining the procedural entitlement to TPD under ORS 656.268(3), because a release to modified work alone is not a sufficient basis for ceasing TTD payments under the statute.

Because the employer was not authorized by ORS 656.268(3) to cease paying procedural TTD and begin paying TPD following the 1994 surgery, the ALJ correctly found that the employer's procedural temporary disability payments from September 1994 onward are properly characterized as *TTD*, rather than TPD. Thus, we agree that the two year limitation of ORS 656.212(2) for receiving *TPD* is not applicable in this case. Moreover, because claimant was not receiving TPD, we do not find that ORS 656.212(2) provides a basis for suspending, withholding or terminating temporary disability benefits. *See* ORS 656.268(3)(d) (allows carrier to cease paying TTD if any other event occurs that causes temporary disability benefits to be lawfully suspended, withheld or terminated under ORS 656.262(4) or other provisions of Chapter 656).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $900, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated March 12, 1998 is affirmed. For services on Board review, claimant's attorney is awarded $900, payable by the employer.

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[3] ORS 656.268(3) provides that TTD 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 offer 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."

In the Matter of the Compensation of
JOHN M. MORLEY, Claimant
WCB Case No. 97-09751
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) set aside its denial of claimant's claim for a left shoulder injury; and (2) awarded a $5,148.50 attorney fee under ORS 656.386(1). On review, the issues are compensability and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt the ALJ's reasoning and conclusion concerning this issue with the following supplementation.

The ALJ "was persuaded by the reports of all of the doctors that the major cause of the need for treatment" was the industrial injury as opposed to the preexisting condition. On this basis, the ALJ set aside the denial. We agree that claimant has established compensability of his combined condition, but we base our conclusion on the following reasoning.

Dr. Weeks, a consulting orthopedist, opined that claimant's preexisting cervical x-ray changes are the major contributing cause of claimant's symptoms rather than the work injury. We find Dr. Weeks' opinion to be conclusory and lacking in explanation and medical analysis. *See Moe v. Ceiling Systems*, 44 Or App 429 (1980). Thus, we accord Dr. Weeks' opinion little weight.

Drs. Brockman and Jessen examined claimant on behalf of SAIF. They opined that claimant's preexisting condition combined with his injury to cause or prolong his disability or need for treatment. They also opined that the preexisitng condition was the major contributing cause of the combined condition and resulting disability. However, Drs. Brockman and Jessen also indicated that the injury had "not stopped being a major cause of the claimant's current condition." We find the opinions of Drs. Brockman and Jessen to be inconsistent and unclear. Thus, we do not find their opinions persuasive.

Dr. Hitzman is claimant's family physician and has treated claimant for the work injury. Dr. Hitzman agrees that claimant's compensable injury is the major contributing cause of his need for treatment and disability. In determining the major contributing cause of claimant's combined condition, Dr. Hitzman considered the contribution from claimant's preexisting condition, noting that despite significant degenerative changes, claimant was free of symptoms prior to the compensable injury. Moreover, we find that Dr. Hitzman's opinion is based on something more that just the temporal relationship between the injury and the onset of symptoms. Dr. Hitzman also relied on an MRI which he believed supported his conclusion that claimant suffered an acute injury involving ruptured discs at C4-5 and C5-6.

After our review of the record, we find Dr. Hitzman's opinion to be well-reasoned and based on complete information; thus, we find it to be the most persuasive opinion in the record. *See Somers v. SAIF*, 77 Or App 259 (1986). In addition, we find no persuasive reason not to rely on the opinion of Dr. Hitzman. *See Weiland v. SAIF*, 64 Or App 810 (1983).

Attorney Fee

After considering the factors set forth in OAR 438-015-0010(4), the ALJ awarded a $5,148.50 assessed attorney fee under ORS 656.386(1). In doing so, he applied "a factor of 2.5 as a multiplier" and a factor for travel costs.

SAIF argues that the attorney fee is excessive, considering the factors set forth in the rule. In addition, SAIF contends that the ALJ erred in reimbursing claimant for his attorney's travel expenses and in applying a "risk related" multiplier. Claimant contends that the fee was reasonable. We modify the ALJ's attorney fee award.

Travel *time* to a hearing or deposition represents hours of legal services rendered on behalf of a party and that time is considered in awarding a reasonable attorney fee. *Rollin R. Bradford*, 50 Van Natta 33 (1998). However, costs of travel such as mileage expenses, lodging and meals are not reimbursable *via* an assessed fee. *Id.* Accordingly, we only consider time expended in providing legal services (as reflected by the record since no statement of services was filed), which do not include claimant's attorney's travel costs.

In addition, we have previously declined to apply a contingency factor or "multiplier" in a strict mathematical sense. *See, e.g., Lois J. Schoch*, 49 Van Natta 788, 790, n 1 (1997); *Lois J. Schoch*, 49 Van Natta 170, 173, n.1 (1997). We decline to do so in this case as well. Instead, in conjunction with the other relevant factors discussed below, the risk that claimant's counsel might go uncompensated for services rendered in this proceeding is considered in our ultimate determination of a reasonable attorney fee.

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 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.

The disputed issue at hearing was the compensability of claimant's neck condition. The record contains 9 exhibits. The hearing lasted 1 hour. No witnesses testified and the transcript was approximately 13 pages long. There were no depositions. The case involved issues of average medical and legal complexity, as compared with compensability issues generally presented to the Board's Hearings Division for resolution. The value of the claim and the benefits secured are significant since claimant lost time from work and there is a possibility of surgery. The parties' respective counsels presented their positions in a thorough manner. No frivolous issues or defenses were presented. Finally, considering the conflicting medical opinions, there was a risk that claimant's counsel's efforts might have gone uncompensated.

Based upon our application of each of the previously enumerated factors and considering the parties' arguments, we conclude that $3,500 is a reasonable attorney fee for services at the hearings level in this case. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the record), the value of the interest involved, the nature of the proceedings and the risk that claimant's counsel might go uncompensated.

Claimant's attorney is entitled to an assessed fee for services on review regarding the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant's attorney is not entitled to an attorney fee for services devoted to the attorney fee issue on review. *See Saxton v. SAIF*, 80 Or App 631 (1986); *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated March 19, 1998 is modified in part and affirmed in part. That portion of the order that awarded a $5,148.50 assessed attorney fee is modified. In lieu of the ALJ's attorney fee award, claimant is awarded a $3,500 attorney fee, payable by the self-insured employer. For services on Board review, claimant's attorney is awarded $1,000, payable by SAIF. The remainder of the order is affirmed.

In the Matter of the Compensation of
NELLDA MORRIS, Claimant
Own Motion No. 96-0356M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE

Claimant requests review of the self-insured employer's October 13, 1997 Notice of Closure which closed her claim with an award of temporary disability compensation from June 27, 1996 through September 24, 1997. The employer declared claimant medically stationary as of September 24, 1997.

Claimant submitted her request for review on April 9, 1998, 176 days after the mailing of the Notice of Closure. To be considered, the request for review must be filed with the Board within 60 days from the date of mailing of the notice of closure, or within 180 days after the mailing date if claimant can establish good cause for the failure to file the request within 60 days. *See* OAR 438-012-0060(1).

Here, claimant contends that she was contacted by the employer representative and was told that despite there being a supplemental medical report dated September 12, 1997 which indicated that claimant was permanently disabled, that it had no bearing on her case because her claim was in own motion status. As a result of that conversation, claimant contends that she "believed at that point that I had no recourse in this matter. It was only yesterday 4-8-98 that I learned that I could have recourse."

We need not resolve whether claimant has established "good cause" for her untimely request. We reach this conclusion because, based on the record before us, we would reject claimant's contention that the closure of her claim was improper.

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 reasonable 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 October 13, 1997 Notice of Closure, considering claimant's condition at the time of closure and not subsequent events. *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 on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12 (1980).

Here, claimant relies on Dr. Gillespie's September 12, 1997 medical report form, which contained a "checked" box indicating that claimant's medically stationary date was "undetermined" because she was "permanently disabled." Yet, Dr. Gillespie further stated that claimant's next appointment date was "in 12 months." Moreover, in a September 24, 1997 report, Dr. Gillespie noted that "Eventually [claimant] may require further dissection and release of the musculature from the surrounding bony structures. No plans have been set at this point since she seems to be performing reasonably well with the current range of motion. However, this is a possibility in the future as are even arthroscopy and total knee revision somewhere down the line." Dr. Gillespie further concludes that claimant should return "on an as needed basis at this point, but at least quarterly."

Although Dr. Gillespie opined that claimant was permanently disabled, his reports do not support a conclusion that further improvement in claimant's condition was anticipated. To the contrary, Dr. Gillespie did not recommend ongoing care, but suggested that claimant return on "an as needed basis at this point, but at least quarterly." Moreover, even if Dr. Gillespie's medical opinion could be interpreted as supporting a conclusion that claimant may require future ongoing care for her permanent disability, such ongoing care does not necessarily establish that claimant was not medically stationary. *See Maarefi v. SAIF*, 60 Or App 527, 531 (1984). Finally, Dr. Gillespie's opinions regarding claimant's future treatment are couched in terms of possibility rather than probability which is not legally sufficient nor persuasive. *Gormley v. SAIF*, 52 Or App 1055 (1981) (opinions in terms of medical possibility rather than medical probability are not persuasive).

In conclusion, although claimant appears to be "permanently disabled," the record does not satisfy claimant's statutory burden of proof to establish that her condition was not "medically stationary" when the employer closed her claim; *i.e.* no further material improvement of her condition would be

reasonably expected from medical treatment or the passage of time. Accordingly, we deny claimant's challenge to the employer's October 13, 1997 Notice of Closure.[1]

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).

In the Matter of the Compensation of
GEORGE D. SNOW, Claimant
WCB Case No. 95-13763
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that upheld the self-insured employer's denial of his injury claim for a neck condition. On review, the issue is compensability.

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

Claimant argues that Exhibit 37 was stricken from the record as a result of the ALJ's Opinion and Order After Reconsideration. In contrast, the employer contends that Exhibit 37 is properly part of the record on review.

Exhibit 37 is a "Jackson County Corrections Receiving Screening Questionnaire," which was completed and signed by Ms. Burns, deputy sheriff. After the ALJ issued an Opinion and Order on February 3, 1998, claimant filed a motion to strike, asking that the testimony of Marsha McBain and Jeanie Burrows and "all exhibits offered through their testimony," be stricken from the case. Claimant's counsel's affidavit, which was included with the motion to strike, indicated that the testimony of Linda Burns was not disputed. The ALJ's Opinion and Order After Reconsideration excluded the testimony of Marsha McBain and Jeanie Burrows and Exhibits 35, 36 and 40. The ALJ's order on reconsideration made no mention of Exhibit 37 or Ms. Burns' testimony.

Claimant correctly asserts that Exhibit 37 was admitted during the testimony of Ms. Burrows. (Tr. 59-60). However, that exhibit was also discussed during Ms. Burns' testimony and Ms. Burns confirmed that she had prepared Exhibit 37 and she was questioned about that form in detail. (Tr. 68-71). Thus, although Exhibit 37 was "offered through the testimony" of Ms. Burrows, the exhibit was also discussed during Ms. Burns' testimony. Because claimant's motion to strike did not request exclusion of Ms. Burns' testimony, we conclude that Exhibit 37 is properly part of the record on review.

ORDER

The ALJ's order dated February 3, 1998, as reconsidered on March 31, 1998, is affirmed.

In the Matter of the Compensation of
BONNIE G. BOOM, Claimant
Own Motion No. 98-0188M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable sprain/strain of the right foot. Claimant's aggravation rights expired on September 20, 1984. SAIF opposes authorization of temporary disability compensation, contending that: (1) claimant's current condition does not require surgery or inpatient hospitalization; (2) claimant's current condition is not causally related to the accepted condition; (3) it is not responsible for claimant's current condition; (4) surgery or hospitalization is not reasonable and necessary for the compensable injury; and (5) 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.*

Claimant has requested that her claim be reopened for the provision of temporary disability compensation and for SAIF to "pay the physical therapy bills." With her request, claimant submits a variety of documents which reflect the physical therapy she underwent in 1996 and 1997, stipulations regarding aggravations in 1985 and 1986 and a 1996 palliative care request.

SAIF contends that claimant is trying to appeal DCBS' October 8, 1997 Final Order which denied her request for palliative care treatment. That order was not appealed and has become final by operation of law. Additionally, SAIF asserts that claimant has not submitted any recent medical reports which would demonstrate a need for surgery and/or hospitalization.

From review of the record, it is clear that claimant is seeking medical benefits. In her own words, claimant requests that we "allow [claimant] physical therapy, under curative care for my back, (r) hip, (r) leg and (r) foot." In essence, claimant is asking for the Board's assessment and order as to the compensability of her medical treatment and the costs. Citing language found in her stipulated agreements, claimant submits her claim for medical benefits to us asserting that her claim is "under the Workers' Compensation Board's own jurisdiction." Although claimant is partially correct in her request, that her claim is within our jurisdiction under ORS 656.278, her request for medical treatment lies solely with the Director. Under ORS 656.327(1), the Director has exclusive jurisdiction over all pending and future disputes arising under ORS 656.327. Consequently, assuming that this is a "327" medical services dispute, exclusive jurisdiction over this case rests with the Director. *Travis J. Thorpe*, 47 Van Natta 2321 (1995); *Thomas L. Abel*, 47 Van Natta 1571 (1995).[1]

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

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[1] It appears from claimant's request that she is unclear as to her rights and benefits under the Workers' Compensation laws. The Workers' Compensation Board is an adjudicative body that addresses issues presented to it by disputing parties. Because of that role, the Board is an impartial body and cannot extend legal advice to either party. However, since claimant is unrepresented, she may wish to contact the Workers' Compensation Ombudsman, whose job it is to assist injured workers regarding workers' compensation matters:

Workers' Compensation Ombudsman
Dept. of Consumer & Business Services
350 Winter Street, NE
Salem, OR 97310
Telephone: 1-800-927-1271

Here, the record submitted to us fails to demonstrate that claimant requires surgery or hospitalization for treatment now or in the near future. As a result, we are not authorized to grant claimant's request to reopen the claim.[2]

Accordingly, we deny claimant's current request for own motion relief. Should claimant's circumstances change (*i.e.* should she require surgery and/or hospitalization for her compensable condition), she may again request reopening of her claim.

IT IS SO ORDERED.

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[2] In light of this conclusion, we need not address the question of whether claimant was in the work force at the time of her current disability.

In the Matter of the Compensation of
MICHAEL J. GALBRAITH, Claimant
WCB Case No. 95-03825
ORDER ON REMAND
Ernest M. Jenks, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *Galbraith v. L.A. Pottsratz Construction*, 152 Or App 790 (1998). The court has reversed our prior order, *Michael J. Galbraith*, 48 Van Natta 351 (1996), that held that claimant was not entitled to an attorney fee award under ORS 656.386(1)[1] when the SAIF Corporation accepted claimant's right hip and femur fractures prior to hearing. Concluding that SAIF's response to claimant's hearing request constituted an express denial of the claim, the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the Administrative Law Judge's (ALJ's) findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant was originally compensably injured on October 26, 1992 when a wall fell on him. The claim was accepted for T12 frankel class B paraplegia with some sensory preservation L3 bilaterally, L1 burst fracture, L2 right lateral mass fracture, right hemothorax, right psoas hematoma. On November 4, 1994, claimant fell from his wheelchair and fractured his right hip.

Prior to the June 19, 1995 hearing, SAIF accepted the right hip fracture claim. At the hearing, claimant argued that he was entitled to an attorney fee pursuant to ORS 656.386(1) because his attorney was instrumental in establishing that the right hip fracture was compensable. The ALJ found that claimant was not entitled to an attorney fee pursuant to ORS 656.386(1) because there was no express denial of compensation.

On review of the ALJ's order, we found that the record did not establish that SAIF refused to pay compensation on the express ground that the right hip and femur fracture was not compensable or did not give rise to an entitlement to any compensation. On this basis, we affirmed the ALJ's order finding that there was no "denied claim" and that no attorney fee could be awarded under ORS 656.386(1). *Michael J. Galbraith*, 48 Van Natta at 352 (1996).

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[1] Under ORS 656.386(1), claimant's attorney is entitled to an attorney fee "in 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." The statute defines a denied claim as a claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation. The statute also provides that a denied claim shall not be presumed from a carrier's failure to pay compensation for a previously accepted injury or condition in a timely fashion.

The court reversed our order. The court concluded that SAIF's response to claimant's hearing request constituted an express denial of the claim and was an implicit refusal to pay compensation in the future. On this basis, the court reversed and remanded the case to us for reconsideration.

In response to claimant's request, we granted supplemental briefing on remand. Having received and considered the parties' supplemental briefs on remand, we proceed with our reconsideration.

In light of the court's decision, claimant is entitled to an attorney fee pursuant to ORS 656.386(1) for his counsel's services in obtaining a rescission of the denial prior to a decision by the ALJ. In determining the amount of a reasonable attorney 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 involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

We note that any services subsequent to SAIF's pre-hearing rescission of its denial of the fractured right hip and femur are not considered in determining a reasonable award. *See Amador Mendez*, 44 Van Natta 736 (1992). In addition, claimant is not entitled to an attorney fee for services regarding the attorney fee issue. *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

The record reveals the following information. The issue in dispute concerned the causal relationship between the right hip/femur fracture and the October 1992 compensable injury resulting in claimant's paraplegia. The record contains the March 27, 1995 hearing request filed by claimant's counsel raising a "de facto" denial of the fractured right hip/femur. Claimant's counsel also filed a supplemental hearing request on June 8, 1995.[2] In addition, the record contains a June 15, 1995 medical report obtained by claimant's counsel from Dr. Isaacson, the physician who performed surgery to repair the right hip/femur fracture. On June 19, 1995, the date of hearing, SAIF accepted claimant's right fractured femur and hip condition.

Seeking a $3,861 attorney fee, claimant's supplemental brief also indicates that some 29.7 hours was spent on research, telephone conferences,[3] preparation of an exhibit list, hearing preparation and the hearing itself. Noting the 1995 legislative amendments, claimant's counsel asserts that a "greater than normal amount of time on research" was expended particularly regarding the definition of an "express denial." As previously noted, claimant's counsel is not entitled to a fee for services expended regarding the attorney fee issue. Likewise, we are not authorized to award an attorney fee for services expended at the appellate levels for obtaining an attorney fee. Rather, claimant is solely entitled to an attorney fee award for his counsel's services in obtaining SAIF's acceptance of the hip and femur claim without a hearing.

As compared to the typical compensability cases which come before us, the compensability issue here was of average complexity. In addition, the parties had entered into a claim disposition agreement regarding the 1992 compensable injury, which would limit claimant's benefits for the injury to medical services. Generally, the value of the interest involved and the benefits secured for medical services, (in this case, medical services for a right hip fracture), are considered to be of minimal value. *See Melvin L. Martin*, 47 Van Natta 268 (1995) (as a general rule, the value of the interest, as well as the benefit secured, in the form of medical services are considered to be rather modest); *see also Derry D. Blouin*, 35 Van Natta 570 (1983). Nonetheless, the value of the medical services required for the hip/femur fracture were more significant than the normal medical services claim because surgery was necessary to repair the fracture. The attorneys presented their respective positions in a skillful manner. Prior to SAIF's pre-hearing acceptance, there was a risk that counsel might have gone uncompensated for his services. No frivolous issues or defenses were raised.

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[2] The record also contains an April 10, 1995 hearing request, an April 24, 1995 hearing request and a May 23, 1995 supplemental hearing request. However, these requests pertained to denials of gym membership and hand controls for a vehicle for the 1992 accepted claim and did not pertain to the hip fracture claim.

[3] Claimant's attorney included phone conferences with SAIF's appellate counsel who was not involved with the case until the Court of Appeals level. Thus, the phone conferences with SAIF's appellate counsel cannot be taken into consideration in the attorney fee award.

After considering the above factors, and having considered the parties' supplemental briefs on remand, we find that a reasonable attorney fee for claimant's counsel's services in obtaining the pre-hearing rescission of SAIF's denial of the fracture is $1,200. In particular, we have considered the time devoted to the issue (as represented by the record - two hearing requests, preparation of the exhibit list, claimant's attorney's telephone conferences with his client and claimant's physician, research regarding the compensability issue and procuring a medical report which apparently prompted the acceptance of the claim) the value of the interest involved, the nature of the proceedings, and the risk that claimant's counsel might have gone uncompensated.

Accordingly, on reconsideration, the ALJ's order dated June 27, 1995 is reversed in part. For services in obtaining the pre-hearing rescission of SAIF's denial, claimant's attorney is awarded $1,200, to be paid by SAIF.

IT IS SO ORDERED.

In the Matter of the Compensation of
JULI L. JOHNSTONE, Claimant
WCB Case No. 98-00073
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Podnar's order that assessed a 25 percent 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," except for the final finding on page two of his order. In its place, we find that, when the insurer issued its denial, it had legitimate doubt regarding its liability for claimant's injury.

CONCLUSIONS OF LAW AND OPINION

Claimant, a legal secretary, injured her hand/wrist after it was caught in an elevator door. Claimant was returning from a paid break at the lower level of the building where she was allowed to smoke. The elevator in question operated from the lower level to the lobby, from which additional elevators served the upper floors, including the sixth floor offices where claimant was employed.

The ALJ set aside the insurer's denial that was based on the contention that claimant's injury did not arise out of and in the course of employment. In doing so, the ALJ found that both elements of the work-connection test were satisfied. In addition, the ALJ concluded that the insurer's denial was unreasonable, thereby meriting the assessment of a 25 percent penalty pursuant to ORS 656.262(11)(a).

On review, the insurer does not contest compensability. Instead, it contends that the ALJ incorrectly assessed a penalty because it had a legitimate doubt regarding its liability for claimant's injury based on prevailing case law. For the following reasons, we agree with the insurer's contention.

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.*

At the outset, we note that "course and scope" cases such as this turn on their own particular facts and that reasoning by analogy to previous cases is of limited value. *Benafel v. SAIF*, 33 Or App 597, 599 (1978); *Casper v. SAIF*, 13 Or App 464, 470 (1973). 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). In *First Interstate Bank of Oregon v. Clark*, 133 Or App 712, 717 (1995), the court held that the "totality of the circumstances" must be considered in determining if the claimant has shown a sufficient work connection.

Here, we find that, considering the "totality of circumstances" surrounding claimant's injury, the insurer had a reasonable doubt regarding its liability for the claim. Although claimant was on a paid break, she was on a personal mission to smoke. Had she not decided to smoke, a break room was available on the same floor on which she worked. Moreover, claimant's injury occurred more than six floors removed from her place of employment. The elevator in which claimant was injured was not the one that led directly to the offices where she worked; it was a separate elevator leading from a parking area to the main lobby. Directly adjacent to the elevator where claimant was injured was a set of stairs leading to the main plaza elevators. Thus, claimant had an alternative route to the elevator leading to the offices where she worked.

Under these circumstances, particularly considering the remote location of claimant's injury when compared to her employer's office, we conclude that the insurer had a legitimate doubt regarding its liability for claimant's injury.

We acknowledge that, in *Henderson v. S.D. Deacon Corp.*, 127 Or App 333, 339 (1994), the court determined that a claimant's injury incurred as she stepped off an elevator while on an unpaid lunch break was compensable. The court reasoned that the claimant's conditions of employment put her in a position to be injured based on the employer's knowledge of her repeated use of the elevator to go to and from her workplace, the lack of alternative means to arrive and leave her workplace, the unavailability of lunch facilities at the workplace, and the employer's preference that claimant leave the building for lunch.

Despite this precedent, we do not find it unreasonable for the insurer to have issued its denial. Here, as was true in *Henderson*, the employer was also aware of and acquiesced in claimant's break routine. (Tr. 18). Like the claimant in *Henderson*, who was in effect required to leave the workplace to eat, claimant was required to go to an area where she was free to smoke because the employer's offices were designated non-smoking. (Tr. 15). Moreover, while the claimant in *Henderson* was on an unpaid lunch break when injured, claimant here was injured while on a *paid* break.

However, unlike the claimant in *Henderson*, the evidence shows that claimant had an alternative route to return to work (a stairway next to the elevator). Moreover, claimant in this case was injured in a more remote location when compared to her employer's office than was the claimant in *Henderson*. While *Henderson* supports the ALJ's finding of a sufficient work connection in this case, we find that the circumstances of this case are sufficiently different for the insurer's denial to have been reasonable; *i.e.*, that the insurer had a legitimate doubt regarding its liability for claimant's injury. Therefore, we disagree with the ALJ's conclusion that the insurer's denial was unreasonable.

ORDER

The ALJ's order dated April 9, 1998 is reversed in part and affirmed in part. That portion of the ALJ's order that assessed a penalty is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
CARL E. SETZER, Claimant
Own Motion No. 98-0211M
OWN MOTION ORDER ON RECONSIDERATION
Pozzi, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

On July 23, 1998, we withdrew our June 23, 1998 Own Motion Order in which we authorized reopening of claimant's 1979 claim for the payment of temporary disability compensation. We took this action to consider the SAIF Corporation's contentions that claimant has not met his burden of proving that he was in the work force at the time of worsening. Having received the parties' respective written positions, we disagree with SAIF's contentions.

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 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 has not proven that he was in the work force at the time of disability because claimant has not responded to its request for completed tax returns. In reply to SAIF's assertion, claimant has submitted copies of his 1997 tax return, which indicates that he reported "business income" during the calendar year 1997.

Previously finding that claimant was working at the time of his disability, we were persuaded by claimant's submission of receipts of payment for work done for various persons between November 13, 1997 through January 13, 1998. On reconsideration, we find no new evidence which would persuade us otherwise. Contrary to SAIF's assertions, we have previously found that, although probative evidence, current tax returns are not necessarily requisite documents of proof of work. *See Michael C. Batori*, 49 Van Natta 535 (1997); *Daniel Martushev*, 48 Van Natta 1033 (1996); *Rodney D. Sullivan*, 48 Van Natta 1143 (1996), *on recon* 48 Van Natta 1176 (1996). In any event, as noted above, claimant has submitted a copy of his 1997 tax return which supports his previous submission and further demonstrates that he was in the work force at the time of the current disability. Thus, we continue to find that claimant has established that he was working at the time of disability.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our June 23, 1998 Own Motion Order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
LAURA W. STEKETEE, Claimant
WCB Case No. 97-09199
ORDER ON REVIEW
Bryant, Emerson, et al, Claimant Attorneys
Stoel Rives, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

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 right carpal tunnel syndrome (CTS). On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following change. In the first full paragraph on page 2, we replace the first sentence with the following:

> "In April 1997, claimant noticed that her right hand would fall asleep at night and become numb when she was running. (Tr. 10-11). She did not notice symptoms at work until approximately two months later. (Tr. 11-12). She started noticing tightness in her wrist when she was taking blood pressures. (*Id.*)"

CONCLUSIONS OF LAW AND OPINION

Claimant is a registered nurse who began working for the employer in June 1996. (Ex. 1). She had a variety of responsibilities, including taking blood pressures, greeting patients, taking histories, weighing patients, administering immunizations, as well as making patient phone calls, ordering prescriptions and supplies and stocking rooms. (Tr. 46, 47). Claimant is right hand dominant. In April 1997, claimant noticed that her right hand would fall asleep at night and become numb when she was running. (Tr. 10-11). She did not notice symptoms at work until approximately two months later. (Tr. 11-12). She started noticing tightness in her wrist when she was taking blood pressures. (*Id.*)

On July 22, 1997, claimant completed an "801" form, referring to numbness and pain in her right wrist and fingers as a result of taking blood pressures. (Ex. 1). She sought treatment from Dr. Mara on August 18, 1997 for right hand numbness and tingling. (Ex. 3). He felt she had right CTS. (*Id.*) Dr. Koller performed nerve conduction studies on December 22, 1997 and diagnosed right CTS. (Ex. 8). Dr. Rosenbaum later provided the same diagnosis. (Ex. 11).

The ALJ concluded that claimant had carried her burden of proving that her work activities were the major contributing cause of the right CTS condition. In reaching this conclusion, the ALJ found the opinion of Dr. Koller more persuasive than the opinions of Drs. Mara and Rosenbaum. On review, the employer argues that the conclusory opinion of Dr. Koller is not persuasive. We agree and reverse.

To establish her occupational disease claim, claimant must prove that employment conditions were the major contributing cause of the right CTS. *See* ORS 656.802(2)(a). Determining the "major contributing cause" involves evaluating the relative contribution of different causes of the disease and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995). When the medical evidence is divided, we give more weight to those opinions that are both well-reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259, 263 (1986).

After reviewing the record, we find that Dr. Rosenbaum's opinion is the better reasoned opinion and is based on complete information. Dr. Rosenbaum took a thorough history, which included a description of the onset of her symptoms in April 1997 while running. (Ex. 11-1). Claimant told him she gardens in the spring for four to five hours approximately two days each week and she was performing this gardening activity in April 1997 when her hand first became symptomatic. (Ex. 11-2). Claimant said she took up to 40 blood pressures per day. (*Id.*) Dr. Rosenbaum concluded that claimant's work activities were not the major contributing cause of her right CTS. (Ex. 11-4). He explained:

> "Even if we accept her estimate that she was using the blood pressure cuff 40 times a day, the frequency of cuff use would be approximately 4 to 5 times per work hour for four days a week. In those industries or tasks for which the evidence is strongest that carpal tunnel syndrome is an occupational hazard, workers are using their hands, fingers and wrists with repetitions once every minute or two rather than once every twelve to fifteen minutes. [Claimant's] work was variable, self-paced, and not the type likely to lead to carpal tunnel syndrome." (*Id.*)

Dr. Rosenbaum noted that claimant's CTS first became symptomatic when she was preparing her garden in the spring and running. He felt it was more likely that those activities would lead to development of CTS than would using the blood pressure cuff. (*Id.*)

Similarly, Dr. Mara did not believe claimant's work activities were the major contributing cause of her right CTS. When Dr. Mara first examined claimant on August 18, 1997, he indicated that she was taking a "lot more" blood pressures "[d]ue to staffing changes[.]" (Ex. 3). In a later report, he said that claimant's increased symptoms coincided with the increase in taking blood pressures. (Ex. 5). Dr. Mara noted that the "contributing cause of her current exacerbation would be her on the job activities." (*Id.*) However, he concluded that the "major overall cause" of her CTS was likely idiopathic. (*Id.*)

Claimant relies on Dr. Koller's opinion to establish compensability. Dr. Koller examined claimant on two occasions. Although we generally defer to the opinion of a worker's treating physician, we do so because of his or her opportunity to observe the claimant over an extended period of time. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here, because Dr. Koller saw claimant on only two occasions, we do not grant any particular deference to his opinion.

Furthermore, we are not persuaded by Dr. Koller's opinion because it is not well-reasoned and lacks adequate explanation. He performed nerve conduction studies in December 1997 and examined claimant on February 9, 1998. (Exs. 8, 9A). Dr. Koller reported that claimant's symptoms first started when she was running. (Ex. 9A-1). Later in the report, however, he said that claimant "first started to note wrist aching" when squeezing the blood pressure bulb at work. (*Id.*) Claimant testified that she first noticed hand numbness when she was running. (Tr. 10-11). In light of Dr. Koller's contradictory report, it is unclear whether he had an accurate history of the onset of claimant's symptoms.

Dr. Koller concluded that, based on claimant's history (which appears to be inaccurate), he felt her right CTS was work-related. (Ex. 9A-2). He commented that there did not appear to be any facts in her personal life that would lead to CTS. (*Id.*) In a later report, Dr. Koller opined that claimant's job activities were the major contributing factor of her CTS and he did not believe her condition was congenital or idiopathic. (Ex. 10).

We are not persuaded by Dr. Koller's conclusory opinion. First, as we mentioned earlier, it is unclear whether he had an accurate history of the onset of claimant's symptoms. Moreover, he did not explain how taking blood pressures could lead to the development of CTS. Unlike Dr. Rosenbaum, Dr. Koller failed to discuss the frequency or duration of claimant's off-work activities and he did not offer any real comparison of her non-work related activities with her work-related activities. We agree with the employer that Dr. Koller did not sufficiently weigh the various causal factors in accordance with the requirements of *Dietz v. Ramuda*, 130 Or App at 401-02.

We conclude that claimant has failed to sustain her burden of proving that her work activities were the major contributing cause of the right CTS condition. Consequently, we reverse the ALJ's order and uphold the employer's denial.

ORDER

The ALJ's order dated May 12, 1998 is reversed. The self-insured employer's denial of claimant's claim for right CTS is reinstated and upheld. The ALJ's attorney fee award is also reversed.

In the Matter of the Compensation of
RICHARD N. UHING, Claimant
Own Motion No. 94-0078M
OWN MOTION ORDER DENYING REQUEST FOR CLARIFICATION
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted a request seeking: (1) an order clarifying the reopening date of claimant's claim for the provision of temporary disability benefits; and (2) an advisory opinion from the Board regarding SAIF's past, present and future claim processing responsibilities.

We requested that the parties submit their written positions and documentary evidence regarding SAIF's request. Having received several briefs from all parties, we proceed with our review.

On March 16, 1995, we issued an order authorizing reopening of claimant's claim for the provision of temporary disability compensation beginning the date he was hospitalized for surgeries to include foraminotomies at L5-S1 and a fusion from L4 to S1, which were recommended by Dr. Misko, his attending physician. Thereafter, prior to undergoing surgery, claimant required treatment at an in-patient pain center. Dr. Flemming, claimant's treating psychiatrist, felt that "in order to get [claimant] ready for the low back fusion, I proposed that we refer him to the Northwest Occupational Medicine program ... It is full time."

In May 1995, claimant entered an in-patient pain center. On May 31, 1995, SAIF began paying claimant temporary disability compensation, effective upon his hospitalization in the pain center. On November 27, 1995, SAIF issued a Notice of Closure. Claimant appealed that closure and on February 28, 1996, we issued our order setting aside the November 27, 1995 closure as premature. We reasoned that, although claimant had not undergone the proposed surgery, the record established that the surgery was reasonable and necessary and was expected to materially improve claimant's compensable condition. That order was not appealed.

The Workers' Compensation Division (WCD) began an audit of SAIF's reimbursement claim under ORS 656.625. Noting that SAIF's reimbursement claim was based on temporary disability arising from claimant's pain center hospitalization, WCD questioned its authority to provide reimbursement. In doing so, WCD observed that our March 16, 1995 Own Motion Order reopened the claimant's claim for the provision of temporary disability compensation beginning the date he was hospitalized for the proposed *surgery*. Determining that our March 16, 1995 order did not authorize the payment of temporary disability compensation beginning the date claimant was hospitalized at the pain center, WCD requested that SAIF return the "reimbursement" proceeds.

As a result of WCD's decision, SAIF requests that we issue an order "clarifying" the opening date of this claim. This request has become moot as a result of another Own Motion Order issued this date. In that order, we addressed SAIF's voluntary reopening of claimant's claim for the provision of temporary disability compensation beginning the date he was hospitalized at the pain center. We found that claimant's treatment at the pain center met the criteria necessary to allow us to treat it as hospitalization. Therefore, we authorized the payment of this compensation beginning May 31, 1995, the date claimant was hospitalized at a pain center for evaluation and treatment.

Accordingly, because we find no current justifiable controversy for our resolution, SAIF's request for clarification is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
RICHARD N. UHING, Claimant
Own Motion No. 94-0078M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has voluntarily reopened claimant's claim pursuant to ORS 656.278 for his compensable lumbar strain. Claimant's aggravation rights expired on July 7, 1992. SAIF 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.*

Accordingly, we have the authority to reopen a claim for pain center treatment requiring inpatient hospitalization. We may also reopen a claim for pain center treatment on an outpatient basis where overnight accommodation away from home is necessary to obtain maximum benefits from the treatment. Under such circumstances, pain center treatment is treated as hospitalization. *Lenne Butcher,* 41 Van Natta 2084 (1989).

Turning to the present case, on March 16, 1995, we issued an order authorizing reopening of claimant's claim for the provision of temporary disability compensation beginning the date he was hospitalized for surgeries to include foraminotomies at L5-S1 and a fusion from L4 to S1, which were recommended by Dr. Misko, his attending physician. Thereafter, prior to undergoing surgery, claimant required treatment at an in-patient pain center. Dr. Flemming, claimant's treating psychiatrist, felt that "in order to get [claimant] ready for the low back fusion, I proposed that we refer him to the Northwest Occupational Medicine program ... It is full time."

In May 1995, claimant entered an in-patient pain center. On November 27, 1995, SAIF issued a Notice of Closure. Claimant appealed that closure and on February 28, 1996, we issued our order setting aside the November 27, 1995 closure as premature. We reasoned that, although claimant had not undergone the proposed surgery, the record established that the surgery was reasonable and necessary and was expected to materially improve claimant's compensable condition. That order was not appealed.

As noted above, treatment at the pain center had been requested by Drs. Flemming and Misko in order to prepare claimant for the proposed low back surgery. In order to maximize the benefits from treatment at the pain center, claimant's physicians requested overnight accommodations away from his home. In an April 18, 1995 letter, Dr. Flemming requested that claimant stay in a facility close to the pain center "in order to avoid additional pain of driving back and forth from home each day." Dr. Wong, who reviewed Dr. Flemming's request on behalf of SAIF, stated that "claimant will require on site housing during Pain Center Evaluation and treatment program." Dr. Misko concurred with Drs. Flemming's and Wong's recommendations.

Accordingly, we conclude that claimant has demonstrated that the pain center treatment satisfied the above criteria which would enable us to treat the pain center treatment as hospitalization. We, therefore, authorize the payment of temporary disability compensation commencing May 31, 1995, the date claimant entered the pain center for evaluation and treatment. When claimant's condition becomes medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055. [1]

IT IS SO ORDERED.

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[1] In authorizing this compensation, we note that there is another order which reopened claimant's claim for his proposed surgery. This order does not affect that order nor does it require SAIF to issue a separate Notice of Closure on this authorization. Rather, SAIF may include the voluntary payment of temporary disability compensation from May 31, 1995 until claimant is declared medically stationary, under Section 2 of Form 2066 (which reflects entitlement to temporary disability for "periods" of eligibility), when it closes the currently reopened claim pursuant to OAR 438-012-0055. Additionally, pursuant to our March 16, 1995 order, temporary disability compensation is required to commence on the date of hospitalization for surgery. If claimant is already receiving temporary disability compensation under this "pain center" reopening when the surgery hospitialization occurs, SAIF is not required to pay TTD for the same period.

In the Matter of the Compensation of
WILLIAM F. WEGESEND III, Claimant
WCB Case No. 97-05479
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Thaddeus J. Hettle, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Menashe's order that set aside its denial of claimant's current right knee 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 set aside the employer's "current condition" denial, reasoning that a preponderance of the evidence established that claimant's compensable right knee injury remained a material contributing cause of his current right knee condition. On review, the employer contends that we should defer to the opinion of Dr. Sedgewick, an orthopedist to whom claimant's prior attending physician, Dr. Lee, referred claimant, and who later performed diagnostic arthroscopy and assumed responsibility for claimant's treatment. Based on that opinion, the employer asserts that claimant's current condition is not compensable. For the following reasons, we conclude that the medical evidence fails to satisfy claimant's burden of proof.

We begin by briefly recounting the factual background of the claim. Claimant, a bus mechanic, sustained a compensable right knee injury on June 30, 1995, stepping out of a bus carrying two 5-gallon containers. Dr. Lee became claimant's attending physician and diagnosed a right knee sprain with possible internal derangement. On August 31, 1995, the employer accepted a right knee sprain.

On September 8, 1995, an MRI was interpreted as showing degenerative change involving the posterior horn of the medical meniscus without a frank tear. (Ex. 13). Dr. Lee declared claimant medically stationary on October 19, 1995 without permanent impairment, but opined that the MRI finding was a result of the work injury. (Ex. 14-2). The claim was then closed on November 14, 1995 by Notice of Closure which awarded no permanent disability.

Claimant sought no further treatment for his right knee until July 23, 1996, when he reported a recurrence of knee pain to Dr. Lee. (Ex. 16). Dr. Lee advised claimant to perform range of motion exercises, to take pain medication, and return if there was no improvement.

Claimant sought no further treatment until January 21, 1997, when he again consulted Dr. Lee, complaining of a constant ache in the knee. Dr. Lee diagnosed persistent right lateral knee pain. (Ex. 16-2). Dr. Lee referred claimant to an orthopedic surgeon, Dr. Sedgewick, for a consultation.

Dr. Sedgewick recommended diagnostic arthroscopy. (Ex. 18). An aggravation claim was then filed on claimant's behalf. (Ex. 19). The arthroscopic evaluation detected no abnormalities, with Dr. Sedgewick operative report describing claimant's knee as "normal" and the medial compartment as "pristine." (Ex. 24). Dr. Sedgewick later confirmed that he could not detect any interarticular pathology that would explain claimant's symptoms from an injury on June 30, 1995. (Ex. 28).

The employer denied the aggravation claim and current right knee condition on June 6, 1997. Claimant appealed the denial.

At the hearing, claimant withdrew the aggravation claim. The sole issue was the compensability of claimant's current right knee condition. The ALJ set aside the current condition denial, relying on the medical opinion of Dr. Lee, as well as on claimant's report that he had experienced ongoing discomfort since the original injury.

The parties do not argue, nor does the evidence establish, the presence of a "combined" or "consequential" condition. *See* ORS 656.005(7)(a)(B) and ORS 656.005(7)(a)(A). Therefore, to establish compensability of his current condition, claimant must prove by a preponderance of the evidence that his 1995 injury is a material contributing cause of his need for treatment. *Fred Meyer, Inc. v. Crompton*, 150 Or App 531 (1997) (affirming compensability determination made under material causation standard where no "combined" or "consequential" condition was present). Because of the passage of time since the 1995 injury, and because of the limited medical treatment claimant received between claim closure in November 1995 and his resumption of treatment in January 1997, we find that the causation issue is a complex medical question which requires expert evidence for its resolution. *See Barnett v. SAIF*, 122 Or App 279 (1993). We rely on those medical opinions which are well-reasoned and based on complete histories. *See Somers v. SAIF*, 77 Or App 259 (1986). We 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, both Dr. Lee and Dr. Sedgewick have treated claimant. Whereas Dr. Lee treated claimant shortly after the original injury in 1995 and continued to do so through February 1997, Dr. Sedgewick only began treating claimant relatively recently. However, Dr. Sedgewick, unlike Dr. Lee, is an orthopedic surgeon, who performed a diagnostic arthroscopy and thus had the opportunity to view the interior of claimant's knee. *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). Based on his observations during surgery, Dr. Sedgewick testified in his deposition that he could not state that claimant's current knee condition was related to the 1995 injury. (Ex. 38-15). Dr. Sedgewick emphasized that there was no objective evidence of injury and that any degenerative changes were not out of the ordinary for someone of claimant's age. (Exs. 38-9, 10, 11, 12). According to Dr. Sedgewick, the arthroscopic evaluation did not reveal any objective explanation for claimant's pain complaints. (Ex. 38-11). Because it is complete, well-reasoned and based on actual observation of claimant's knee joint, Dr. Sedgewick's opinion is persuasive. Moreover, we find that it is more persuasive than Dr. Lee's opinion.

Dr. Lee's causation opinion consists of a concurrence with the contents of a letter from claimant's counsel that states that it is Dr. Lee's opinion that claimant's right knee condition is related in major part to the 1995 injury. (Ex. 37). We give little weight, however, to the report because it contains no explanation for the conclusory statement contained within it. *See Lloyd A. Terpening*, 50 Van Natta 799, 800 (1998) (discounting unexplained medical opinion). We find the report especially unpersuasive because Dr. Lee does not acknowledge, let alone discuss, Dr. Sedgewick's surgical findings.

We are mindful of claimant's testimony that he had no prior injuries and has had ongoing symptoms since the 1995 injury. However, this case involves a complex question of medical causation. We thus require medical evidence for its resolution. Our *de novo* review of the medical record does not reveal a *persuasive* medical opinion that causally relates claimant' current right knee condition to the compensable 1995 injury.[1] For this reason, we find that claimant failed to sustain his burden of proof. Therefore, we reverse.

ORDER

The ALJ's order dated May 11, 1998 is reversed in part and affirmed in part. The employer's denial of claimant's current right knee condition is reinstated and affirmed. The ALJ's attorney fee award is also reversed. The remainder of the order is affirmed.

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[1] On July 7, 1997, a consulting physician, Dr. Brenneke, diagnosed internal derangement of claimant's knee "secondary to a work related injury June 30, 1995." Ex. 34-1). However, Dr. Brenneke provided no explanation of the causation statement contained within the diagnosis. Thus, we do not find Dr. Brenneke's report satisfies claimant's burden of proof.

In the Matter of the Compensation of
DWIGHT I. BERGLUND, Claimant
WCB Case No. 97-04332
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Stephen Brown's order that modified the Order on Reconsideration to reinstate claimant's permanent total disability award. On review, the issue is permanent total disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant suffered a compensable injury, which resulted in a finding in 1992 that he was permanently totally disabled. In 1995, claimant was re-examined regarding his disability status; a Determination Order continued the permanently totally disabled status. SAIF requested reconsideration, and an Order on Reconsideration found that claimant was capable of suitable and gainful employment. A hearing was requested, and the ALJ concluded that SAIF had failed to prove that claimant was capable of regularly working at a suitable and gainful occupation. On review, SAIF argues that claimant is no longer permanently totally disabled. We agree.

Employers have an obligation periodically to reexamine permanent total disability awards. ORS 656.206(5). A claimant's award of permanent total disability can be modified if the employer proves by a preponderance of the evidence that he is presently able to perform gainful and suitable employment, even if his physical condition remains essentially unchanged. *Harris v. SAIF*, 292 Or 683 (1982); *Lehman v. SAIF*, 107 Or App 207, 211 (1991); *Kytola v. Boise Cascade Corp.*, 78 Or App 108, 111, *rev den* 301 Or 765 (1986).

Here, claimant was examined by a panel at Progressive Rehabilitation Associates in July 1995. They found that claimant's physical condition had improved since 1992, and found no medical, gastrointestinal or psychiatric reasons why claimant could not return to light work for four hours per day, increasing to eight hours per day after completion of one month of physical therapy. They indicated several job descriptions which were within claimant's physical capabilities. (Exs. 61-2, 62, 63-1, 64, 65-3, 66, 76). Mr. Scopacasa, the sole vocational consultant offering an opinion, agreed. (Ex. 85-23, 25, -26, -27).

The ALJ, however, reasoned that SAIF failed to produce medical evidence showing that claimant could sustain the level of activity required to remain *regularly* employed. There is evidence that claimant experiences ongoing gastroenterological and psychological problems. (Exs. 61-2, 76, 80, 81-2). Mr. Scopacasa indicated that it was possible that these problems might lead to an unacceptable level of absenteeism. (Ex. 85-13 through 85-16). However, this evidence merely suggests the possibility that claimant may not be able to maintain employment, depending on the job and the employer[1]. Such a suggestion is insufficient to rebut the direct vocational evidence provided by Mr. Scopasa that claimant is employable. Therefore, based on the record as a whole, we conclude that SAIF has carried its burden to prove that claimant is presently capable of performing work at a gainful and suitable occupation.

ORDER

The ALJ's order dated April 13, 1998 is reversed. The Order on Reconsideration is reinstated and affirmed. The attorney fee is reversed.

[1] Speculation about a claimant's ability to engage in regular employment because of possible absenteeism will not suffice to overcome the type of evidence presented here.

In the Matter of the Compensation of
HARLEY J. GORDINEER, Claimant
WCB Case No. 96-10148
ORDER ON REVIEW
David C. Force, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The insurer requests review of those portions of Administrative Law Judge (ALJ) McWilliam's order that: (1) found that claimant was entitled to additional temporary disability; (2) found that claimant was entitled to additional permanent disability payments as a result of the insurer's incorrect offsets; (3) awarded penalties and attorney fees for an allegedly unreasonable failure to pay temporary disability benefits at the correct rate; (4) found that claimant was entitled to interest on the unpaid temporary and permanent disability benefits; (5) awarded claimant's counsel "out-of-compensation" attorney fees based on increased temporary and permanent disability benefits; (6) awarded claimant's counsel an "out-of-compensation" attorney fee for the interest due on the unpaid temporary and permanent disability benefits; (7) awarded claimant a penalty and related attorney fee pursuant to ORS 656.268(4)(f); (8) awarded claimant a penalty and related attorney fee pursuant to ORS 656.268(4)(g); and (9) awarded claimant an assessed attorney fee for the insurer's unreasonable resistance to the payment of compensation. In its brief, the insurer contends that the ALJ erred in refusing to admit Exhibit 96 into evidence, and requests that the matter be remanded to the ALJ. The insurer also moves to strike claimant's respondent's/cross appellant's brief on the ground that the brief was untimely filed. Claimant cross-requests review of that portion of the ALJ's order that found that claimant was not permanently and totally disabled. On review, the issues are temporary disability benefits, permanent disability benefits, interest, penalties and attorney fees, remand and permanent total disability. We deny the insurer's motions to strike and to remand.[1] We affirm the ALJ's order.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

PRELIMINARY MATTERS

Motion to Strike

The insurer moves to strike claimant's respondent's/cross-appellant's brief on the ground that the brief was untimely filed. The insurer argues that it filed an appellant's brief on May 4, 1998 and claimant, therefore, had until May 25, 1998 to file his brief.

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 of record to the parties. The respondent is required to file its brief within 21 days after the date of mailing of the appellant's brief. For purposes of appellate 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, claimant's brief was filed on May 26, 1998. The insurer acknowledges that May 25, 1998 was Memorial Day - a federal holiday. To support its motion, however, the insurer relies on *Corrie M. Harp*, 50 Van Natta 212 (1998). In *Harp*, we granted a motion to strike an appellant's brief despite the fact that the brief was due on a federal holiday and the U.S. Postal Service was closed.

We find *Harp* to be distinguishable. In that case, we specifically noted that the holiday (Columbus Day) was not a state holiday. Consequently, even though the day was a federal holiday, state offices, including the Board's permanently staffed offices, were not closed and a hand-delivered brief at the Board's offices on that day would have been accepted as "filed." *Harp*, 50 Van Natta at 212.

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[1] Claimant also has submitted additional materials regarding the insurer's processing of his claim subsequent to the filing of his counsel's appellate brief. Inasmuch as claimant has an attorney-of-record, we have forwarded this submission to his counsel along with a copy of this order. We have also sent a copy of this submission to the insurer's attorney along with a copy of this order.

In the present case, however, the insurer concedes that the state's offices, and therefore, the Board's offices were closed and delivery to a permanent staffed Board office was not an option. Accordingly, because there was no U.S. mail on the holiday at issue and because the Board's offices were closed, we conclude that extraordinary circumstances beyond claimant's control prevented him from filing his respondent's/cross-appellant's brief on May 25, 1998. Therefore, a waiver of our rules is warranted. *See* OAR 438-011-0030. Under the circumstances, we deny the insurer's motion to strike claimant's brief.

Remand

At hearing, the ALJ excluded Exhibit 96 on the grounds that it was hearsay and that it was untimely disclosed. On review, the insurer argues that the exhibit should be admitted as evidence regarding claimant's time loss rate.

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

As noted by the ALJ, the insurer did not timely disclose Exhibit 96, notwithstanding the fact that it had been directed to do so pursuant to a prior ALJ's interim order. Under the circumstances, we conclude that the ALJ did not abuse her discretion in declining to admit the exhibit. Consequently, the insurer's motion for remand is denied.

CONCLUSIONS OF LAW AND OPINION

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

On review, the insurer requests reversal or clarification of the ALJ's order regarding the issue of interest. Specifically, the insurer contends that the ALJ's order could be construed to require it to pay interest payments not set forth in ORS 656.313. However, the insurer does not contest its duty to pay statutory interest as set forth in the statute for time loss benefits accruing prior to the date the denial was set aside.

We do not find that the ALJ's order requires clarification on this issue. ORS 656.313 provides that benefits withheld under the statute, if ultimately found payable under a final order, shall accrue interest "from the date of the order appealed from through the date of payment." ORS 656.313(1)(b). The ALJ's order which directed the insurer to pay interest "on the unpaid TTD from the time that it was due until actual payment," is consistent with the statute.

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 $1,332.50, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues and the value of the interest involved. We note that claimant is not entitled to an attorney fee for services on review devoted to the issues of permanent total disability, penalties, or attorney fees. *See Saxton v. SAIF*, 80 Or App 631 (1986); *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated March 7, 1998, as amended March 9, 1998, is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,332.50, to be paid by the insurer.

In the Matter of the Compensation of
JOHN W. GURLEY, Claimant
WCB Case No. 97-06620
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) Brazeau's order that upheld the SAIF Corporation's denial of his combined/consequential condition claim for a low back condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld SAIF's denial of an L5-S1 disc herniation condition. In doing so, the ALJ found that claimant failed to satisfy the major contributing cause standard of either ORS 656.005(7)(a)(B) or ORS 656.005(7)(a)(A).[1]

On review, claimant contends that he has proved the compensability of a "combined" condition. For the following reasons, we conclude that claimant has proved the compensability of a L5-S1 nerve root condition, applying either ORS 656.005(7)(a)(B) or ORS 656.005(7)(a)(A).

We first briefly recount the factual background of the claim. In November 1991, claimant injured his low back in a non-work related automobile accident. During the course of treatment, a herniated disc at L5-S1 was identified. After approximately 10 months of treatment, claimant apparently recovered without significant residuals.

In August 1995, claimant suffered a compensable cervical strain in a work-related motor vehicle accident. He eventually came under the care of Dr. Hoppert. Dr. Hoppert noted during a closing examination for the cervical injury on January 6, 1997 that claimant reported the onset of low back pain after performing a maneuver in physical therapy prescribed for the cervical injury.

By February 1997, low back and left leg pain became the primary complaint. A February 12, 1997 MRI scan revealed a L5-S1 lateral disc herniation compressing the S1 and S2 nerve roots. Thereafter, Dr. Hoppert recommended an L5-S1 discectomy. Examining physicians, Drs. Rosenbaum and Gritzka, later evaluated claimant's low back condition. On June 20, 1997, SAIF denied reopening of the claim for a "consequential" condition on the ground that the August 1995 cervical injury was not the major contributing cause of the L5-S1 disc herniation. Claimant requested a hearing.

At the hearing, claimant clarified the issues to be litigated. Claimant stated that he was not pursuing an aggravation claim. (Tr. 7). Rather, claimant sought reversal of SAIF's denial on the grounds that he sustained a new injury to the L5-S1 nerve roots or aggravated the preexisting L5-S1 disc condition as a result of the physical therapy provided for the compensable cervical injury. (Tr. 5). Alternatively, claimant raised the issue of "de facto" denial in case the claim for nerve root irritation was not encompassed within SAIF's denial. (Tr. 11).

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

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

ORS 656.005(7)(a)(A) provides:

"No injury is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition."

The ALJ determined that SAIF's denial encompassed any claim for L5-S1 nerve root irritation. Thus, the ALJ held that there was no "de facto" denial. The ALJ then noted that either ORS 656.005(7)(a)(B) or 656.005(7)(a)(A) applied to the case because claimant's current low back condition involved a "combined" condition and because the low back condition also developed as a consequence of medical treatment (physical therapy) prescribed for the cervical condition. As previously noted, the ALJ then upheld SAIF's denial under consequential or combined condition theories.

We agree with the ALJ that both statutes could apply to the claim. Dr. Gritzka opined that the preexisting low back condition "combined" with the August 1995 injury and related physical therapy to cause claimant's need for treatment. (Ex. 31). Thus, application of ORS 656.005(7)(a)(B) is triggered. Moreover, claimant's current low back condition did develop as a consequence of physical therapy prescribed for the compensable cervical injury. Therefore, the consequential condition statute (ORS 656.005(7)(a)(A)) is also relevant. *See Barrett Business Services v. Haines*, 130 Or App 190, 193, *rev den* 320 Or 492 (1994) (where reasonable and necessary treatment of a compensable injury is the major contributing cause of a new injury, the compensable injury itself is properly deemed the major contributing cause of the consequential condition for purposes of ORS 656.005(7)(a)(A)).

This claim presents a complex question of medical causation because of the preexisting low back condition and the manner in which the current low back complaints developed. 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).

Based on our review of the medical evidence from Drs. Gritzka, Rosenbaum and Hoppert, we find that claimant has satisfied the compensability requirements of both statutes. After concluding that claimant's preexisting low back condition combined with the August 1995 compensable injury to produce the need for treatment, Dr. Gritzka further opined that it was "probable" that the physical therapy maneuvers caused a pathological worsening of the preexisting low back condition by increasing the tear or rupture of the annulus fibrosis at L5-S1. (Ex. 31). In a subsequent report, Dr. Gritzka reiterated his prior opinion, explaining that the physiological cause of the radicular symptoms claimant experienced after the physical therapy maneuvers was a "slight" worsening or enlargement of the disc herniation and release of irritating substances from the nucleous pulposis at L5-S1. (Ex. 41).

Because it is well-reasoned and based on an accurate and complete history, we find Dr. Gritzka's opinion persuasive. *Somers v. SAIF*, 77 Or App at 263. It establishes that the 1995 injury is the major contributing cause of claimant's need for treatment of the "combined" condition, *i.e.*, a combination of claimant's preexisting low back lateral L5-S1 disc herniation and the tear or rupture of the nucleous pulposis at L5-S1 resulting from the physical therapy.

Although the ALJ and SAIF consider Dr. Rosenbaum's opinion to be in conflict with Dr. Gritzka's, a close examination reveals that it, too, supports compensability under combined or consequential condition theories. Dr. Rosenbaum initially opined that claimant experienced a symptomatic, but objective, exacerbation of the L5-S1 disc protrusion during physical therapy maneuvers. (Ex. 34-4). Dr. Rosenbaum explained that claimant's need for treatment was related to the physical therapy maneuvers and thus that the major contributing cause of claimant's exacerbation was the 1995 industrial injury. Dr. Rosenbaum stated, however, that the major contributing cause of the lumbar disc herniation was the preexisting condition. *Id.*

Dr. Rosenbaum explained his opinion in depth at a deposition. There, Dr. Rosenbaum drew a distinction between the overall herniated disc, of which the 1995 injury was not the major cause, and nerve root irritation, in which the physical therapy maneuvers were the primary factor. As Dr. Rosenbaum testified, the physical therapy maneuvers caused microscopic inflammation and swelling of the nerve roots. (Ex. 43-4). Dr. Rosenbaum emphasized that, while claimant's herniation preexisted the therapy, the treatment provided to claimant was for the inflammation and irritation of the nerve root brought on by the physical therapy maneuvers. (Ex. 43-8). According to Dr. Rosenbaum, this inflammation and irritation was a "new problem," a "new injury," or a "new entity." (Exs. 43-12, 13, 19). The cause of the new condition (the nerve root irritation) was the physical therapy prescribed for the compensable 1995 injury. (Ex. 43-19).

Based on our *de novo* review of Dr. Rosenbaum's opinion, we find that it supports a finding that either the 1995 injury and related medical treatment was the major contributing cause of medical treatment for a "combined" condition, *see SAIF v. Nehl*, 148 Or App 101, *recon* 104 Or App 309 (1997), or, if viewed as a consequential condition claim, the major contributing cause of a consequential condition (nerve root irritation). In either case, Dr. Rosenbaum's opinion supports compensability.

Dr. Hoppert also provided a medical opinion regarding causation. He initially opined that physical therapy worsened claimant's preexisting low back condition. (Ex. 30). Dr. Hoppert later concurred with Dr. Gritzka's medical opinion. (Ex. 40). In another report, Dr. Hoppert wrote that he would "guess" that malpositioning of the spine (presumably due to physical therapy maneuvers) caused a disc herniation. (Ex. 42). In his final report, however, Dr. Hoppert appeared to back off his earlier opinion by again "guess[ing]" that an MRI in 1992 probably was not much different from one taken in 1997 and, therefore, opining that the 1995 injury did not cause a disc herniation or any worsening of the underlying condition. (Ex. 45).

We give little weight to Dr. Hoppert's opinion because his reports were not well explained and were based, at least partly, on speculation. In addition, they are somewhat contradictory.

In conclusion, we find that the most persuasive medical evidence (that which Drs. Gritzka and Rosenbaum provided) satisfied claimant's burden of proving compensability of claimant's medical treatment and disability for his current low back condition. Because the ALJ concluded that claimant did not prove a compensable claim for his current low back condition, 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 $4,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issues, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated April 17, 1998 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 attorney is awarded an assessed fee of $4,000, to be paid by SAIF.

August 19, 1998 Cite as 50 Van Natta 1619 (1998)

In the Matter of the Compensation of
HEIDI C. BEYERS, Claimant
WCB Case No. 97-09860
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Herman's order that: (1) found that claimant's "chronic lumbar syndrome" was encompassed within the insurer's acceptance of claimant's "sacroiliac/hip strain and left shoulder" claim; and (2) held that claimant's "chronic lumbar syndrome" claim had not been "de facto" denied. On review, the issue is claim processing.

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

Claimant contends that there is a difference between a lumbar strain and sacroiliac strain, as is demonstrated by the ICD-9-CM codes used by Dr. Conklin to diagnose claimant's condition. We understand claimant's contention as a request that we take administrative notice of these codes.

First, it is highly questionable whether we can take notice of the codes. Although we may, under limited circumstances, take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned," *see Groshong v. Montgomery Ward Co.*, 73 Or App 403 (1985), we have generally declined to take administrative notice where the submission constitutes evidence from a source not subject to confrontation and cross-examination. *See, e.g., Michael A. Crause*, 49 Van Natta 1022 (1997) (Board declined to take administrative notice of a submission from the DSM-IV manual because it was taken from a source not subject to confrontation and cross- examination); *Richard H. Olsen*, 41 Van Natta 1300 (1989) (Board did not have authority to consider the most recent version of a medical treatise where the evidence was not admitted at the hearing and not a part of the record). However, we need not resolve this question, because the medical opinions in this case do not establish a difference between "chronic lumbar syndrome" and "sacroiliac/hip strain." Therefore, on this record, claimant's "chronic" condition is encompassed within the accepted condition.

ORDER

The ALJ's order dated May 4, 1998 is affirmed.

August 19, 1998 Cite as 50 Van Natta 1620 (1998)

In the Matter of the Compensation of
DENISE D. BROWN, Claimant
WCB Case No. 97-08293
ORDER ON REVIEW
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Brazeau's order that upheld the SAIF Corporation's denial of her claim for a back injury. On review, the issue is compensability.

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

In her brief, in addition to challenging the ALJ's determination that she failed to sustain her burden of proof on compensability, claimant also raises two issues that were not presented at hearing.[1] Specifically, claimant asserts that SAIF failed to pay interim compensation and that its denial was untimely and unreasonable. As a general rule, we do not consider issues that are raised for the first time on review. *See Stevenson v. Blue Cross*, 108 Or App 247, 252 (1991); *Gunther H. Jacobi*, 41 Van Natta 1031, 1032 (1989) (new issues or legal theories presented for the first time on review are not considered where prejudice would result to one of the parties); *see also Fister v. South Hills Health Care*, 149 Or App 214 (1997) (absent adequate reason, Board should not deviate from its well-established practice of considering only those issues raised by the parties at hearing). In this case, we find no reason to deviate from the general rule. Consequently, we decline to consider the penalty and interim compensation issues raised for the first time on review.

ORDER

The ALJ's order dated January 20, 1998 is affirmed.

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[1] At hearing, the parties (through their respective counsel) agreed that the only issues to be determined were compensability and, in the event claimant prevailed, attorney fees. (Tr. at 4-5).

In the Matter of the Compensation of
DENNIS L. KELLER, Claimant
WCB Case No. 93-11978 & 93-07002
ORDER ON REMAND
Welch, Bruun, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney
Scheminske, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. SAIF v. Keller, 153 Or App 369 (1998) (slip opinion). The court has reversed our prior order, which, on remand from the court, followed the court's mandate and directed the SAIF Corporation to accept claimant's degenerative back condition. Citing Bay Area Hospital v. Landers, 150 Or App 154 (1997), the court has remanded again, in light of amended ORS 656.262(10).

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Claimant injured his back in August 1980, while working for SAIF's insured. On September 3, 1980, SAIF issued a Notice of Claim Acceptance that identified claimant's injury but did not specify which condition was being accepted. (Ex. 4). The claim was eventually closed in 1986.

In 1991, claimant sustained a nondisabling low back and right leg injury while working for Standard's insured. Claimant sought treatment again in 1993 for low back and right leg symptoms. His diagnoses included recurrent back pain, muscle strain, chronic mild lumbar subluxation sprain and sprain complex, and degenerative spinal disease. (Exs. 84, 86, 89, 92, 106, 109, 110). SAIF denied compensability of and responsibility for claimant's 1993 condition. Standard denied responsibility.

Claimant requested a hearing and the ALJ held that, in 1980, SAIF had accepted claimant's degenerative back condition. Applying the material contributing cause standard of former ORS 656.245(1), the ALJ concluded that claimant had established compensability of his current need for medical services.

SAIF requested Board review and asserted that its 1980 acceptance was limited to a low back strain. It also contended that, because the medical evidence established that claimant's need for treatment in 1993 was caused, in major part, by his preexisting degenerative spinal condition, his current low back condition was not compensable under former ORS 656.005(7)(a)(B).

We did not address either of SAIF's arguments in our order. Rather, relying on Messmer v. Deluxe Cabinet Works, 130 Or App 254, rev den 320 Or 507 (1995)(Messmer I), we concluded that SAIF was barred by claim preclusion from denying that claimant's degenerative spinal condition was part of his 1980 back claim. That conclusion was based on SAIF's failure to challenge two Determination Orders that included an award for claimant's noncompensable degenerative condition. Accordingly, we affirmed the ALJ's conclusion that claimant's current low back condition was compensable.

SAIF sought judicial review by the Court of Appeals. Thereafter, the parties jointly moved for remand to the Board under Cabex Mills, Inc. v. Duval, 137 Or App 525 (1995). In Duval, the employer sought judicial review of a Board order holding that the employer's failure to contest a previous determination order precluded it from contesting the compensability of the claimant's condition. The court reversed and remanded for reconsideration in light of the intervening amendments to the Workers' Compensation Act. Or Laws 1995, ch 332.

On remand, we held that, pursuant to amended ORS 656.262(10), Messmer, supra, was no longer good law and, therefore, SAIF was not precluded from contesting compensability of claimant's current low back condition. Under the amended statute and consistent with our decision in Craig L. Hiatt, 47 Van Natta 2287 (1995), we concluded that SAIF could contest the compensability of a condition rated by a closure order, so long as it had not formally accepted that condition. Consequently, because we found that SAIF had not formally accepted claimant's degenerative condition, we proceeded to the merits of claimant's claim.

After examining the medical evidence, we concluded that claimant had not met his burden of proving that either of his compensable low back injuries was the major contributing cause of his current disability or need for treatment, as required by ORS 656.005(7)(a)(B). Accordingly, we found that the claim was not compensable and we reversed the ALJ's order.

Claimant sought review of our order and the court reversed, relying on its decision in Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996) (Messmer II). In Messmer II, the court held that the 1995 amendment to ORS 656.262(10) did not affect its original holding in Messmer I, and an employer's failure to challenge a determination order precluded the insurer from subsequently contesting the compnesability of a condition rated therein. The court concluded that, in light of its decisions in Messmer I and II, our order must be reversed and the case should be remanded for acceptance of the claim.

On May 14, 1997, we issued an Order on Remand which, consistent with the court's mandate, directed SAIF to accept claimant's degenerative back condition. SAIF subsequently requested review by the court. In light of amended ORS 656.262(10) and Bay Area Hospitals v. Landers, supra, the court has reversed and remanded to us once again. Having received the parties' supplemental briefs on remand, we proceed with our review.

On remand, claimant first argues that SAIF did not appeal the court's 1997 order to the Supreme Court. In its 1997 decision, the court remanded the matter to the Board for an order instructing SAIF to accept claimant's back condition. Consequently, because SAIF did not appeal the court's decision, claimant contends that the court's decision was final and SAIF is now barred from contesting compensability. We disagree.

As noted by SAIF, claimant did not argue a "preclusive" theory to the court following our first order on remand. Under the circumstances, we are not inclined to consider claimant's argument at this time. *See e.g. Stevenson v. Blue Cross*, 108 Or App 247, 252 (1991). Moreover, even if we were to consider claimant's argument, we do not agree with claimant that the order became final. Following our May 14, 1997 Order on Remand, SAIF again requested review by the court. Accordingly, the case did not become "final" as claimant contends.

Turning to the merits of the case, we conclude that, because this case was "existing" on the effective date of HB 2971, amended ORS 656.262(10) applies to this case. See Bay Areas Hospital v. Landers, supra. Moreover, 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 two Determination Orders awarded permanent disability for claimant's current back condition, SAIF is not precluded from now denying that condition.

In our 1996 Order on Remand, we reasoned that SAIF had not accepted claimant's degenerative condition which did not become apparent until after SAIF issued its notice accepting the August 1980 injury. We adopt that prior reasoning and adhere to it in our current order.

As explained above, in our 1996 Order on Remand, we further concluded that, based on the expert medical evidence, claimant failed to establish that his current condition was compensable under ORS 656.005(7)(a)(B). Again, we adopt that reasoning and adhere to it in this order.

Consequently, on remand, we reverse the ALJ's order which set aside SAIF's denial of compensability. Moreover, because we have found that claimant's current low back condition is not compensable, we also reverse the portion of the ALJ's order which assigned responsibility for the condition to SAIF. Finally, we adopt and affirm the ALJ's conclusions regarding penalties.

ORDER

The ALJ's order dated February 4, 1994 is reversed in part and affirmed in part. That portion of the ALJ's order setting aside the SAIF Corporation's denial of claimant's current low back condition is reversed, and SAIF's denial is reinstated and upheld in its entirety. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
JUDITH L. MALEY, Claimant
WCB Case No. 97-06033
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Myzak's order that: (1) set aside its denial of claimant's claim for a low back injury; and (2) awarded an assessed fee of $4,000 for claimant's attorney's services at hearing. On review, the issues are compensability and attorney fees.

We adopt and affirm the ALJ's order with the following supplementation.[1]

The ALJ set aside SAIF's denial of claimant's injury claim and awarded an assessed attorney fee of $4,000 pursuant to ORS 656.386(1). 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. SAIF moves to remand the case to the ALJ to make reviewable findings supporting the award of attorney fees in light of the factors in OAR 438-015-0010(4).[2]

We may remand a case to the ALJ if we find that the case has been improperly, incompletely or otherwise insufficiently developed. *See* ORS 656.295(5); *Bailey v. SAIF*, 296 Or 41, 45 n 3 (1983). In order to satisfy this standard, a compelling reason must be shown for remanding, including a showing that evidence was not obtainable at the time of hearing.

Here, in her written closing argument, claimant made a specific request for an attorney fee of $4,000, based on the time expended on the case, and the significant value of the benefit involved, in addition to the remaining factors set forth in OAR 438-015-0010(4).[3] SAIF made no objection to the amount of the requested attorney fee or any argument regarding how the rule-based factors should be weighed in determining a reasonable fee. Under such circumstances, although the ALJ must specify that the factors in OAR 438-015-0010(4) were considered, the ALJ is not obligated to make specific findings regarding the rule-based factors, in order to have a reviewable order. *Russell L. Martin*, 50 Van Natta 313 (1998) (finding that the absence of a fee request *or* argument on the rule-based factors distinguishes a case from *Schoch v. Leupold & Stevens*, 325 Or 112, *on remand* 49 Van Natta 788 (1997), which required a

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[1] We note that SAIF does not contend that the ALJ's attorney fee award is excessive.

[2] Dr. Lewis' final opinion (Ex. 27) properly and sufficiently considers and weighs the competing contributing causes of claimant's need for surgical treatment and satisfied claimant's burden of proof. *Dietz v. Ramuda*, 130 Or App 397, *rev dismissed* 321 Or 416 (1995); *SAIF v. Nehl*, 148 Or App 101, *on recon* 149 Or App 397 (1997).

[3] OAR 438-015-0010(4) provides that "[i]n any case where an [ALJ] or the Board is required to determine a reasonable attorney fee, the following factors shall be considered:

"(a) The time devoted to the case;

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

"(c) The value of the interest involved;

"(d) The skill of the attorneys;

"(e) The nature of the proceedings;

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

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

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

"sufficient explanation" of how the rule-based factors were weighed in deciding that a "reasonable" fee was substantially less than the amount requested).[4] As we stated in *Martin*, if the claimant's attorney's fee request is uncontested, it would be unnecessary to explain how the factors set forth in OAR 438-015-0010(4) were applied, unless a lesser fee is awarded. 50 Van Natta at 316.

In any event, we do not find the record to be improperly, incompletely or otherwise insufficiently developed. *See* ORS 656.295(5). In other words, because we are authorized to modify or supplement the ALJ's findings and conclusions under ORS 656.295(6), it would be unnecessary to remand this case to the ALJ for the supplementation of findings regarding claimant's attorney fee award. Consequently, we deny SAIF's motion to remand.

We may make such disposition of a case as determined to be appropriate. ORS 656.295(6); *Destael v. Nicolai Co.*, 80 Or App 596 (1986). The scope of our *de novo* review encompasses all issues considered by the ALJ's order. Accordingly, because the issue of entitlement to an attorney fee pursuant to ORS 656.386(1) was an issue before the ALJ, we now address that issue on review.

Claimant's attorney is entitled to an assessed fee for services at hearing in regard to 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 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), 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 rendered in defending against SAIF's request for review regarding the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $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.[5]

ORDER

The ALJ's order dated May 6, 1998 is affirmed. For services on review, claimant's attorney is awarded a fee of $500, to be paid by the SAIF Corporation.

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[4] We note that our *en banc* decision in *Martin* issued February 27, 1998. SAIF's appellant's brief was submitted to the Board on June 19, 1998. Inasmuch as *Martin* provides the Board's interpretation of the *Schoch* decision, an appellate forum would expect to receive for review a discussion of the reasoning expressed in *Martin*. Nonetheless, SAIF has neither discussed nor distinguished the *Martin* holding.

[5] Because attorney fees are not "compensation" within the meaning of ORS 656.382(2), claimant's attorney is not entitled to an assessed fee regarding the ALJ's attorney fee award. *Saxton v. SAIF*, 80 Or App 631 (1986); *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

In the Matter of the Compensation of
CARL C. GEIER, Claimant
Own Motion No. 98-0150M
OWN MOTION ORDER OF ABATEMENT
Alice M. Bartelt (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our July 20, 1998 Own Motion Order, in which we reopened the above claim for the payment of temporary disability compensation.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
DEVON J. SISK, Claimant
WCB Case No. 97-04375
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Hall and Bock.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Brazeau's order that set aside its denial of claimant's injury claim for left elbow overuse syndrome. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings with the following supplementation.

In early January 1996, claimant transferred his care to Dr. Davis, M.D.

Claimant changed jobs in March 1996 and went to work for a different employer as a metal polisher. On or around February 17, 1997, claimant experienced pain and swelling in his left elbow after continuously operating a hydraulic polishing machine for seven hours. Claimant sought further treatment from Dr. Wilson, M.D., on February 18, 1997, and claimant transferred his care to Dr. Davis on February 26, 1997. Dr. Davis' chart notes for this examination attribute claimant's symptoms to an overuse syndrome.

CONCLUSIONS OF LAW AND OPINION

We affirm the ALJ's compensability ruling with the following supplemental analysis.

In concluding that the record established compensability of claimant's injury claim for his left elbow overuse syndrome, the ALJ relied on Dr. Davis' opinion that claimant's December 1995 injury materially contributed to the syndrome. Implicit in the ALJ's ruling is a finding that the overuse syndrome was the direct result of the injurious event itself. *See Albany General Hospital v. Gasperino*, 113 Or App 411 (1992) (material contributing cause standard establishes compensability of conditions that are the direct result of injurious event, as distinct from conditions that are the consequence of an injury resulting from that event).[1]

On review, SAIF contends that Dr. Davis' identification of a material causal relationship is not sufficient to prove compensability, as the record does not establish a *direct* causal link between the injury and the overuse syndrome.[2] We are not persuaded by SAIF's argument.

Dr. Davis is the only medical expert who has rendered an opinion regarding the causation of the overuse syndrome. In his January 19, 1998 opinion at Exhibit 30, Dr. Davis answered the following written question in the negative:

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[1] The ALJ also concluded that the record did not establish that the injury was the major cause of the overuse syndrome. Claimant does not challenge that ruling on review.

[2] SAIF does not challenge the ALJ's conclusion that Dr. Davis' opinion persuasively establishes a material causal relationship between the injury and the overuse syndrome.

"4) Is the diagnosis of left elbow overuse syndrome a valid diagnosis for [claimant's] December 15, 1995 left elbow injury?"

This response does not support a finding that the injurious event directly contributed to the overuse syndrome. However, Dr. Davis' most recent February 25, 1998 opinion at Exhibit 31 does support such a finding. At that time, Dr. Davis answered the following written questions in the affirmative:

"Is it correct that on February 19, 1997 [claimant reported] identical symptoms to those reported after his December 15, 1995 on-the-job injury?

* * * *

"Is it correct that [your 3-24-97, 3-25-97 and 4-4-97] chart notes reflect that you continued to view one of the conditions *arising out of* [claimant's] December 15, 1997 on-the-job injury to be "overuse syndrome" and that you directed treatment toward that condition? (Emphasis supplied).

* * * *

"As of May 14, 1997[,] based on medical probability, was the correct diagnosis of conditions *arising out of* [claimant's] December 15, 1995 injury claim left elbow strain, left medial epicondylitis, and left elbow over-use syndrome? (Emphasis supplied).

* * * *

"Based on the history, your findings on examinations, your diagnosis, and your treatment as reflected by the medical records set out herein above, did you answer [question 4] in error on Exhibit 30 with respect to whether [claimant] does or does not have left elbow overuse syndrome, that has waxed and waned with use *since* December 15, 1995? (Emphasis supplied).

* * * *

"At this time do you retract your answers to [question 4] on Exhibit 30, and are you willing to, at this time, state that based on medical probability, one of the three diagnosed conditions arising out [of the] December 15, 1995 injury is left elbow over-use syndrome?"

We reject SAIF's contention that Dr. Davis' revised opinion is not persuasive because it is unexplained. To the contrary, Dr. Davis' responses indicate that a more thorough review of the complete medical record prompted him to correct his earlier opinion. Accordingly, we conclude that Dr. Davis' unrebutted opinion at Exhibit 31 persuasively establishes a direct causal link between the injurious event on December 1995 and his overuse syndrome.

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

ORDER

The ALJ's order dated March 23, 1998 is affirmed. Claimant is awarded a $1,200 attorney fee for his attorney's services on review, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
GERASIMOS TSIRIMIAGOS, Claimant
WCB Case No. 98-00153
ORDER ON REVIEW
Pozzi, Wilson, 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) Lipton's order that affirmed an Order on Reconsideration which rescinded a Determination Order and reclassified claimant's injury claim as disabling. On review, the issue is claim classification. We reverse.

FINDINGS OF FACT

Claimant was involved in a motor vehicle accident in the course and scope of his employment on July 27, 1996. He sought treatment the following day and was diagnosed with a dorsal lumbar and bilateral shoulder strain. Dr. Kazmierski recommended local heat, rest and Vicodin. As claimant was about to leave the country on an extended vacation, he was advised to return for a follow up evaluation in five to six weeks. (Ex. 1).

On December 18, 1996, claimant completed an 801 form, explaining that he sustained a back strain in the July 27, 1996 motor vehicle accident. (Ex. 2). The insurer accepted a cervical lumbar strain as a nondisabling injury on February 20, 1997. (Ex. 3).

Claimant returned to Dr. Kazmierski on June 17, 1997, complaining of continued low back pain, worse on the left side into the buttock. He was diagnosed with a lumbar strain secondary to the motor vehicle accident. (Ex. 4). X-rays of claimant's lumbar spine revealed degenerative joint disease and degenerative disc changes with no acute abnormality. (Ex. 5).

On July 15, 1997, claimant wrote to the Department of Consumer and Business Services, Workers' Compensation Division, requesting that his claim be reclassified as disabling. On August 6, 1997, the Department issued a Determination Order affirming the nondisabling claim status. Thereafter, claimant requested reconsideration and a medical arbiter panel examination.

On December 5, 1997, claimant was examined by Drs. Schilperoort, Woodward and Williams. The arbiter panel noted that claimant complained of pain in the left para-lumbar area, including the left gluteal buttock and thigh. The arbiters measured claimant's cervical and lumbar ranges of motion, sensation and motor strength, and diagnosed cervical and lumbar strains. The panel also noted that they considered claimant's examination findings valid. In responding to the specific questions posed by the Appellate Unit, the arbiters anticipated no permanent loss of function of any of claimant's accepted body parts based on the accepted conditions. (Ex. 9).

A December 17, 1997 Order on Reconsideration rescinded the Determination Order and reclassified claimant's claim as disabling, finding that, notwithstanding the arbiters' conclusion to the contrary, there was a very strong likelihood of permanent loss of use or function of the accepted body parts as a result of the accepted conditions.

CONCLUSIONS OF LAW AND OPINION

In affirming the Order on Reconsideration, the ALJ determined that the arbiters' valid findings of reduced range of motion under the disability rating standards were more persuasive than their conclusion that permanent loss of function due to the accepted conditions was not anticipated. On review, the insurer contends that there is no medical opinion establishing a likelihood of permanent disability. We agree and reverse.

Pursuant to ORS 656.005(7)(c), an injury is not disabling if no temporary disability benefits are due and payable, "unless there is a reasonable expectation that permanent disability will result from the injury."[1] In construing this statute and determining whether a compensable injury is disabling, we have

[1] There is no evidence in the record that claimant is entitled to temporary disability benefits. Thus, the only issue on review is whether there is a reasonable expectation of permanent disability.

required expert medical opinion indicating that a permanent disability award was likely or expected. *See, e.g., Robert K. Schiller,* 48 Van Natta 905 (1996) (Board reclassified claim as disabling where the attending physician indicated that permanent disability was likely, based on the chronicity of the claimant's symptoms); *compare Brenda Guzman,* 48 Van Natta 1034 (1996) (Board found no persuasive medical evidence of a reasonable likelihood of permanent disability); *see also Clifford E. Clark,* 47 Van Natta 2130 (1995) (Board declined to classify injury as disabling where there was no medical evidence concerning whether permanent disability was reasonably expected).

In this case, the only medical evidence in the record concerning the likelihood of a permanent disability award comes from the medical arbiter panel, who expressly concluded that no permanent loss of function was anticipated from claimant's accepted cervical and lumbar strains. (Ex. 9-2). Although the arbiters documented a loss of cervical and lumbar motion ratable under the standards, they did not indicate whether this loss of motion was due to the compensable injury and did not opine that this impairment was permanent. Consequently, on this record, we find no persuasive medical evidence of a reasonable likelihood of permanent disability resulting from the accepted injury.

We recognize that, in "extent" cases, if a treating doctor or medical arbiter makes impairment findings consistent with a claimant's compensable injury and does not attribute the impairment to causes other than the compensable injury, such findings may be construed as showing that the impairment is due to the compensable injury. *See SAIF v. Danboise,* 147 Or App 550 (1997); *Margaret M. Morgan,* 49 Van Natta 1943 (1997). In this case, however, the medical arbiter panel was not asked to determine whether claimant was medically stationary or to make impairment findings for the purpose of rating claimant's permanent disability due to the compensable injury. Instead, they were specifically asked to provide their "best estimate of the likelihood of permanent loss of use or function of any of the accepted body parts as a result of this injury" for purposes of classifying claimant's claim.

Considering the arbiters' express medical opinion that no permanent impairment was anticipated, we decline to find that a loss of cervical and lumbar motion a year and a half post-injury constitutes a reasonable likelihood of *permanent* disability due to the accepted conditions. *See, e.g., Michael P. McCollum,* 48 Van Natta 2203 (1996) (doctor's opinion that the claimant's disability from a finger laceration may extend to 18 months did not establish a reasonable expectation of permanent disability); *Barbara Addington,* 46 Van Natta 1474 (1994) (doctor's statement that the claimant still had a physical problem that would be present for a long time did not establish a substantial likelihood of permanent impairment, but rather implied an eventual resolution of the claimant's pain complaints). We therefore reverse the ALJ's order.

ORDER

The ALJ's order dated April 24, 1998 is reversed. The December 17, 1997 Order on Reconsideration classifying claimant's injury as disabling is set aside, and the August 6, 1997 Determination Order affirming the nondisabling claim status is reinstated and affirmed. The ALJ's attorney fee award is also reversed.

In the Matter of the Compensation of
KIM P. NICHOLS, Claimant
WCB Case Nos. 97-05686 & 97-05611
ORDER ON RECONSIDERATION
Black, Chapman, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Pursuant to our July 22, 1998 Order on Review, we affirmed an Administrative Law Judge's (ALJ's) award of temporary total disability benefits for the period of "June 14, 1996 to September 3, 1996." The SAIF Corporation seeks reconsideration of that award, contending that the benefits should be awarded for the period of June 14, 199Z to September 3, 199Z. In support of its contention, SAIF relies on correspondence to the ALJ in which counsel for SAIF and counsel for claimant acknowledge that the temporary disability benefits should be awarded for a period in 1997. The parties made the same acknowledgment at hearing.

In light of such circumstances, we conclude that our prior order contains a clerical error. To correct this oversight, we withdraw our July 22, 1998 order. On reconsideration, we modify that order to identify June 14, 1997 to September 3, 1997 as the period for which temporary disability benefits are sought and awarded. As supplemented and modified herein, we adhere to and republish our July 22, 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
ROSE M. WAKEFIELD, Claimant
WCB Case No. 97-07394
ORDER ON RECONSIDERATION
Pozzi, Wilson, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

On August 7, 1998, we withdrew our July 23, 1998 order that had affirmed the Administrative Law Judge's (ALJ's) order that had affirmed an Order on Reconsideration awarding no scheduled permanent disability for loss of use or function of the left foot. We took this action to retain jurisdiction to consider the parties' revised "Disputed Claim Settlement," which is designed to "settle all issues, raised or raisable." Having received the parties' amended agreement, we proceed with our review of their settlement.

Pursuant to the amended settlement, the parties agree that the self-insured employer's denial, which is contained in their agreement, "shall remain in full force and effect." The agreement further provides that "claimant hereby withdraws her Request for Hearing," which "shall be dismissed with prejudice."

We have approved the parties' amended settlement, thereby fully and finally resolving this dispute.[1] Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

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[1] In our August 7, 1998 abatement order, the parties were requested to confirm that claimant retains her entitlement to future benefits arising under ORS 656.245, 656.273, 656.278, and 656.340 insofar as those rights may be related to her original, accepted left ankle strain. *See* OAR 438-009-0010(4)(b). In response to that request, the parties have submitted a revised settlement that deletes by interlineation a section of the prior agreement that provided that "[c]laimant shall have no further entitlement to compensation, or any other legal right under Oregon workers' compensation law relating to her left ankle/foot/leg conditions, however diagnosed." With the deletion of that provision, the revised agreement contains a denial that also states that claimant retains the aforementioned rights to future benefits to the extent those rights are related to her original, accepted claim. In light of such circumstances, we conclude that the revised settlement is in compliance with OAR 438-009-0010(4)(b).

In the Matter of the Compensation of
BRAD WINSLOW, Claimant
WCB Case No. C8-01448
ORDER DENYING RECONSIDERATION
Daniel E. Hitchcock, Claimant Attorney
VavRosky, et al, Defense Attorney

On August 4, 1998, the Board disapproved the parties' claim disposition agreement (CDA) in the above captioned matter. In our order, we disapproved the agreement because the parties failed to comply with the Board's request to provide the order paragraph in prominent or bold face type, lines for the date of approval and signatures of the Board members at the conclusion of the agreement. *See* OAR 438-009-0020(3).

Simultaneously, on August 7, 1998, we received claimant's original letter asking for disapproval of the CDA and an addendum from the carrier's attorney, providing the previously requested omissions. We treat the carrier's addendum as a motion for reconsideration of the disapproved CDA. Although the motion is timely filed (OAR 438-009-0035(1)), we decline to reconsider our decision. We reach this conclusion for the following reason.

Our August 4, 1998 order stated that if the "parties" wished to comply with our prior request to supplement the agreement, they could do so by timely submitting the requested addendum. Inasmuch as claimant has submitted a response indicating his unwillingness to proceed with the CDA, we conclude that the "parties" have not submitted an addendum to the CDA as mandated by our prior order. Because the carrier's submission of the CDA addendum does not comply with our previous order, we deny the motion for reconsideration of our prior decision.

IT IS SO ORDERED.

In the Matter of the Compensation of
JODIE M. DUBOSE, Claimant
WCB Case No. 97-01993
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by the Board *en banc*.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) T. Lavere Johnson's order that: (1) set aside its "noncooperation" denial issued under ORS 656.262(15)[1]; and (2) awarded an assessed attorney fee under ORS 656.386(1). In her brief, claimant moves to dismiss SAIF's request for review on the basis that the ALJ's order is not a final, appealable order. On review, the issues are dismissal, the propriety of the denial, and attorney fees.

We deny the motion to dismiss and, on the merits, adopt and affirm the ALJ's order with the following supplementation.

Motion to Dismiss

Claimant moves for dismissal of SAIF's request for review, contending that the ALJ's order is not a "final" order because it neither allowed nor denied her claim for compensation. We disagree and deny the motion for the following reasons.

Only "final" orders are appealable to the Board under ORS 656.289(3). *See, e.g., Bradley H. Bishop*, 48 Van Natta 1729 (1996); *Allen H. Howard*, 42 Van Natta 2706 (1990). The test for determining whether an order is final was established generally in *Winters et al. v. Grimes et al.*, 124 Or 214, 216-17 (1928), and reiterated in the workers' compensation context in *Hammond v. Albina Engine & Mach.*, 13 Or App 156 (1973). The test is that "an order, to be final, must be one which determines the rights of the parties so that no further questions can arise before the tribunal hearing the matter." *Mendenhall v. SAIF*, 16 Or App 136, 138, *rev den* (1974) (citing *Winters* and *Hammond*). *See also Price v. SAIF*, 296 Or 311, 315 (1984) (an order determining that a heart condition is not compensable was final and appealable because no further action was required to dispose of the claim).

Applying the *Winters/Hammond* test to this case, the dispositive inquiry is whether the ALJ's order determined the rights of the parties so that no further questions could arise before the ALJ in this matter.[2] The only "matter" before the ALJ was SAIF's February 25, 1997 *denial* of her occupational disease claim. The denial letter itself stated that claimant's "claim for benefits" was being denied because of her alleged failure to cooperate with SAIF's investigation of her claim. Claimant requested a

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[1] The entire provision of ORS 656.262(15) states:

"If the director finds that a worker fails to reasonably cooperate with an investigation involving an initial claim to establish a compensable injury or an aggravation claim to reopen the claim for a worsened condition, the director shall suspend all or part of the payment of compensation after notice to the worker. If the worker does not cooperate for an additional 30 days after the notice, the insurer or self-insured employer may deny the claim because of the worker's failure to cooperate. The obligation of the insurer or self-insured employer to accept or deny the claim within 90 days is suspended during the time of the worker's noncooperation. After such a denial, the worker shall not be granted a hearing or other proceeding under this chapter on the merits of the claim unless the worker first requests and establishes at an expedited hearing under ORS 656.291 that the worker fully and completely cooperated with the investigation, that the worker failed to cooperate for reasons beyond the worker's control or that the investigative demands were unreasonable. If the Administrative Law Judge finds that the worker has not fully cooperated, the Administrative Law Judge shall affirm the denial, and the worker's claim for injury shall remain denied. If the Administrative Law Judge finds that the worker has cooperated, or that the investigative demands were unreasonable, the Administrative Law Judge shall set aside the denial, order the reinstatement of interim compensation, if appropriate, and remand the claim to the insurer or self-insured employer to accept or deny the claim."

[2] In response to the special concurrence's analysis regarding ORS 656.283(1) and 656.704(3), we agree that this case involves a "matter concerning a claim." Nonetheless, we must still resolve the question of whether the ALJ's order was "final" within the meaning of ORS 656.289(3) and therefore appealable to the Board. For the reasons expressed in this decision, we conclude that the ALJ's order constitutes a final order under ORS 656.289(3).

hearing on the "noncooperation" denial, thereby placing the denial before the ALJ for disposition. (Pleadings file). The merits (*i.e.*, compensability) of the underlying claim were not before the ALJ, because the compensability issue was not raised by the parties and, in any event, ORS 656.262(15) barred the ALJ from considering that issue in this "noncooperation denial" proceeding.

The ALJ found that claimant's conduct was reasonable and set aside the "noncooperation" denial. In doing so, the ALJ finally determined the parties' rights with regard to the "matter" at issue: SAIF's "noncooperation" denial. The ALJ's decision left no further questions regarding the "matter" before him. Under the *Winters/Hammond* test, the ALJ's order was final and appealable to the Board.[3]

We recognize that the Court of Appeals has stated that "[a] decision which does not either finally deny the claim, or allow it and fix the amount of compensation, is not a final decision." *Lindamood v. SAIF*, 78 Or App 15, 18 (1986) (quoting *Mendenhall*, 16 Or App at 139). That statement appeared to reformulate the *Winters/Hammond* test by shifting the focus from the "matter before the tribunal" to the "claim" itself. However, *Mendenhall* and *Lindamood* are distinguished by the fact that neither case involved an order that set aside or upheld a claim *denial*. In *Mendenhall*, the court was reviewing a Board order that found that a claim had been timely filed and, because the claim had not yet been accepted or denied, remanded the claim to the carrier for acceptance or denial of the claim on its merits. In *Lindamood*, the court was reviewing a referee's order that set aside a disputed claim settlement and reinstated (without resolving) a request for hearing concerning the compensability of the underlying disputed claim. In each case, the order did not reach the merits of a claim denial.

By contrast, the order in this case actually set aside a claim denial, thus "allowing" the claim. Although the ALJ's order did not reach the underlying compensability issue and, instead, remanded the claim to SAIF for further processing in accordance with ORS 656.262(15), the merits of the "noncooperation" denial nevertheless were determined by the order. As we stated above, that denial was of the underlying occupational disease claim and, had claimant not prevailed over the denial in this proceeding, would have resulted in the total disallowance of her claim for compensation. For these reasons, we find this case to be distinguishable from *Mendenhall* and *Lindamood*[4] and conclude that the ALJ's order was final and appealable to the Board.[5]

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[3] We note that the statutes do not exempt ALJ orders issued under ORS 656.262(15) from "orders" that are subject to the parties' right of appellate review by the Board under ORS 656.289(3). ORS 656.262(15) does not state that orders setting aside or upholding "noncooperation" denials are not appealable to the Board. Because the legislature has expressly restricted the appeal rights available for other types of orders, such as those issued under ORS 656.236(2) and 656.327(1)(b), we conclude that the absence of a similar restriction in ORS 656.262(15) indicates the legislature's intent not to exempt "262(15)" orders from the right of Board review under ORS 656.289(3).

[4] At the time of the court's decisions in *Mendenhall* and *Lindamood*, the Workers' Compensation Law did not provide for issuance of a claim denial based solely on the *procedural* defense that the worker did not cooperate with the claim investigation. Further, under the law in effect at the time of those decisions, an order upholding a denial was a decision that finally denied the underlying claim, while an order setting aside the denial was a decision allowing the claim *and* fixing the amount of compensation. However, with the recent enactment of ORS 656.262(15), the legislature has created a type of denial that, if upheld, is a final denial of the underlying claim but, if set aside, only allows the claim for further processing on the merits and does not fix the amount of compensation. Because this newly created denial could not have been anticipated by the court when it decided *Mendenhall* and *Lindamood*, we conclude that the more reliable test for finality in this case is the *Winters/Hammond* test, rather than the more restrictive, reformulated test in *Mendenhall/Lindamood*. In reaching this conclusion, we are not stating that the *Mendenhall/Lindamood* test is less reliable merely because it was decided prior to the enactment of ORS 656.262(15), as the special concurrence asserts. Rather, we are suggesting that, at the time that the Court of Appeals decided those cases and reformulated the *Winters/Hammond* test to narrow the statutory definition of a "final" order under ORS 656.289, the court could not have anticipated the creation of "noncooperation" denials and, therefore, the more reliable test is the one that was originally formulated by the Supreme Court in *Winters* and reiterated more recently (1984) by the Court in *Price*. In other words, given the choice between the original test as formulated and reiterated by the Supreme Court, and the reformulated test articulated by the Court of Appeals (at a time when the type of denial at issue in this case did not exist), we are inclined to defer to the Supreme Court's interpretation of the statute.

[5] Our decision, while supported by case law, also avoids the troubling consequences that would likely flow from a decision that the Board has no appellate authority to review an order setting aside a "noncooperation" denial. One of those consequences is the inherently unequal treatment that would result from holding that, while an order upholding a "noncooperation" denial is clearly final and appealable to the Board (under either the *Winters/Hammond* test or the reformulated test in *Mendenhall/Lindamood*), an order setting aside the same denial could not be appealed to the Board. Further, our decision avoids

Propriety of Denial

Turning to the merits of the "noncooperation" denial, we begin by summarizing the relevant facts. After claimant filed her occupational disease claim for bilateral carpal tunnel syndrome and situational anxiety, SAIF placed the claim in deferred status and scheduled claimant for an independent medical examination (IME) on January 3, 1997. Claimant did not attend the IME due to hazardous road conditions.

On February 6, 1997, the Department issued an "Order Suspending Compensation Pursuant to ORS 656.262(15)," finding that claimant "failed to reasonably cooperate in the investigation of a claim[.]" On February 25, 1997, SAIF issued a denial of the claim "for [claimant's] failure to cooperate per the February 6, 1997 suspension order." On March 5, 1997, claimant requested a hearing on the denial. After the hearing, the ALJ decided that claimant's "failure to cooperate" in not attending the IME was "for reasons beyond the control of the injured worker" because the hazardous road conditions prevented her from traveling to the facility. The ALJ set aside SAIF's "noncooperation" denial.

SAIF first contends that its denial should stand because claimant did not request an expedited hearing under ORS 656.291. In making this assertion, SAIF relies on language in ORS 656.262(15) that, following a carrier's denial for failure to cooperate, "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" certain findings.

ORS 656.291(1) requires the Board to establish an "Expedited Claims Service" for "prompt, informal disposition of claims." The Board must assign cases to the Service when "the only matters unresolved do not include compensability of the claim and the amount in controversy is $1,000 or less" or "the only matters unresolved are attorney fees or penalties." ORS 656.291(2)(a), (b). For cases in the first category, hearings must be convened within 30 days of the request for hearing and the ALJ must issue an order within 10 days of the close of the hearing. ORS 656.291(3)(b). For attorney fee or penalty cases, no hearing is held unless the ALJ finds that the case cannot be resolved based on stipulated facts. ORS 656.291(3)(c). By rule, the Board requires that a request for hearing "be referred to Expedited Claims Service" if "the request involves a denial under ORS 656.262(15) for a worker's failure to cooperate in a claim investigation." OAR 438-013-0010(1)(c).

In interpreting a statute, our first task is to discern the legislature's intent. ORS 174.020; *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610 (1993). In attempting to discern the intent of the legislature, the first level of analysis is to examine the text and context of the statute. 317 Or at 610-11. The context of the statute includes other provisions of the same statute and other related statutes. *Id.* at 611. If the legislature's intent is clear from those inquiries, further inquiry is unnecessary. *Id.*

The language relied upon by SAIF states that "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* * *." We find that this text shows an intent that the worker must first overcome a denial issued for noncooperation under ORS 656.262(15) before the worker may challenge the denial based on the merits of the claim. We disagree with SAIF, however, that the statute evinces an intent that an expedited hearing is the only avenue for overcoming a "noncooperation" denial. For instance, the statute does not provide that "the worker first requests and establishes *only* at an expedited hearing * * *." In the absence of such limiting language, we find that the statute shows that an expedited hearing is an option, not a requirement.

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the procedural confusion that would result if an ALJ's order awarded interim compensation while setting aside a "noncooperation" denial. Inasmuch as such an order "fixes" an amount of compensation, the interim compensation decision would be final and appealable, *see Darrell D. Brown*, 44 Van Natta 861, 862-63 (1992), while at the same time, the "noncooperation" denial decision would not be appealable. In that circumstance, the Board would have appellate review authority over the interim compensation award, but no authority to review the underlying basis (propriety of the "noncooperation" denial) for the award. Essentially, the Board would theoretically have review authority over the interim compensation award but, as a practical matter, would be powerless to disturb the award.

SAIF's argument also is not supported by the context of the statute. Under ORS 656.291 and OAR 438-013-0010(1)(c), the *Board* assigns certain cases to the Expedited Claims Service. In other words, there is no statutory procedure for the *worker* to request an expedited hearing. We are to give effect to the more specific provision. ORS 174.020. Because ORS 656.291 relates specifically to the Expedited Claims Service, we give effect to its language that it is the Board's duty to assign cases to the Service rather than putting a requirement on the worker to request such a hearing.

In sum, based on the text and context of ORS 656.262(15), we conclude that, in challenging a "noncooperation" denial, the worker must first request a hearing from that denial before the merits of the claim can be addressed. Following that request, if appropriate, it is the Board's duty to assign the case to an Expedited Claims Services. Because claimant's request for hearing did not concern the merits of the claim but was to challenge the "noncooperation" denial, we find it sufficient under ORS 656.262(15).

Attorney Fees

Finally, SAIF objects to the ALJ's attorney fee award under ORS 656.386(1). Specifically, SAIF contends that a "noncooperation" denial issued under ORS 656.262(15) does not qualify as a "denied claim" under ORS 656.386(1). We disagree.

"Denied claim" is defined as:

> "A claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation." ORS 656.386(1)(b)(A).

Based on our review of SAIF's "noncooperation" denial letter and the statute authorizing such denials, we find that SAIF expressly denied claimant's entitlement to any compensation under her occupational disease claim. Although the *basis* for SAIF's denial was claimant's alleged failure to cooperate with its claim investigation, the denial letter clearly stated that it was a denial of the underlying *claim* for benefits. The denial letter stated: "[W]e are * * * denying your claim for benefits for your failure to cooperate per the February 6, 1997 suspension order." (Ex. 14). Because SAIF stated that it was denying the "claim for benefits," we find that SAIF refused to pay on the express ground that the condition claimed "[did] not give rise to an entitlement to any compensation," within the meaning of ORS 656.386(1)(b)(A).

Our interpretation of the denial letter is supported by the language of ORS 656.262(15), which provides that if a worker does not cooperate within 30 days after receiving notice from the Director, "the insurer or self-insured employer may deny the claim because of the worker's failure to cooperate." Based on our review of the entire text of the statutory provision, we conclude that the term "claim" is the "initial claim to establish a compensable injury or an aggravation claim to reopen the claim for a worsened condition," which are mentioned earlier in the same provision. ORS 656.262(15) further provides that if the ALJ upholds the "noncooperation" denial, "the worker's claim for injury shall remain denied." Based on the text of the statute, it appears that the legislature contemplated that a "noncooperation" denial was a denial of the underlying *claim* for benefits, *i.e.*, the worker's entitlement to any compensation for the claimed condition. It therefore follows that, by prevailing over a "noncooperation" denial, a worker has prevailed over a "denied claim" within the meaning of ORS 656.386(1)(b)(A). Accordingly, we conclude that the ALJ's attorney fee award was authorized under ORS 656.386(1).[6]

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[6] The availability of a "386(1)" attorney fee is dependent on whether the carrier elects to issue a "noncooperation" denial. ORS 656.262(15) does not require the carrier to issue such a denial; it provides that "the insurer or self-insured employer *may* deny the claim because of the worker's failure to cooperate." (Italics added.) If the carrier elects to issue a "noncooperation" denial, and the worker later prevails over the denial, the carrier would be liable for an attorney fee. If, on the other hand, the carrier elects not to issue a denial, a "386(1)" attorney fee would not be available, and the Director's suspension of the payment of compensation would remain in effect until the worker reasonably cooperates with the claim investigation.

Claimant's attorney also is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the denial issue is $1,200, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and her attorney's statement of services), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an assessed fee for her attorney's services on review regarding her unsuccessful motion to dismiss, as well as services concerning the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated July 3, 1997 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,200, to be paid by the SAIF Corporation.

Board Member Haynes and Board Chair Bock specially concurring.

Although the majority correctly concludes that it has jurisdiction of this matter, we cannot agree with its reasoning. This case in part raises the issue of whether we have jurisdiction to review an ALJ's decision under ORS 656.262(15) setting aside a carrier's "noncooperation" denial. In addressing this issue, the majority relies only on case law to decide that the ALJ's order is "final" for purposes of review.

The majority's order lacks any consideration of what the statute meant to accomplish. The Board must apply statutory analysis, and in particular follow the template set out in *PGE v. Bureau of Labor and Industries*, 317 Or 606 (1993), to determine jurisdiction. *See, e.g., SAIF v. Shipley*, 326 Or 557 (1998) (jurisdiction of medical services cases was with the Department based on text of ORS 656.245, 656.260, 656.307 and 656.704); *Jordan v. Brazier Forest Products*, 152 Or App 15 (1998) (pursuant to ORS 656.704, Board had jurisdiction over order that resolved request for reconsideration of notice of closure); *Lankford v. Copeland*, 141 Or App 152 (1996) (Board lacked jurisdiction under ORS 656.704 to review an ALJ's decision that the claimant was not a subject worker); *SAIF v. Calles*, 138 Or App 269 (1995) (based on ORS 656.382(1) and 656.385(5), Board improperly awarded attorney fees for employer's unreasonable resistance to payment of vocational assistance, because disputes regarding vocational benefits were within exclusive jurisdiction of director and Board could not award attorney fees for matters arising under director's jurisdiction). Pursuant to that template, we begin with the text and context of the statute and then, if necessary, examine legislative history to ascertain legislative intent. 317 Or at 610-11.

The majority cites to cases that, for the most part, involve the finality of an order under ORS 656.289(3).[1] *Hammond v. Albina Engine and Mach.*, 13 Or App 156 (1973), concerned whether the Board's order affirming a hearings officer's grant of a motion to reinstate a request for hearing was a "final order." *Mendenhall v. SAIF*, 16 Or App 136, 139 (1974), determined that the Board's order finding that a claim had been timely filed and remanding to the carrier for acceptance or denial of the claim was not a "final order." *Lindamood v. SAIF*, 78 Or App 15, 18 (1986), held that a referee's order setting aside a settlement and reinstating the original request for hearing on compensability of the claim was not a "final reviewable order." None of these cases addressed the statute at issue in this case and, for that reason, we find them to be of limited help.[2]

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[1] ORS 656.289(3) in part provides: "The [Administrative Law Judge'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 a review by the Workers' Compensation Board under ORS 656.295."

[2] In footnote 4, the majority explains that, because *Mendenhall* and *Lindamood* were decided before the enactment of ORS 656.262(15), "the more reliable test for finality in this case is the *Winters/Hammond* test, rather than the more restrictive, reformulated test in *Mendenhall/Lindamood*." We are unsure why the holdings in *Winters* and *Hammond* should provide more guidance in applying ORS 656.262(15) when those cases, being older than *Mendenhall* and *Lindamood*, also were decided before the existence of the statute.

The text of the statute does not directly answer whether or not a party can appeal an ALJ's decision to set aside a "noncooperation" denial. Some portions of the statute support the conclusion that the Board lacks review. In this regard, the statute refers only to a "hearing" and provides for the appropriate resolution depending on what the ALJ "finds." Particularly relevant to this case, if the ALJ finds that the worker "cooperated, or that the investigative demands were unreasonable," the ALJ must set aside the denial, reinstate interim compensation, if appropriate, "*and remand the claim to the insurer or self-insured employer to accept or deny the claim.*" Because the statute provides that the claim is remanded to the carrier following the ALJ's decision, without indicating that the decision may be appealed, such language shows an intent to restrict the proceeding to a hearing before an ALJ.

We find that the best textual evidence of legislative intent, however, is the statute's reference to an "expedited hearing." Under ORS 656.291, the Board assigns for expedited service those claims that either do not include compensability and the amount in controversy is $1,000 or less or concern only the matters of attorney fees or penalties. Such claims are heard within 30 days of the request for hearing and the ALJ must issue an order within 10 days of the close of hearing; furthermore, such claims are decided only on stipulated facts. ORS 656.291(3)(b), (c).

Because ORS 656.262(15) states that the worker "first requests and establishes at an expedited hearing under ORS 656.291" certain showings before being granted a hearing or any other proceeding concerning the merits of the claim, there is a statutory intent to provide a relatively quick and uncomplicated resolution to the "noncooperation" denial. Furthermore, because we review expedited hearing cases, we find this portion of the statute supports the conclusion that we have the authority to review this case, whether or not the hearing was conducted under ORS 656.291. *See George McClellan*, 50 Van Natta 43 (1998) (Board reviewed and affirmed ALJ's order upholding "noncooperation" denial issued under ORS 656.262(15) and conducted under ORS 656.291).

We find further support for this conclusion in the *absence* of any statutory language preventing the Board from reviewing the ALJ's order in this case. Unlike amendments to ORS 656.704(3) that explicitly exclude from the definition of "matters concerning a claim" any disputes arising under certain statutes, the legislature did not indicate that a party may not appeal an ALJ's decision under ORS 656.262(15) setting aside a carrier's "noncooperation" denial. For that reason, if the matter resolved under ORS 656.262(15) concerns the "worker's right to receive compensation, or the amount thereof," then it is a "matter concerning a claim" over which the Board has jurisdiction to review. *See* ORS 656.704(3), 656.283(1), 656.289(3), 656.295.[3]

Here, SAIF's denial of the claim for noncooperation concerned claimant's "right to receive compensation" because it prevented her from obtaining any benefits for her claim. That is, even though the denial was based on noncooperation, it had the same effect in denying benefits as a denial based on compensability; if the ALJ found that claimant had not fully cooperated, the denial would have been affirmed and the claim "shall remain denied." ORS 656.262(15). Such an outcome supports the conclusion that this case constitutes a "matter concerning a claim." As such, the ALJ was authorized to conduct a hearing under ORS 656.283(1) to resolve the parties' dispute and, following the issuance of the ALJ's decision, the parties were entitled to seek Board review of that order pursuant to ORS 656.289(3). Thus, we agree with the majority's ultimate conclusion that we have jurisdiction to review the ALJ's order.

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[3] Moreover, there is no doubt that the Board, in its appellate capacity, must have both subject matter and appellate jurisdiction. Clearly, the Board and its Hearings Division may have subject matter jurisdiction although this does not necessarily confer appellate jurisdiction upon the Board. For the reasons expressed in this concurrence, our analysis of ORS 656.262(15) within the text and context of the statutory scheme leads us to the conclusion that the Board is statutorily authorized to review an appeal of an ALJ's order setting aside a carrier's "noncooperation" denial.

In the Matter of the Compensation of
THOMAS L. LEARY, Claimant
WCB Case Nos. 97-08916 & 97-06823
ORDER ON REVIEW
Richard A. Sly, Claimant Attorneys
Reinisch, et al, Defense Attorneys
Julene Quinn (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Menashe's order that set aside its denial of claimant's right carpal tunnel syndrome. 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:

In February 1982, in the course of treatment for an industrial injury to his right elbow, claimant complained to his then-treating doctor of tingling in the thumb and index finger while driving or writing. Dr. Struckman diagnosed possible carpal tunnel syndrome, but did not pursue treatment of these symptoms. (Ex. 9).

On February 1, 1997, claimant compensably injured his right hand tying down a load on his truck. His hand slipped and struck the edge of the flatbed, causing an abrasion and fracture of the proximal phalanx of the little finger. On March 8, 1997, Dr. Fortes surgically reduced the fracture by wiring the proximal phalanx. (Exs. 12A, 12B, 12D)

Claimant returned to Dr. Fortes on May 1, 1997 and reported continued swelling and hypersensitivity of the little finger. Claimant also complained of numbness in the thumb and middle finger since the injury. Dr. Fortes noted that this "was an old problem" for claimant in that he had previously been diagnosed with carpal tunnel syndrome, but that the condition had worsened since the accident. (Ex. 13). On June 18, 1997, Dr. Fortes noted that claimant had two complaints, flexion contracture of the fifth finger and worsening carpal tunnel syndrome in the right wrist. (Ex. 14).

In July 1997, claimant was referred to Dr. Rosenbaum for nerve conduction studies. Dr. Rosenbaum recorded a history of mild symptoms of right carpal tunnel syndrome over the past 15 years, worsening in the last few months especially after claimant's February 1997 hand injury. Claimant's nerve conduction studies confirmed right carpal tunnel syndrome with severe median nerve compression as well as asymptomatic right ulnar motor slowing which was probably not clinically significant. (Ex.14A).

On July 29, 1997, Dr. Fortes reported that claimant had severe, long-standing carpal tunnel syndrome with involvement of both sensory and motor distribution of the median nerve, likely secondary to chronic scarring. (Ex. 15). On August 22, 1997, Dr. Fortes reported that claimant's worsened carpal tunnel syndrome is "likely secondary to the trauma sustained by the hand" in February 1997. Dr. Fortes explained that claimant's known carpal tunnel syndrome had been exacerbated by the swelling and scarring resulting from the February 1997 injury. He concluded that "whatever the cause," claimant was in dire need of carpal canal release surgery to increase the likelihood of recovering normal median nerve function. (Ex. 17).

The employer denied that claimant's worsened carpal tunnel syndrome was related to his work activity. (Ex. 19). In an October 30, 1997 letter, Dr. Fortes indicated that he could not be definitive as to the cause of claimant's carpal tunnel syndrome or its worsening. He concluded that "all I know is that [claimant] had an existing carpal tunnel diagnosis and that at this time it requires urgent treatment." (Ex. 20).

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant's February 1,1997 injury was the major contributing cause of claimant's worsened carpal tunnel syndrome. On review, the employer argues that claimant has failed to prove that his worsened carpal tunnel syndrome is compensable, either as a combined condition or as a consequence of his little finger injury. We agree with the employer.

Under ORS 656.005(7)(a)(A), claimant must prove that the compensable injury is the major contributing cause of the consequential condition. Under ORS 656.005(7)(a)(B), claimant must show that his little finger fracture combined with his preexisting carpal tunnel syndrome and was 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.

To satisfy the "major contributing cause" standard, claimant must establish that his compensable injury contributes more to the claimed condition (worsened carpal tunnel syndrome) than all other factors combined. *See, e.g. McGarrah v. SAIF*, 296 Or 145, 146 (1983). In other words, the persuasive medical opinion must evaluate the relative contribution of different causes and explain why the compensable injury to claimant's little finger contributes more to the worsening of claimant's preexisting carpal tunnel syndrome than all other causes or exposures combined. *See Dietz v. Ramuda*, 130 Or App 397 (1994). Furthermore, the fact that a work injury precipitated the symptoms of a condition does not necessarily mean that the injury was the major contributing cause of the condition. *Id.; see also Robinson v. SAIF*, 147 Or App 157, 162 (1997).

Here, the only evidence concerning the cause of claimant's worsened carpal tunnel syndrome comes from Dr. Fortes. Dr. Fortes initially related this condition to "chronic scarring." (Ex. 15). In a later report, he indicated that claimant's worsened symptoms were exacerbated by the swelling and scarring resulting from the February 1997 injury. (Ex. 17). In a third report, Dr. Fortes admitted that he could not be definitive as to the causative mechanism of claimant's carpal tunnel syndrome, he only knew that claimant's condition had worsened and was in need of urgent treatment. (Ex. 20).

In the absence of further explanation regarding how an injury to, and resultant swelling of, the little finger can cause additional compression of the median nerve at the wrist and worsened symptoms of carpal tunnel syndrome, we find Dr. Fortes' inconsistent and conclusory opinions insufficient to sustain claimant's burden of proof. *See, e.g. Kelso v. City of Salem*, 87 Or App 630 (1987) (unexplained change of opinion renders physician's opinion unpersuasive); *Moe v. Ceiling Systems*, 44 Or App 429 (1980) (an unexplained change of opinion is given little probative weight); *see also Gormley v. SAIF*, 52 Or App 1055 (1981) (a possibility of a causal relationship is insufficient to meet claimant's burden of proof).

Indeed, even if we were to accept Dr. Fortes' contention that swelling and scarring resulting from the February 1, 1997 injury exacerbated claimant's carpal tunnel syndrome, this opinion would not satisfy the major contributing cause standard, as Dr. Fortes does not address or explain how the compensable injury contributed more to the worsened carpal tunnel condition than all other causes or exposures combined.[1] *See Dietz v. Ramuda*, 130 Or App 397. Consequently, on this record, we find that claimant has failed to sustain his burden of proof under ORS 656.005(7)(a)(A) or (B).

ORDER

The ALJ's order dated April 29, 1998 is reversed in part and affirmed in part. That part of the order that set aside AIG's denial is reversed. The employer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed. The remainder of the order is affirmed.

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[1] For example, Dr. Fortes repeatedly acknowledged that claimant's carpal tunnel compression was a "long-standing" problem. (Exs. 15, 17). Dr. Rosenbaum noted that claimant had mild symptoms of right carpal tunnel syndrome for over 15 years. (14A-1) Further, claimant has a history of injuries to his right elbow and treatment for chronic epicondylitis and forearm pain dating back to 1978. (Exs. 5, 6, 8, 10). It is not evident from the record that Dr. Fortes evaluated the relative contribution of the swelling and scarring resulting from claimant's February 1997 hand injury vis a vis these other preexisting factors.

In the Matter of the Compensation of
ROBERT B. MYERS, JR., Claimant
WCB Case No. 97-09045
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Saif Legal Department, Defense Attorney

Reviewed by Board Members Moller and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that: (1) declined to remand claimant's claim to the Director for the promulgation of a temporary rule amending the standards for rating disability; and (2) affirmed the Order on Reconsideration that awarded 6 percent (8.1 degrees) scheduled permanent disability for the loss of use or function of the left foot. On review, the issues are remand and extent of scheduled permanent disability.

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

On review, claimant contends that the ALJ erred in holding that the Hearings Division lacked authority to review the Director's refusal to promulgate a temporary rule under ORS 656.726(3)(f)(C). We need not address that contention, however, because we agree with the ALJ's alternative conclusion that claimant did not carry his burden to prove that the loss of sensation on the dorsum (top) of his right foot resulted in any loss of use or function of the foot. *See* OAR 436-035-0007(25) ("Not all medical conditions or diagnoses result in loss of use or function and/or loss of earning capacity. Accordingly, not all medical conditions or diagnoses receive a value under these rules.")

Here, neither the attending physician nor the medical arbiter identify any loss of use or function of the foot attributable to the sensory loss. Because claimant did not carry his burden of proving that there is disability not addressed by the standards, there is no authority for remanding the claim to the Director for the promulgation of a temporary rule.

ORDER

The ALJ's order dated March 26, 1998 is affirmed.

In the Matter of the Compensation of
JOHN L. O'DAY, Claimant
WCB Case Nos. 97-06573 & 97-04460
ORDER ON REVIEW
Greg Noble, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order that: (1) upheld the insurer's denial of claimant's current low back condition claim; and (2) upheld the insurer's denial of claimant's low back injury claim. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation to address the insurer's motion to strike claimant's reply brief and motion for sanctions.

The insurer first moves to strike claimant's reply brief on the ground that it was not timely filed. An appellant's reply brief is due within 14 days after the date of mailing of the respondent's and/or cross-appellant's brief. OAR 438-011-0020(2). Because the insurer mailed its respondent's brief on June 15, 1998, claimant's reply brief was due by June 29, 1998. Claimant, however, did not file the reply brief until June 30, 1998. Consequently, because the reply brief was not timely filed, we grant the insurer's motion to strike the reply brief and we have not considered it on review.

The insurer also moves for sanctions, asserting that claimant's position on review concerning the compensability of his current low back condition is frivolous. Pursuant to ORS 656.390(1), the Board may impose an appropriate sanction upon a party if the request for review was frivolous or was filed in bad faith or for the purpose of harassment. "Frivolous" means the matter is not supported by substantial evidence or 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).

Although the record contains little, if any, medical evidence showing that claimant's current condition was in major part caused by a February 1997 compensable injury, under certain circumstances, expert medical opinion is not necessary for a worker to carry his or her burden of proof. *E.g., Barnett* v. *SAIF*, 122 Or App 279 (1993). Consequently, we find that claimant's testimony supporting causation is enough to present at least a colorable argument and show that his appeal was not initiated without a reasonable prospect of prevailing. *See Sheri A. Wheeler*, 48 Van Natta 1780 (1996). Thus, we conclude that claimant's request for review concerning this issue is not "frivolous" and we deny the insurer's motion for sanctions.

ORDER

The ALJ's order dated April 14, 1998 is affirmed.

In the Matter of the Compensation of
RICHARD A. SCHIEL, Claimant
Own Motion No. 97-0374M
OWN MOTION ORDER
Glen J. Lasken, Claimant Attorney

The self-insured employer has submitted claimant's request for temporary disability compensation for claimant's compensable low back, L4-5 injury. Claimant's aggravation rights expired on September 19, 1991. The employer initially recommended against reopening on the grounds that: (1) the current condition is not causally related to the accepted condition; (2) the employer is not responsible for the current condition; (3) surgery or hospitalization is not reasonable or necessary; and (4) claimant was not in the work force at the time of the current disability.

On September 12, 1997, we postponed action pending the outcome of the medical services dispute.[1] By Administrative Order dated December 24, 1997, the Director found that the proposed instrumented lumbar fusion revision was appropriate for claimant and held that the employer was "liable for reimbursement of all costs associated with the provision of the approved surgery." That order was not appealed, and has become final by operation of law.

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).

Following the resolution of the medical services dispute, we requested the parties' positions regarding claimant's work force status. The employer responded to our inquiry, asserting that claimant "isn't currently in the work force." Claimant submitted an affidavit and a vocational expert's testimony in a 1992 hearing. Thereafter, the employer contended that claimant had still not proven that he was in the work force "at the time of disability." Additionally, the insurer submitted copies of a 1992 vocational report and a 1995 doctor's report.

We have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction,[2] is the date he enters the hospital for the proposed surgery. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). The relevant time period for which claimant must establish he was in the work force is the time prior to his pending August 19, 1998 surgery, when his condition worsened requiring that surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App at 273; *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997); *Michael C. Batori*, 49 Van Natta 535 (1997); *Kenneth C. Felton*, 48 Van Natta 725 (1996).

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[1] The employer submitted an August 12, 1997 letter, stating that "there is no issue of causation or compensability of the underlying claim or condition." Furthermore, the record does not indicate that a denial of the compensability of or responsibility for, claimant's current condition has been issued, or that a hearing request has been filed to appeal any denial issued in claimant's 1985 injury claim. Thus, we conclude that the employer's initial compensability and responsibility challenges to claimant's reopening requests have been withdrawn.

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

In order to satisfy the third *Dawkins* criterion, claimant must demonstrate that he was willing to work, but was unable to do so due to his compensable condition and that it would have been futile for him to work. On May 7, 1997, in response to a request from the employer, claimant completed a light/part-time work questionnaire which described his efforts to return to work and demostrate that he was employed, albeit for a short period of time, in March of 1997. In his February 4, 1998 affidavit, claimant attests that, although he has "performed little or no work since 1992. *** [he] has not 'retired' and continue[s] to be willing to work in some capacity." Based on claimant's statements and his effort to return to work in 1997, we find that he has demonstrated his willingness to work.

Having satisfied the "willingness" standard, claimant bears the burden of proving that it is futile for him to work and/or seek work due to his compensable condition. In support of his contentions, claimant submitted a partial transcript of a vocational counselor's testimony taken during a 1992 hearing. The vocational counselor opined that, based on his review of the medical record, claimant was not employable at that time. However, this document clearly does not address claimant's *current* ability to work and/or seek work. Additionally, even if this expert's opinion had been recently rendered and addressed claimant's current condition, we have found that a vocational expert's opinion, to the extent it addressed claimant's physical capacities based on his/her assessment of claimant's medical condition, not persuasive. *Frances I. Bowman*, 45 Van Natta 500 (1993); *Loren L. Shinn*, 43 Van Natta 1141 (1991); *Jeff D. Powell*, 42 Van Natta 791 (1990).

Dr. Tiley, claimant's treating physician, rendered his opinion regarding claimant's ability to work and/or seek work in his June 21, 1995 report. Dr. Tiley opined that claimant's compensable condition was painful and, primarily due to the pain, claimant was disabled. However, Dr. Tiley stated "It is certainly reasonable to assume that given the fact that [claimant] functions, he is capable of doing some work, probably in the light moderate category." Therefore, even if this report were more contemporaneous, Dr. Tiley clearly opined that claimant was capable of working.

In an October 6, 1997 report, Dr. Hill, a consulting physician, reported that "[claimant] does not have any radicular pain but his life is such that he is unable to work." However, as noted above, the period of time for the purpose of determining whether claimant was in the work force is the time prior to his pending August 19, 1998 surgery date. Dr. Hill's report does not address claimant current ability to work and/or seek work. In any event, Dr. Hill's reference to claimant's "life is such" is so general that we consider it insufficient to establish that the physician is relating claimant's inability to work to his compensable condition.

We, therefore, conclude that the record before us contains no medical evidence which would support claimant's contention that it was futile for him to work and/or seek work at the time of his current disability.

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

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

IT IS SO ORDERED.

In the Matter of the Compensation of
GERALD D. DIETZ, Claimant
WCB Case Nos. 97-03625 & 97-03622
ORDER ON RECONSIDERATION
Craine & Love, Claimant Attorneys
VavRosky, et al, Defense Attorneys

The insurer has requested reconsideration of our June 29, 1998 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order that set aside its partial denial of claimant's injury claim for a left flexor tendon tenosynovitis condition. Specifically, the insurer contends that we erred in adopting the ALJ's legal analysis. On July 28, 1998, in order to consider the insurer's contentions and to allow claimant an opportunity to respond, we abated our prior order. Having now received claimant's response, we proceed with our reconsideration.

The insurer argues that the ALJ did not address the issue of "when and how" claimant's tenosynovitis condition was caused. However, the ALJ found that Dr. Buehler had provided the most persuasive opinion in this case, and his explanation for the diagnosis of tenosynovitis was well-reasoned.

After reviewing the record, we continue to agree with the ALJ's conclusions regarding the persuasiveness of the expert medical evidence. Moreover, we find that Dr. Buehler's opinion does establish both medical and legal causation. Dr. Buehler diagnosed tenosynovitis based on claimant's tenderness of the tendon and found that the tenderness had been consistently reproducible. Dr. Buehler explained that the diagnosis was supported by claimant's good symptomatic response to cortisone injections administered into the flexor tendon. Finally, Dr. Buehler agreed that because claimant had experienced no prior problems with his wrist, and because he had experienced persistent symptoms since the injury, based on claimant's description of the injury, the work incident was the cause of claimant's condition. (Ex. 50A).

Consequently, consistent with the ALJ's conclusion, we find that Dr. Buehler's opinion establishes compensability. Accordingly, we continue to adhere to our prior decision.

Claimant's counsel is awarded an assessed attorney fee for services provided in responding to the insurer's reconsideration request. 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 reconsideration is $250, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's response to the insurer's arguments regarding the issue of compensability), the complexity of the issue, and the value of the interest involved.

Accordingly, we withdraw our prior order. On reconsideration, as supplemented and modified herein, we adhere to and republish our June 29, 1998 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
KATHLEEN A. EPPERSON, Claimant
WCB Case No. 97-07438
ORDER ON REVIEW
Mitchell & Associates, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

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

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

We agree with the ALJ's analysis of the medical opinions. On review, we address the employer's argument that Dr. Gritzka's opinion is not persuasive because, among other things, he had an incorrect understanding of the onset of claimant's symptoms.

Dr. Gritzka reported that claimant's work activities as a fabric cutter involved lifting heavy bolts of fabric. (Ex. 21-1). He said that claimant "had the sudden onset of pain in the region of her left scapula." (*Id.*) He noted that, as time went by, claimant's pain seemed to localize or move toward her left shoulder. (*Id.*) Dr. Gritzka indicated that claimant had denied any problem with her left shoulder before December 1996. (Ex. 21-3). He explained that claimant had moved into a new building and, whereas previously it had not been necessary to carry bolts of fabric very far, she now had to carry them about 75 feet. (*Id.*) He descibed claimant's work activities in detail and he noted that claimant did not perform any significant overhead activities with her shoulders except at work. (*Id.*) He did not believe claimant had a degenerative condition involving her left rotator cuff and he found no preexisting shoulder conditions. (Ex. 21-7, -8). Dr. Gritzka concluded that claimant's condition was caused by repetitive occupational exposure at the employer. (Ex. 21-7).

Claimant testified that she first began feeling left shoulder symptoms just before Christmas 1996. (Tr. 7-8, 14). She initially felt pain below her shoulder blade and it later migrated to the top of the shoulder. (Tr. 8). Claimant initially thought the pain would go away in a few days. (*Id.*) When it did not improve, she sought treatment from Dr. Winjum. (Tr. 9). On January 7, 1997, Dr. Winjum reported that claimant's left shoulder pain started 2 1/2 weeks previously, inferior to the left shoulder blade and had moved to her shoulder and was now part way down her arm. (Ex. 4).

Based on claimant's testimony, as well as Dr. Winjum's history, we are not persuaded that Dr. Gritzka had an inaccurate history of claimant's symptoms. We agree with claimant that although Dr. Gritzka referred to a "sudden onset" of pain in the region of the left scapula, he was explaining that claimant experienced an onset of pain in December 1996. Dr. Gritzka had an accurate history that claimant's pain later migrated into her left shoulder. Moreover, when discussing causation, Dr. Gritzka referred to claimant's "repetitive occupational exposure at the employer" (Ex. 21-7), which supports an occupational disease analysis and is consistent with his detailed discussion of her repetitive work activities. For the reasons discussed by the ALJ, we agree that Dr. Gritzka's opinion establishes that claimant's work activities were the major contributing cause of her left shoulder condition.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, payable by the 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 15, 1998, as reconsidered May 5, 1998, is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by the employer.

In the Matter of the Compensation of
ROBERT E. KELLY, Claimant
WCB Case No. 97-04871
ORDER ON REVIEW
Geoffrey G. Wren, Claimant Attorney
Wallace, Klor & Mann, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's occupational disease claim for a lumbar strain. In his brief, claimant contests that portion of the ALJ's order that declined to assess penalties for an allegedly unreasonable failure to provide timely discovery. On review, the issues are compensability and penalties.

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

Motion for Remand

As a preliminary matter, claimant has attached an affidavit regarding the discovery issue to his brief and has also attached a letter from an ALJ pertaining to another case. The employer objects to the documents on the ground that they are not part of the record. We treat claimant's submissions as a motion to remand to the ALJ for admission of additional evidence. *See* ORS 656.295(5); *Judy A. Britton*, 37 Van Natta 1262 (1985).

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

Because there has been no showing that the affidavit and letter were unobtainable with due diligence at the time of the hearing and because the documents are not reasonably likely to affect the outcome of the case, we deny the motion for remand and decline to consider the documents.

Compensability

With regard to the compensability issue, the employer argues that Dr. Gritzka changed his opinion on causation and that his opinion is unpersuasive on this basis. We disagree. After reviewing x-rays that did not confirm his initial diagnosis, Dr. Gritzka changed his diagnosis from lumbar spondylosis related to vibration to a less severe lumbar strain caused by bouncing in truck cabs. Because Dr. Gritzka had a reason for his change in opinion, (the new information provided by the x-rays), we do not find his opinion unpersuasive on this basis. *See Kelso v. City of Salem*, 87 Or App 630, 634 (1987).

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 the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's attorney's statement of services), the complexity of the issue, and the value of the interest involved. We have not considered time devoted to the penalty issue.

Penalties

Claimant seeks penalties for the employer's allegedly unreasonable failure to provide discovery. The facts pertinent to the discovery issue are summarized as follows. On September 11, 1997, claimant's attorney wrote to the employer's attorney advising that he had been retained to represent claimant regarding the claim and requesting discovery of material pertaining to the claim. The

September 11, 1997 letter included a request for complaints regarding truck seats made by the employer's drivers between January 1, 1993 and February 9, 1997.[1]

On October 20, 1997, the employer's attorney wrote claimant's attorney and indicated that the employer had partially responded to the September 11, 1997 discovery request on September 22, 1997, and that correspondence dated October 6, 1997 had advised that further discovery would be forwarded "after review of your request and search of our file." In the letter, the employer's attorney set out the employer's objections to the request for complaints regarding truck seats from the employer's truck drivers. The letter stated:

> "This request is overly broad and cumbersome. Furthermore, it requests information which is not specific to this case. Therefore, we objecting [sic] on the grounds that this is an irrelevant request for the time period of January 1, 1993 to February 9, 1997. Without waiver, the self-insured employer states that such material would not lead to admissible evidence."

Prior to the hearing, claimant did not seek relief from the ALJ concerning the employer's response to his discovery request. Instead, at hearing, claimant sought a penalty for the employer's allegedly unreasonable discovery violation.

The ALJ found that four months passed after the employer's refusal to provide the requested discovery and that claimant took no further action during that period to obtain the desired materials. On this basis, the ALJ found that the employer's refusal to provide the documents was not unreasonable.[2]

On Board review, claimant argues that the employer is liable for a penalty because it did not respond to his request for discovery within 15 days as required by OAR 438-007-0015(2). In addition, claimant argues that the complaints of other drivers regarding the employer's trucks "pertain[ed] to the claim" being litigated and could have led to the discovery of admissible evidence.

It is the express policy of the Board to promote the full and complete disclosure of all facts and opinion pertaining to the claim. OAR 438-007-0015(5). Failure to comply with discovery requirements (including requests for documents "pertaining to a claim") if found unreasonable, constitutes delay or refusal to pay compensation. *Id.*

Here, the employer's initial response to claimant's discovery request was within 15 days. The employer later made specific objections to two of claimant's requests. With regard to the requested information regarding complaints, the employer objected that the request was overly broad. After our review, we agree that the request for general complaints regarding truck seats was broadly phrased and was not specific to complaints regarding defective seats in trucks that claimant drove. Given the lack of specificity in the request, we find that the employer did not act unreasonably in failing to supply the material. Under such circumstances, we find that no penalty is warranted.[3]

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[1] The letter also included a request for driver's logs showing hours worked and miles logged by claimant from January 1, 1993 to February 9, 1997. With regard to the request for claimant's driving logs, the employer indicated that because claimant retained possession of his driving logs, this information was already accessible to claimant. Claimant does not argue on review that the employer's failure to provide the logs was unreasonable.

[2] Claimant also moved for a continuance to allow the employer to provide the requested discovery. The ALJ denied claimant's motion for continuance and claimant has not raised the ALJ's continuance ruling as an issue on Board review.

[3] Claimant seeks clarification regarding the ability of ALJs to issue orders regarding discovery. ALJs are not bound by technical or formal rules of procedure and may conduct hearings in any manner that will achieve substantial justice. ORS 656.283(7). The administrative rules contemplate the filing of pre or post hearing motions by parties. OAR 438-006-0045. ALJs may be asked by parties to rule on pre-hearing matters regarding what material is discoverable under the rules. For example, in cases involving a dispute over what may be withheld as impeachment evidence, we have held that ALJs should review the evidence in camera to determine whether the evidence constitutes impeachment evidence or is discoverable material. *See Herbert L. Lockett*, 50 Van Natta 154, 155 (1998); *Marilyn L. Hunt*, 49 Van Nattta 1456 (1997). The statute and rules clearly contemplate that ALJs may address such issues. The sanctions for failure to comply with the discovery rules are set out in the administrative rule. If found unreasonable, the failure may give rise to a penalty and may also be considered grounds for continuance of a hearing or exclusion of evidence under OAR 438-007-0018(4). *See* OAR 438-007-0015(5).

Had claimant responded to the employer's letter and made a more specific request for complaints regarding the seats in trucks driven by claimant, and the employer had failed to comply with the request, we may well have found the employer's conduct in failing to provide the discovery unreasonable. However, in this particular case, in light of claimant's broad request (which included materials that did not pertain to the claim) and the employer's response (followed by claimant's lack of reply), we do not consider the employer's conduct to have been unreasonable. *See International Paper Co. v. Huntley*, 106 Or App 107 (1991) (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; *see also* ORS 656.262(11)(a) (carrier is liable for a penalty if it "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim").

In light of our decision (that the employer's failure to provide the discovery was not unreasonable because the request was non-specific and sought material which did not pertain to the claim), we find it unnecessary to address the question of whether the claimant's failure to take action to obtain the discovery prior to the hearing affected the reasonableness of the employer's actions.[4]

ORDER

The ALJ's order dated March 4, 1998 is affirmed. For services on Board review, claimant's attorney is awarded $1,500, payable by the employer.

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[4] Although the discovery rule that applies to this case does not require the party requesting the discovery to seek relief from the ALJ prior to hearing, it is possible that the failure to take action could be relevant in determining whether the opposing parties' continued failure to provide the material is unreasonable. In this regard, claimant's inaction could conceivably have misled the employer into believing that claimant agreed that the employer's objections to the discovery request had merit, or that claimant was not challenging the employer's refusal to provide the material. However, it is unnecessary to reach this issue because, we find, based on reasoning different than the ALJ's, that the employer's failure to provide the documents was not unreasonable.

In the Matter of the Compensation of
JAN L. THOMAS, Claimant
WCB Case Nos. 97-05794 & 97-00961
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Kekauoha's order that set aside its denial of claimant's current cervical condition. Claimant cross-requests review of that portion of the ALJ's order that upheld the employer's denial of claimant's claim for her current respiratory condition. On review, the issue is compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a whiplash injury to her neck and upper back in an off-the-job motor vehicle accident in 1992. She lost time from work and received conservative treatment for a cervical/trapezius strain. Diagnostic studies revealed degenerative disc disease with minimal bulging, hypertrophic spurs and perhaps a soft disc protrusion at C5-6. Claimant was treated by Dr. Bert for the cervical problems. Dr. Bert anticipated that claimant would eventually require cervical discectomy and fusion surgery. However, claimant elected not to have surgery. Claimant returned to her regular job and last received treatment from Dr. Bert in 1994. She continued to have occasional neck pain after discontinuing treatment, but lost no more time from work.

On May 5, 1995, claimant was exposed to fumes from a wax stripper being used at work. Claimant experienced symptoms including shortness of breath, tightness in the chest and a burning sensation. Claimant lost time from work as a result of the exposure. She filed a claim for the incident which the employer accepted for transitory respiratory episode. Claimant's respiratory symptoms progressively worsened over time, with more frequent and severe episodes. The employer subsequently denied claimant's current respiratory condition and need for treatment.

On the night of August 23, 1996, a supervisor sent claimant to the emergency room because of breathing difficulties. During his examination of claimant, the emergency room physician placed his palms on the sides of claimant's neck and head and suddenly jerked very hard. Claimant had the immediate onset of pain in the head, neck and shoulders. Claimant filed a claim for a neck injury based on the August 23, 1996 incident. The employer denied the neck injury claim on January 20, 1997.

Claimant appealed the denials of the current cervical and respiratory conditions. The ALJ set aside the denial of the current cervical condition, but upheld the denial of the respiratory condition.

Compensability of Current Respiratory Condition

We adopt the ALJ's conclusion and reasoning regarding the compensability of the current respiratory condition.

Compensability of Current Cervical Condition

Claimant asserted that she sustained a compensable cervical injury when her supervisor sent her to the employer's emergency room for treatment of her respiratory condition and the emergency room physician jerked on her neck during his examination. Relying on Dr. Bert's opinion, the ALJ set aside the denial of claimant's cervical condition.

There are two medical opinions addressing the cause of claimant's current cervical condition. Drs. Rich and Donahoo, who examined claimant on behalf of the employer, noted that claimant had imaging evidence of multilevel degenerative disease in her cervical spine. The doctors also believed that if claimant injured her neck in the emergency room, the injury combined with the preexisting condition. Drs. Rich and Donahoo opined that more than 51 percent of claimant's current neck symptomatology was related to chronic, progressive, cervical spine degenerative disease.

Dr. Bert, who treated claimant's neck condition, acknowledged that claimant had some preexisting problems from the 1992 motor vehicle accident which were contributing to her need for treatment. Nevertheless, he opined that the emergency room incident was the major cause of claimant's current discomfort and need for treatment. Dr. Bert based his opinion largely on claimant's history that she was injured when her neck was manipulated in the emergency room and that she had been doing reasonably well prior to that episode.

We find Dr. Bert's opinion to be entitled to little weight because it is conclusory and poorly explained. *See Moe v. Ceiling Systems*, 44 Or App 429 (1980). This is especially true in light of the documented history of significant degenerative disc disease in claimant's cervical spine for which surgery was considered, and Dr. Bert's failure to persuasively explain why the emergency room incident contributed more to claimant's current disability or need for treatment than all other causes or exposures combined. *See Dietz v. Ramuda*, 130 Or App 397, *rev dismissed* 321 Or 416 (1995) (persuasive medical opinion must evaluate the relative contribution of different causes and explain why the work exposure or injury contributes more to the claimed condition than all other causes or exposures combined). Under such circumstances, we find Dr. Bert's opinion unpersuasive.

Because the remaining medical evidence in the record does not support compensability of the cervical condition, we find that claimant has not satisfied her burden of proof. Accordingly, we uphold the employer's denial of claimant's cervical condition.

ORDER

The ALJ's order dated January 6, 1998 is reversed in part and affirmed in part. That portion of the ALJ's order that set aside the employer's denial of claimant's current cervical condition is reversed. The denial is reinstated and upheld. The ALJ's award of an attorney fee is also reversed. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
JAMES I. DORMAN, Claimant
WCB Case No. 97-08449
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock, and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Black's order that increased claimant's unscheduled permanent disability for his low back condition from 16 percent (51.2 degrees), as awarded by an Order on Reconsideration, to 34 percent (108.8 degrees). On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant has a compensable low back injury. A Determination Order awarded 16 percent unscheduled permanent disability based only on impairment. An Order on Reconsideration affirmed.

The ALJ agreed with claimant that he was entitled to additional values for age, education and adaptability. In particular, the ALJ decided that claimant had not returned to "regular work" and, thus, was entitled to more than an impairment value. In reaching this conclusion, the ALJ applied *Vincent Drennen*, 48 Van Natta 819 (1996), rather than *Margaret M. Morgan*, 49 Van Natta 1934 (1997). After including factors for age, education, and adaptability, the ALJ awarded 34 percent unscheduled permanent disability.

The insurer challenges the ALJ's order. According to the insurer, claimant may have changed the manner of doing his job but he performed the same duties, showing that, under *Margaret M. Morgan*, he returned to regular work. Because claimant returned to regular work, the insurer contends that he is entitled only to an impairment value. *See* ORS 656.726(3)(f)(D).

In *Vincent Drennen*, the claimant was released for regular work after the claimant requested that his physician do so because of the absence of light duty work. The claimant returned to his regular job but modified his regular duties by avoiding as much as possible any stooping, twisting, and heavy lifting. Under those circumstances, we found that the physician's release was not a "medical release" and the claimant did not actually return to his job-at-injury. 48 Van Natta at 820. Thus, we concluded that the claimant did not return to regular work. *Id.*

Subsequently, in *Margaret M. Morgan*, we addressed whether the claimant returned to regular work when the work site had been substantially modified. Because the claimant had been released to regular work and the record did not show that there was any change in job duties as compared to the claimant's pre-injury work, we concluded that the claimant returned to the same job held at the time of injury. 49 Van Natta 1935. In reaching this conclusion, we distinguished *Drennan*, where we had found that the claimant had not been released to regular work and his "post-injury" job duties had been modified. *Compare Jeri L. Hanson*, 50 Van Natta 1047 (1998) (physician's job restrictions required modification of job duties in that the claimant worked fewer hours and in a more limited area which was more than a change in the manner of performing work and, thus, the claimant did not return to regular work).

In both *Drennen* and *Morgan*, we applied ORS 656.726(3)(f)(D) to determine whether the claimant returned to "regular work." That statute in part provides that, when a worker "returns to regular work at the job held at the time of injury," only impairment is rated to determine permanent disability. ORS

656.726(3)(f)(D)(i)[1]; OAR 436-035-0005(17)(a) (WCD Admin. Order 96-072). "Regular work" is defined as "the job the worker held at the time of injury or employment substantially similar in nature, duties, responsibilities, knowledge, skills and abilities." OAR 436-035-0005(17)(c).

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). If the legislature's intent is clear from those inquiries, further inquiry is unnecessary. *Id.* at 611.

In examining the text of ORS 656.726(3)(f)(D)(i), we first note that, unlike subsections (ii) and (iii), a return to regular work does not require a release from the attending physician. Rather, the provision requires that the worker "returns to regular work at the job held at the time of injury." Thus, we find a statutory intent that we consider a physician's release to regular work as a factor in determining whether the worker returned to regular work without being an absolute requirement. We proceed to examine the record to determine if claimant returned to regular work.

Following surgery, claimant's treating surgeon, Dr. Goodwin, released claimant to "full duty" and found "no restrictions." (Ex. 12). Dr. Goodwin declined to give a closing examination, so one was provided by examining orthopedic surgeon, Dr. James. Dr. Goodwin concurred with Dr. James' report.

Dr. James reported that claimant was "working full time but he is cautious in how he uses his back." (Ex. 13-2). Dr. James further recorded that claimant "is very careful about lifting, limiting it to maybe 20-30 pounds" and was "also cautious in how he squats" and "in general, doing a lot of things differently than he used to, to protect his back[.]" (*Id.*) Dr. James "released [claimant] to return to work as a truck driver," putting him in the "light work category, occasional lifting no more than 20 pounds at a time with frequent lifting or carrying objects weighing up to 10 pounds." (*Id.* at 5).

We find that such evidence shows that claimant returned to regular work. That is, claimant is performing the same truck driver job that he performed at the time of injury, with the same duties, responsibilities, knowledge, skills and abilities. Although Dr. James stated that claimant was "doing a lot of things differently than he used to, to protect his back," there is no proof that the different manner was due to a change in job duties; rather, Dr. James' report indicates that claimant *self-modified* his manner of carrying out the same job duties he performed at the time of injury.[2]

Consequently, we conclude that claimant returned to regular work held at the time of injury and, thus, the only factor we consider is impairment. *See* ORS 656.726(3)(f)(D)(i).

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[1] ORS 656.726(3)(f)(D) provides:

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

"(i) The worker returns to regular work at the job held at the time of injury;

"(ii) The attending physician releases the worker to regular work at the job held at the time of injury and the job is available but the worker fails or refuses to return to that job; or

"(iii) The attending physician releases the worker to regular work at the job held at the time of injury but the worker's employment is terminated for cause unrelated to the injury."

[2] As discussed above, whether the attending physician releases the worker to regular work is only one factor in applying subsection (i) of ORS 656.726(3)(f)(D). Thus, it is not dispositive whether or not a physician's release constitutes a "medical release." Furthermore, it is not enough to show that the worker modified the manner of performing any job duties. Rather, we find it more consistent with legislative intent that a worker does not return to "regular work" when there is insufficient evidence that job duties or responsibilities changed when compared to the work held at the time of injury. Our decision in *Drennan* is consistent with today's holding in that, in *Drennan*, we considered all relevant evidence regarding "post-injury" job duties and responsibilities, including the claimant's "medical release" (which we found to have been, in effect, a release to work with limitations). In *Drennan*, had our decision been solely premised on the claimant's "self-modification" of "post-injury" job duties, such reasoning would have been contrary to the rationale expressed in today's decision.

ORDER

The ALJ's order dated March 25, 1998 is reversed. The Order on Reconsideration awarding unscheduled permanent disability of 16 percent (51.2 degrees) is affirmed. The ALJ's attorney fee award also is reversed.

Board Member Hall dissenting.

Because I disagree with the majority's conclusion that claimant returned to his regular work at the time of his compensable injury, I would consider his age, education, and adaptability in rating the extent of his permanent disability. Consequently, I respectfully dissent.

As I have previously explained in my dissenting opinion in *Margaret M. Morgan*, 49 Van Natta 1934 (1997), the incorporation of the term "abilities" in the analysis of "regular work" under OAR 436-035-0005(17)(c) recognizes a loss of earning capacity resulting from a claimant's "post-injury" physical limitations. Consequently, regardless of whether claimant can perform all the duties and functions of his "pre-injury" job with his employer (as a result of modifications and accomodations), I continue to assert that it is inappropriate to evaluate his disability based on these accomodations or to expect future employers to permit these modifications needed to allow him to perform his "regular" work duties.

Consistent with this rationale, I am persuaded that the consulting physician's opinion (as ratified by the treating physician) establishes that the physical restrictions followed by claimant while performing his work activities were medically approved. Moreover, these same medical experts expressly released claimant to return to work, subject to a light duty, lifting limitation. Thus, even if claimant's so-called "self-modification" was not considered - a principle that I do not accept - the preponderance of the evidence supports a conclusion that he did not return to "regular work" in that his "post-injury" employment was not "substantially similar in nature, duties, responsibilities, knowledge, skills and abilities." *See* OAR 436-035-0005(17)(c).

Consequently, in accordance with ORS 656.726(3)(f)(D)(i) and OAR 436-035-0005(17)(a), and (c), claimant's permanent disability must be evaluated after consideration of his age, education, and adaptability, in conjunction with his permanent impairment. Because the majority limits its evaluation to only claimant's impairment, I must dissent.

In the Matter of the Compensation of
ELLEN E. HANCOCK, Claimant
WCB Case No. 97-10176
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Hall and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Livesley's order that affirmed the Order on Reconsideration awards of 5 percent (9.6 degrees) scheduled permanent disability for loss of use or function of the left arm and 9 percent (13.5 degrees) scheduled permanent disability for loss of use or function of the right forearm (wrist). In its briefs, the employer argues that a letter dated April 15, 1998 from Dr. Winthrop should be included in the record and the employer contends that we should take administrative notice that claimant is currently pursuing an aggravation of this claim. On review, the issues are administrative notice/remand and extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

In June 1996, claimant began having bilateral wrist and hand symptoms. (Ex. 7). In November 1996, she sought treatment from Dr. Winthrop for numbness and tingling in both arms and hands, worse on the right. (Ex. 4). On December 11, 1996, Dr. Winthrop diagnosed bilateral tendinitis. (Ex. 6). On March 14, 1997, the employer accepted nondisabling bilateral wrist tendinitis. (Ex. 11).

On March 21, 1997, Dr. Winthrop reported that claimant was still having problems with her hands. (Ex. 13). He referred claimant to Dr. Hubbard, neurosurgeon. (Ex. 16). Nerve conduction studies of both upper extremities were normal. (Ex. 17). On July 3, 1997, Dr. Winthrop reported that claimant had been on vacation and she began having right wrist symptoms after returning to work. (Ex. 25). He authorized time loss from July 3, 1997 through July 10, 1997. (Ex. 28-2). On July 10, 1997, Dr. Winthrop said that claimant's hands were less swollen and painful after being off work one week. (Ex. 27). Dr. Winthrop concluded that claimant's bilateral wrist condition had pathologically worsened between March 1997 and June 1997 and her work activities were the major contributing cause of the pathological worsening. (Ex. 28-3).

On July 31, 1997, Dr. Winthrop reported that claimant had been on light duty and her bilateral wrist tendinitis was resolving. (Ex. 29). On the same date, the employer accepted disabling bilateral wrist tendinitis. (Ex. 30). On August 22, 1997, Dr. Winthrop explained that claimant had a wrist overuse syndrome and the only real treatment was light duty. (Ex. 32). He explained that "chances are, however, that when she resumes her repetitive job [at the employer] she will develop tendinitis again." (*Id.*) He said that whether claimant's condition is stationary will depend on what happens when she resumes her job. (*Id.*)

Claimant was released to regular work on September 3, 1997. (Ex. 33). On September 8, 1997, Dr. Winthrop reported that claimant had been on light duty for more than a month and was basically asymptomatic. (Ex. 34). He allowed her to return to unrestricted work activities based on her "normal" examination. He explained that claimant was medically stationary, but "time will tell whether this job will cause a flare-up." (*Id.*)

A September 23, 1997 Notice of Closure awarded no permanent disability and indicated that claimant's condition was medically stationary on September 8, 1997. (Ex. 35). On the same date, the employer issued an updated notice of claim acceptance at closure referring to claimant's accepted disabling bilateral wrist tendinitis condition. (Ex. 36). Claimant requested reconsideration, asserting that the claim was prematurely closed, disagreeing with the impairment findings and disagreeing with the rating of scheduled permanent partial disability. (Exs. 38, 40).

On October 10, 1997, Dr. Winthrop reported that he had seen claimant on October 1, 1997 and she "clearly had a flareup of the tendinitis in both wrists." (Ex. 42). He felt that claim closure was premature and inappropriate and claimant's tendinitis was "worse than ever." (*Id.*) Claimant's attorney forwarded a copy of that report to the Department for inclusion in the record. (Ex. 43).

On October 23, 1997, the employer wrote to the Department responding to claimant's request for reconsideration. (Ex. 47). The employer urged the Department to reject claimant's argument of premature claim closure. (*Id.*) The employer explained that Dr. Winthrop's October 10, 1997 report was not persuasive because he relied on a change in claimant's condition after closure. (Ex. 47-2). The employer asserted that the real issue was whether claimant's accepted condition aggravated following claim closure. (*Id.*) The employer contended that, to the extent claimant suffered an aggravation, appointment of a medical arbiter was inappropriate because it appeared that claimant's condition may have changed. (*Id.*) The employer requested that the Department deny claimant's request for a medical arbiter and affirm the Notice of Closure. (*Id.*)

Dr. Mayhall, medical arbiter, examined claimant on November 25, 1997. (Ex. 48). He diagnosed bilateral wrist tendinitis, possible mild first dorsal compartment tendinitis or residuals thereof and "[s]igns and symptoms of 'overuse syndrome' with recent recurrence after returning to work." (Ex. 48-4). Dr. Mayhall reported that claimant had returned to Dr. Winthrop for further treatment and he had taken her off work because there was no light duty available. (*Id.*)

An Order on Reconsideration issued on December 19, 1997. (Ex. 54) The Department referred to the employer's argument that claimant's request for a medical arbiter should be denied:

> "The insurer requested that the worker not be examined by a medical arbiter based on the worker's non-medically stationary status and on an aggravation basis. The record does not contain medical evidence that the worker is not medically stationary nor has the Appellate Review Unit received an aggravation claim form from either the insurer or the worker. The worker did not contact the Department to express a concern that a medical arbiter examination was inappropriate. The worker is entitled to a medical arbiter examination and the insurer's objections will be made a part of the reconsideration record." (Ex. 54-2).

The Order on Reconsideration awarded 5 percent (9.6 degrees) scheduled permanent disability for loss of use or function of the left arm and 9 percent (13.5 degrees) scheduled permanent disability for loss of use or function of the right forearm (wrist). (Ex. 54-3). The employer requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ found Dr. Mayhall's opinion persuasive and affirmed the Order on Reconsideration. The ALJ reasoned that there was no evidence that Dr. Mayhall's range of motion findings were due to the aggravation as opposed to the effects of the original injury.

At hearing, claimant requested an increase in scheduled permanent disability for her left wrist. The employer objected on the basis that claimant had neither requested a hearing nor filed a cross-request for hearing. The ALJ found that claimant's failure to request a hearing within 30 days of the Order on Reconsideration precluded the award of additional scheduled permanent disability.

Administrative Notice/Remand

On review, the employer contends that an April 17, 1998 letter from Dr. Winthrop should be included in the record. The employer asserts that the April 17, 1998 letter was not available at the hearing and the record will not be complete without it.

Although the employer failed to include a copy of Dr. Winthrop's April 17, 1998 letter with its brief, we interpret the employer's request as a motion for remand. *Judy A. Britton,* 37 Van Natta 1262 (1985). We may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. *See* ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 n.3 (1983). To warrant remand, the moving party must show good cause or a compelling basis. A compelling basis exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. *See Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

We agree with the employer that Dr. Winthrop's April 17, 1998 *letter* was not available at the March 9, 1998 hearing. Nonetheless, it is questionable whether the *substance* of that letter was unobtainable at the hearing. Moreover, pursuant to ORS 656.283(7), we are statutorily prohibited in "extent" cases from considering "[e]vidence on an issue regarding a notice of closure or determination order" if that evidence was not submitted on reconsideration and made a part of the reconsideration record. *See, e.g., Precision Castparts v. Plummer,* 140 Or App 227 (1996); *Janet R. Christensen,* 50 Van Natta 1152 (1998). Dr. Winthrop's April 17, 1998 letter was not part of the reconsideration record. In light of such circumstqances, consideration of that letter is not reasonably likely to affect the outcome of the case. We decline to remand the case for consideration of Dr. Winthrops' April 17, 1998 letter.

Furthermore, Dr. Winthrop's April 17, 1998 letter submitted by the employer does not meet the standard of being facts "[c]apable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." *Janet R. Christensen,* 50 Van Natta at 1153; *see Groshong v. Montgomery Ward Co.*, 73 Or App 403 (1985). Therefore, we decline to take administrative notice of this letter.

In its reply brief, the employer argues that we should take administrative notice that claimant is currently pursuing an aggravation of "this very claim" in WCB No. 98-01495. However, we need not address the issue of administrative notice of claimant's aggravation claim because we conclude the result in this case (which pertains to the extent of her permanent disability resulting from the initial closure of the claim based on the Director's reconsideration record) would be the same even if we took "notice" of this subsequent aggravation claim. *See Janet R. Christensen,* 50 Van Natta at 1153.

Extent of Permanent Disability

The ALJ found that Dr. Mayhall, the medical arbiter, provided the most persuasive medical opinion addressing claimant's disability. The ALJ reasoned that there was no evidence that claimant's range of motion findings were due to the aggravation as opposed to the effects of the original injury. Consequently, the ALJ affirmed the permanent disability awards granted by the December 19, 1997 Order on Reconsideration.

On review, the parties do not dispute that claimant was medically stationary on September 8, 1997, the date claimant's attending physician, as well as the Notice of Closure and Order on Reconsideration, found she was medically stationary. However, the employer contends that the ALJ erred by relying on Dr. Mayhall's findings because claimant was not medically stationary at the time of the November 25, 1997 arbiter examination.[1]

OAR 436-035-0007(13) (WCD Admin Order No. 96-072) provides that on reconsideration, where a medical arbiter is used, impairment is established by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. In evaluating claimant's permanent disability, we do not automatically rely on a medical arbiter's opinion in evaluating permanent impairment. *Kenneth W. Matlack*, 46 Van Natta 1631 (1994). Instead, we rely on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment. *See Carlos S. Cobian*, 45 Van Natta 1582 (1993).

Claimant's treating physician, Dr. Winthrop, indicated that claimant's tendinitis condition would wax and wane, depending on her work activities. On July 31, 1997, Dr. Winthrop reported that claimant had been on light duty and her bilateral wrist tendinitis was resolving. (Ex. 29). On August 22, 1997, he explained that "chances are, however, that when [claimant] resumes her repetitive job [at the employer] she will develop tendinitis again." (Ex. 32). Dr. Winthrop said that whether claimant's condition is stationary would depend on what happens when she resumes her job. (*Id.*) On September 8, 1997, Dr. Winthrop reported that claimant had been on light duty for more than a month and was basically asymptomatic. (Ex. 34). He explained that claimant was medically stationary, but "time will tell whether this job will cause a flare-up." (*Id.*)

Dr. Mayhall performed a medical arbiter examination on November 25, 1997. (Ex. 48). He diagnosed bilateral wrist tendinitis, possible mild first dorsal compartment tendinitis or residuals thereof and "[s]igns and symptoms of 'overuse syndrome' with recent recurrence after returning to work." (Ex. 48-4). He reported that claimant's wrist ranges of motion were, from right to left, pronation 85/75, supination 85/85, flexion 52/50, extension 56/58, radial deviation 16/20 and ulnar deviation 32/29. (Ex. 48-3). In reaching these conclusion, Dr. Mayhall did not suggest that claimant's condition was not medically stationary. Based on Dr. Mayhall's range of motion findings, we conclude that claimant is entitled to 5 percent scheduled permanent disability for loss of use or function of the left wrist/arm and 4 percent scheduled permanent disability for loss of use or function of the right wrist. *See* OAR 436-035-0080; 436-035-0100(4).

Dr. Mayhall also explained:

> "Her recurrent pain after returning to work at a relatively repetitive and forceful job would suggest that she is significantly limited to repetitively use the wrist due to the residuals of her tendonitis. This involves primarily the right wrist. This is mildly true on the left." (Ex. 48-4).

OAR 436-035-0010(5) provides, part:

> "A worker is entitled to a 5% scheduled chronic condition impairment value for each applicable body part, stated in this section, when a preponderance of medical opinion establishes that, due to a chronic and permanent medical condition, the worker is *significantly limited in the repetitive use* of one or more of the following body parts:

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[1] Citing ORS 656.268(7)(h)(B), the employer also argues that the Appellate Unit could have, and should have, stopped the arbiter's examination. ORS 656.268(7)(h)(B) provides:

> "If the worker's condition has subsequently changed since the notice of closure or the determination, *upon the consent of all the parties to the claim*, the director shall postpone the proceeding until the worker's condition is appropriate for claim closure under subsection (1) of this section." (Emphasis added).

Here, the record does not establish that all parties consented to a postponement of the reconsideration proceeding. Thus, contrary to the employer's argument, ORS 656.268(7)(h)(B) does not apply under the circumstances of this case. *See Brian A. Bergrud*, 48 Van Natta 802, 803 (1996).

"* * * * *

"(c) Forearm (below elbow/hand/wrist)[.]" (Emphasis added).

Dr. Mayhall's report establishes that claimant is significantly limited in the repetitive activities performed by the right wrist. Therefore, she is entitled to a 5 percent award for loss of repetitive use of her right wrist. *See* OAR 436-035-0010(5).

Claimant contends that she is entitled to a 5 percent increase in the award of scheduled permanent disability for her left wrist, to a total of 10 percent. However, Dr. Mayhall's report does not establish that claimant is *significantly limited* in the repetitive use of her left wrist. Rather, we interpret Dr. Mayhall's opinion to mean that claimant was mildly limited in the repetitive use of her left wrist. Under these circumstances, we conclude that claimant is not entitled to a 5 percent increase in the award of scheduled permanent disability for her left wrist.

In sum, we affirm the Order on Reconsideration awards of 5 percent (9.6 degrees) scheduled permanent disability for loss of use or function of the left arm and 9 percent (13.5 degrees) scheduled permanent disability for loss of use or function of the right forearm (wrist).

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 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 14, 1998 is affirmed. For services on review, claimant's attorney is awarded $750, payable by the self-insured employer.

August 25, 1998 Cite as 50 Van Natta 1655 (1998)

In the Matter of the Compensation of
JOHN L. MARTIN, Claimant
WCB Case Nos. 97-07445, 97-07444, 97-07443, 97-02862 & 96-11483
ORDER ON REVIEW
Burt, Swanson, et al, Claimant Attorneys
Lane, Powell, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Adminstrative Law Judge (ALJ) Livesley's order that set aside its denial of claimant's low back injury claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

In May 1989, claimant sought treatment for low back pain after working in his garden. He was diagnosed with paraspinal muscle spasm. (Exs. 14, 17). An MRI revealed an L2-3 disc protrusion and degenerative disc disease at L4-5 and L5-S1. (Ex. 16).

Claimant did well until he changed jobs at work, which required heavy lifting of 100 pounds to reload a strapper. (Ex. 21).

The last sentence of the last paragraph on page 2 should read: "The November 14, 1994, March 20, 1995 and August 21, 1995 injuries were administered as new and discrete (original) injuries. (Exs. 47A, 47B, 47C, 47D, 47E, 47F, 47G)."

The November 14, 1994 and March 20, 1995 claims were closed with no award of permanent disability.

CONCLUSIONS OF LAW AND OPINION

We adopt and affirm the ALJ's reasoning and conclusions on the compensability issue with the following supplementation to address the employer's argument.

Claimant works for a wood products company. Since 1988, he has sustained a number of compensable low back strains. He was also diagnosed with disc space narrowing in 1989. On November 19, 1996, he sought treatment at an emergency room for low back pain occasioned by lifting a chain saw to trim the ends of a unit of wood at work. X-rays demonstrated increased disc space narrowing at L2-3. The ALJ analyzed the claim under ORS 656.005(7)(a)(B), and found that claimant proved that he sustained a new compensable injury under that statute.

On review, the employer contends that the opinions of Drs. Farris, Buller and Ballard are more persuasive than that of Dr. Larson, claimant's attending physician. We do not agree.

The medical evidence establishes that claimant has preexisting degenerative disc disease at L2-3, and that both the preexisting condition and the November 18, 1996 work incident contributed to claimant's need for treatment. Therefore, in order to establish compensability, claimant must prove that the work incident on November 18, 1996 was the major contributing cause of his need for medical treatment or disability for his combined condition. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101, *recon* 104 Or App 309 (1997), *rev den* 326 Or 389 (1998). The fact that a work injury is the immediate or precipitating cause of a claimant's condition does not necessarily mean that that injury was the major contributing cause of the condition. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995). Instead, determination of the major contributing cause involves evaluating the relative contribution of different causes of claimant's need for treatment of the combined condition and deciding which is the primary cause. *Id.*

Drs. Farris, Fuller and Ballard each opined that claimant's degenerative disc disease, rather than his on-the-job lifting incident, was the major contributing cause of claimant's need for treatment for his low back strain. (Exs. 64, 66, 67, 68). Dr. Fuller, however, based his opinion upon an erroneous understanding of claimant's work activity. He stated that claimant's job involved "standing at a conveyor belt using hand controls," and "bending from the waist in an easy fashion to pick up a relatively weightless metal band." (Ex. 64-8). Dr. Fuller's opinion fails to consider the specific work activity claimant was performing at the time of his injury, namely, lifting a heavy chain saw to shoulder height and twisting to trim the ends of a unit of wood, nor does he consider the specific lifting incidents claimant was performing each time he sustained prior acute low back strains.

The opinions of Dr. Farris and Dr. Ballard are likewise unpersuasive, as they are also based on an inaccurate history of claimant's work activity. Dr. Farris also thinks that claimant simply stands at a conveyor belt and pulls controls. Although that is claimant's primary work activity, Dr. Farris did not address the effect of the specific lifting incident of November 18, 1996. Dr. Ballard stated that claimant's recurrent back strains were not related to the type of work he was doing because "he is not doing a lot of lifting or twisting." Dr. Ballard, like Dr. Farris and Dr. Fuller, does not address the effect of the November 18, 1996 lifting incident, nor the correlation discussed by Dr. Larson, claimant's attending physician, between claimant's history of acute strains and specific lifting and twisting incidents. Because the opinions of Drs. Fuller, Farris and Ballard are based upon an inaccurate history, we do not find them persuasive. *Somers v. SAIF*, 77 Or App 259 (1986).

In contrast, Dr. Larson, who has treated claimant since 1992, weighs the contribution of claimant's degenerative disc disease at L2-3, to which she attributes claimant's low-grade, chronic back pain, against the lifting incident that resulted in claimant's acute low back strain and required claimant to seek treatment. (Exs. 65, 75). Accordingly, we agree with the ALJ that Dr. Larson's opinion is more persuasive than those of Drs. Fuller, Farris and Ballard.

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 February 19, 1998 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,000, to be paid by the self-insured employer.

In the Matter of the Compensation of
BETTY L. MARTINEZ, Claimant
WCB Case Nos. 96-01346, 96-00819 & 95-02012
SECOND ORDER ON REMAND
Malagon, Moore, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Wal-Mart requests reconsideration of our August 4, 1998 Order on Remand, which found it responsible for claimant's occupational disease claim for a right carpal tunnel syndrome condition. Contending that our analysis of the last injurious exposure rule (LIER) was premature because we neglected to make a finding that claimant's employment for Wal-Mart involved potentially causal working conditions, Wal-Mart asserts that such a finding is necessary to complete our order so that it is sufficient for judicial review. We disagree.

LIER provides that, where a worker proves that an occupational disease was caused by work conditions that existed when more than one carrier was on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. *Boise Cascade Corp. v. Starbuck*, 296 Or 238 (1984). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. *Bracke v. Baza'r*, 293 Or 239, 248 (1982). If a worker receives treatment for a compensable condition before experiencing time loss due to the condition, the date the claimant first received treatment related to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim, unless subsequent employment contributes independently to the cause or worsening of the condition, *Timm v. Maley*, 125 Or App 396, 401 (1993), *rev den* 319 Or 81 (1994), or it is impossible for the carrier on the risk at the time of disability to have caused the disease or the evidence establishes that a prior employment is the sole cause of the disease. *Roseburg Forest Products v. Long*, 325 Or 305, 313 (1997).

In this case, claimant established, and the ALJ found that, under the "rule of proof" portion of LIER, all of claimant's employment (which would include that for both Wal-Mart and Perfect Look) was the major contributing cause of her right carpal condition. This necessarily means that all of her employment was potentially causal, including that for Wal-Mart. The "rule of assignment" portion of LIER then assigns responsibility to the carrier on the risk when treatment for right carpal tunnel condition was first sought as the last potentially causal employment. Because claimant first sought treatment for her right carpal tunnel condition while Wal-Mart was on the risk, the ALJ correctly assigned responsibility to Wal-Mart as the last potentially causal employment prior to the "onset of disability." Further, because there is no evidence that it was impossible for claimant's work at Wal-Mart to have caused her right carpal tunnel condition or that a prior employment was the sole cause of that condition, Wal-Mart remains responsible.

Alternatively, even if we accept Wal-Mart's contention that we must make a specific finding that its employment was potentially causal, we find the record contains sufficient evidence to make such a finding. Claimant's right carpal tunnel condition did not develop until her employment for Wal-Mart began in April 1995. On February 1, 1996, a panel of examining physicians (Drs. Tesar and Wilson) concluded that claimant's work activities may be a contributing factor in her bilateral carpal tunnel syndrome. (Ex. 123A-11). In addition, Dr. Pollard, the attending physician, opined on April 4, 1997 that claimant's employment at Wal-Mart probably worsened the symptoms of her carpal tunnel condition. (Ex. 128).

Based on the above evidence, we conclude that claimant's employment for Wal-Mart was potentially causal.[1] *See Meyer v. SAIF*, 71 Or App 371, 374 (1984), *rev den* 299 Or 203 (1985) (appropriate inquiry under LIER is not whether the conditions of the last employment actually caused the disease, but whether those conditions were of a kind which could have caused the disease over some indefinite period of time). Therefore, we adhere to our conclusion that Wal-Mart is the responsible employer for claimant's right carpal tunnel condition under LIER.

Accordingly, we withdraw our August 4, 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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[1] We continue to adopt the ALJ's finding that claimant's employment for Wal-Mart only involved light lifting and very little repetitive activity with her hands and arms. However, this does not mean that the Wal-Mart employment could not have potentially contributed to claimant's right carpal tunnel condition, particularly in light of the above medical opinions.

In the Matter of the Compensation of
GEORGIA TELFER, Claimant
WCB Case No. 97-06984
ORDER ON REVIEW
Brothers & Ash, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the insurer's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome (CTS). On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant, age 62, began working part time for the employer at about the beginning of 1995, performing production work on the jug line as a kitty litter capper. (Tr. 10 through 14). During her approximately two and a half year employment, claimant's work consisted of holding a metal bar to tamp kitty litter into jugs while the litter was pouring into the jugs from hoppers; capping the jugs, sometimes using both hands at the same time; lifting and swinging the jugs to the conveyor belt; lifting the jugs for weighing; and lifting the jugs to put them in a box. The jugs weighed either 6 pounds or 11 pounds apiece. (Tr. 11, 12, 13, 17, 18, 27, 28, 29, 30, 40). Claimant's shifts were variable in length, generally from five to six hours to about 12 hours. (Ex. 1, Tr. 14, 27).

Six to eight months after beginning work, claimant experienced right wrist pain that radiated into her thumb, and, about two months later, she experienced similar symptoms in her left hand. (Tr. 15, 21; Ex. 2). She reported her symptoms at work, and the employer provided her with wrist supports. (Tr. 15, 16, 33, 34). Claimant continued to perform the same work until March 1997, when she was terminated by the employer. (Ex. 2, 7; Tr. 19).

On May 13, 1997, claimant sought treatment from Dr. Brennan, osteopath, who diagnosed bilateral CTS due to repetitive work and prescribed conservative treatment. (Ex. 2)

After six weeks of unsuccessful treatment, claimant saw Dr. Buchholz, neurologist, who found electrodiagnostic evidence of CTS, left greater than right, and recommended surgical release. (Ex. 7).

On July 31, 1997, Dr. Radecki examined claimant for the employer. He concluded that claimant's CTS was due to idiopathic causes. (Ex. 9).

On August 12, 1997, the insurer denied claimant's bilateral CTS claim. (Ex. 12).

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant had failed to carry her burden to prove, by a preponderance of the evidence, that her work activities were the major contributing cause of the pathological worsening of her bilateral CTS. In reaching this conclusion, the ALJ found that the opinion of Dr. Radecki was more persuasive than the opinions of Dr. Buchholz and Dr. Brennan. On review, claimant argues that the opinions of Dr. Buchholz and Dr. Brennan are more persuasive than that of Dr. Radecki. We agree and reverse.

To establish her occupational disease claim, claimant must prove that employment conditions were the major contributing cause of the bilateral CTS. *See* ORS 656.802(2)(a).[1] 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); *Gregory C. Noble*, 49 Van Natta 764, 765-66 (1997), *aff'd mem* 153 Or App 125 (1998). Based on the medical record, we find that there are multiple potential causal factors involved in claimant's CTS; therefore, the causation issue presents a complex medical question which must be resolved on the basis of expert medical evidence. *See Uris v. Compensation Dept.*, 247 Or 420, 426 (1967); *Barnett v. SAIF*, 122 Or App 279, 283 (1993). Claimant has the burden of proving her claim by a preponderance of the evidence. *See* ORS 656.266.

It is well-settled that we give the greatest weight to medical opinions that are well-reasoned and based on a complete and accurate history. *Somers v. SAIF*, 77 Or App 259 (1986); *Michelle L. Andreasen*, 48 Van Natta 515 (1996).

Opinions regarding the cause of claimant's CTS condition were provided by Dr. Radecki, whose specialties are physical and electrodiagnostic medicine, Dr. Buchholz, neurologist, and Dr. Brennan, osteopath, claimant's attending physician.

Dr. Radecki opined that, based on his review of medical literature and application of a mathematical formula that predicts median nerve slowing on the basis of "personal factors" (such as age, wrist ratio, and body mass index), "familial factors," and "possibly other unknown idiopathic factors," claimant's carpal tunnel condition was not related to her employment activities. (Ex. 13-26 through -47). Dr. Radecki also discounted claimant's work as a causative factor because there was no statistical evidence that work caused CTS. (Ex. 13-17 through -19).

We have previously held that medical evidence grounded in statistical analysis is not persuasive when it is not sufficiently directed to a claimant's particular circumstances. *See Steven H. Newman*, 47 Van Natta 244, 246 (1995); *Catherine M. Grimes*, 46 Van Natta 1861, 1862 (1994); *Mark Osterniller*, 46 Van Natta 1556, 1558, *on recon* 46 Van Natta 1785 (1994). In this case, Dr. Radecki relied on statistically based studies that purport to show a causal connection between CTS and intrinsic factors such as age, body mass index, wrist ratio, and a family history of CTS. Because these studies are not directed toward this claimant's particular circumstances, we do not find Dr. Radecki's opinion to be persuasive.

In support of his opinion that claimant's work activity was the major contributing cause of her bilateral carpal tunnel condition, Dr. Buchholz reasoned that, even though claimant may have had some predisposition to the development of carpal tunnel, her condition became symptomatic because of the

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[1] The ALJ applied ORS 656.802(2)(b) to require evidence of a pathological worsening of claimant's CTS. Like the ALJ, we find claimant's testimony that her wrists were asymptomatic until the summer of 1995 to be credible. Moreover, there is no record evidence that claimant sought medical treatment for her wrists at any time prior to May 13, 1997. In addition, neither Dr. Radecki, Dr. Buchholz nor Dr. Brennan's opinions establish that claimant's carpal tunnel condition preexisted her work. Dr. Radecki stated that "it is possible" that claimant's median nerve injury in the carpal tunnel had finally gotten to the point where symptoms were going to develop, and they just started to occur while she was working. (Ex. 13-24). Likewise, Dr. Buchholz stated only that claimant "could have had" or that it "may be" that claimant had carpal tunnel syndrome prior to her work. (Exs. 15-2, 15-4, 19-16). Finally, Dr. Brennan opined that, because claimant has predisposing wrist anatomical wrist measurements, she "could have" had some swelling without overt symptoms. (Ex. 20-28, 20-29). Because these opinions appear to be based on speculation, we find they do not rise to the level of reasonable medical probability required to establish that claimant's bilateral CTS preexisted her work activities at the employer or that her claim is for a worsened CTS condition. *See Gormley v. SAIF*, 52 Or App 1055 (1981); *see also Cassandra J. Hansen*, 50 Van Natta 174 (1998).

repetitive work she was doing with her wrists and hands over a period of seven months, which would create stress in the carpal tunnel. (Ex. 15-2). Dr. Buchholz also stated that once CTS becomes established, conservative therapy may not result in improvement, thereby rejecting Dr. Radecki's opinion that claimant's condition should have improved after she stopped working. (Ex. 15-2, -3). Dr. Buchholz also eliminated underlying metabolic factors, such as thyroid dysfunction, diabetes, or connective tissue conditions as the cause of claimant's bilateral CTS condition.[2] (Ex. 15-3).

Dr. Brennan also opined that it was claimant's repetitive employment activities that were the major contributing cause of her condition.[3] (Ex. 17). She explained that repetitive motion over the time claimant worked at the employer, specifically claimant's twisting caps and tossing the filled containers with both wrists, caused the tissues to become edematous and swell with inflammation. (Ex. 20-22 through 20-25).

We conclude that Dr. Buchholz' and Dr. Brennan's medical opinions are well-reasoned and based on a complete and accurate history. Accordingly, we find them persuasive. Therefore, we conclude that claimant's bilateral carpal tunnel syndrome 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 appellant's brief), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated February 27, 1998 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant's attorney is awarded a fee of $4,000, to be paid by the insurer.

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[2] After reviewing x-rays of claimant's carpal bones, Dr. Radecki also eliminated claimant's degenerative arthritis as a causative factor in her CTS condition. (Ex. 9-7).

[3] Dr. Brennan initially opined that there was no medical evidence that claimant had a preexisting medical condition that predisposed her to the development of CTS. However, after being provided with Dr. Radecki's report, she agreed that claimant may have had a predisposition to the development of CTS, based on her wrist measurements. (Ex. 20-28). Recognition of such a predisposition, however, did not result in a change of opinion regarding causation.

In the Matter of the Compensation of
TAMARA ZALESKI, Claimant
WCB Case No. 97-09155
ORDER ON REVIEW
Cathcart & Borden, Claimant Attorneys
Stoel, Rives, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

The self-insured employer requests review of Administrative Law Judge (ALJ) Menashe's order that set aside its denial of claimant's claim for a slip and fall injury. On review, the issue is compensability.

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

Claimant was injured when she fell on a private sidewalk after slipping on a rock. The sidewalk where claimant fell was situated between the entrance to the building in which she worked for the employer, and the parking lot used by claimant and her co-workers. The employer leased the building "together with the appurtenances thereto" and the parking lot from a third party.

Under the "coming and going" rule adopted in Oregon, when an employee traveling to or from work sustains an injury on or near the employer's premises, there is a "sufficient work relationship" between the injury and the employment only if the employer exercises some "control" over the place where the injury is sustained. *Cope v. West American Ins. Co.*, 309 Or 232, 239 (1990). The requisite control can be established "by increased, employer-created risks, or by the employer's property rights to the area where the injury is sustained[.]" *Id.* Here, the ALJ concluded that the employer exercised the requisite control over the sidewalk where claimant fell. We agree with the ALJ's conclusion and supporting rationale, and we offer the following additional analysis.

The employer's lease agreement encompassed spaces in the parking lot adjacent to the sidewalk on which claimant was injured, and the leased office building "together with the appurtenances thereto." Given the location of the sidewalk between the building and the parking lot, we find that it was an "appurtenance thereto" the leased building and was, therefore, encompassed by the lease. We also note that, under the lease agreement, the employer was required to pay its share of "[a]ll costs of operating and maintaining the Building and related improvements[.]" We conclude that these "related improvements" include the "appurtenances thereto" the leased building, including the sidewalk in question. Thus, we conclude that the scope of the employer's lease and its obligation to share the cost of maintaining the sidewalk in question support the ALJ's ultimate conclusion that the employer exerted control over that sidewalk. *Cf. Henderson v. S.D. Deacon Corp.*, 127 Or App 333, 337 (1994) ("Ownership, or even a leasehold interest in the place where the injury occurred, is not always required."); *see also Margaret A. Kohl*, 48 Van Natta 2492 (1996) (fall in employer-leased parking lot from snow and ice provided sufficient work connection to find that injury occurred in the course of employment).

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

ORDER

The ALJ's order dated March 25, 1998 is affirmed. Claimant is awarded a $1,200 attorney fee for his attorney's services on review, to be paid by the self-insured employer.

In the Matter of the Compensation of
BRIAN A. BERGRUD, Claimant
WCB Case Nos. 96-05027 & 96-05026
ORDER ON REVIEW
Black, Chapman, Webber & Stevens, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Boise Cascade Corporation (Boise Cascade), a self-insured employer, requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) set aside its responsibility denial of claimant's right-sided disc herniation at L5-S1; and (2) upheld the responsibility denial of the same condition issued by the SAIF Corporation, on behalf of Tim Ply Inc. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

On March 12, 1992, claimant compensably injured his low back while working for Boise Cascade. (Ex. 36). An MRI on August 21, 1992 showed a left posterolateral herniation of the L5-S1 disc. (Exs. 9, 13). On October 1, 1992, Dr. Louie performed a left L5-S1 microlumbar diskectomy. (Ex. 15). Boise Cascade accepted a herniated disc at L5-S1 on the left. (Ex. 37).

By April 1993, claimant was performing his regular work. (Ex. 32). On June 22, 1994, Dr. Louie reported that claimant had some residual numbness and leg discomfort. (Ex. 39). A July 29, 1994 Determination Order awarded 13 percent unscheduled permanent disability for claimant's low back condition. (Ex. 41). An Order on Review increased the award to 22 percent unscheduled permanent disability for the low back condition and 5 percent scheduled permanent disability for loss of use or function of the left foot. (Ex. 68).

In 1995, claimant began working for SAIF's insured. On January 24, 1996, claimant was pushing a load when the mat slipped and he injured his right hip/low back. (Ex. 53, 54). Claimant was initially diagnosed with an acute lumbosacral strain. (Ex. 54). An MRI on February 5, 1996 showed a very large sequestered disc fragment occupying a position in the right lateral recess of the S1 vertebra associated with a large right posterior focal protrusion of the L5-S1 disc. (Ex. 59). On February 8, 1996, Dr. Louie performed a right L5-S1 microdiscectomy. (Ex. 61).

On April 23, 1996, SAIF denied responsibility for the claim. (Ex. 71). On May 10, 1996, Boise Cascade denied claimant's aggravation claim, asserting that SAIF was responsible for claimant's current condition. (Ex. 80). In June 1996, the Department issued an order pursuant to ORS 656.307(1) designating Boise Cascade as the paying agent. (Ex. 84).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that the 1996 herniation was not the "same condition" as the 1992 herniation and, therefore, ORS 656.308(1) did not apply. The ALJ determined that the rebuttable presumption in *Industrial Indemnity v. Kearns*, 70 Or App 583 (1984), applied to this case. The ALJ held that Boise Cascade failed to rebut the second prong of the *Kearns* presumption, concluding that Boise Cascade was responsible for claimant's low back condition.

On review, Boise Cascade argues that the ALJ incorrectly applied the *Kearns* presumption to this case. Boise Cascade contends that SAIF is responsible for the 1996 right-sided disc herniation, either under ORS 656.308(1) or the last injurious exposure rule. SAIF agrees that the *Kearns* case does not apply, but it argues that Boise Cascade is responsible for claimant's condition pursuant to ORS 656.308. Although claimant agrees that the *Kearns* case does not apply, he contends that SAIF is responsible for the 1996 claim.

The *Kearns* case created a rebuttable presumption that, in the context of successive accepted injuries involving the same body part, the last carrier with an accepted claim remains responsible for subsequent conditions involving the same body part. 70 Or App at 585-87. Encompassed in the "*Kearns* presumption" is the "last injury rule," which fixes responsibility based on the last injury to have independently contributed to the claimant's current condition. *See id.* at 587. The carrier with the last accepted injury can rebut the *Kearns* presumption by establishing that there is no causal connection between the claimant's current condition and the last accepted injury. *Id.* at 588.

In the present case, Boise Cascade is the only carrier with an accepted claim. When only one accepted claim is involved, the *Kearns* presumption does not apply. *See Daral T. Morrow*, 47 Van Natta 2384 (1995), *aff'd mem Barrett Business Services v. Morrow*, 142 Or App 311 (1996); *Lynnette D. Barnes*, 44 Van Natta 993 (1992).

We need not resolve the question of whether claimant's current low back condition (right L5-S1 herniated disc) is the "same condition" as the condition accepted by Boise Cascade (left L5-S1 herniated disc) because, regardless of whether the current condition is the "same condition," we conclude that SAIF is responsible for claimant's current low back condition.[1]

For the following reasons, we conclude that the medical evidence establishes that the 1996 injury with SAIF's insured was the major contributing cause of claimant's disability and need for treatment of the right-sided L5-S1 disc herniation.

Several physicians have commented on the causation of the right-sided disc herniation at L5-S1: Drs. Louie, White, Church, Dixon, Donahoo, Gilmore, Eyre and Frank. Where 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). SAIF argues that we should give greater weight to the opinion of Dr. Louie because he is the treating surgeon. *See Weiland v. SAIF*, 64 Or App 810 (1983). We find, however, that the dispute in this case (the major contributing cause of claimant's right-sided herniated disc at L5-S1) primarily 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).

We are not persuaded by Dr. White's opinion because it is based on the inaccurate finding that claimant's L5-S1 disc herniated through the same defect in 1992 and 1996. Dr. White compared the MRI scans and said it was "quite clear that the defect in the annulus through which this herniation occurred is identical in 1992 and in 1996." (Ex. 67-6, -7). He opined that the 1992 MRI showed that the largest mass of the herniation was "midline," with some eccentricity extended to the left. (Ex. 67-5). He concluded that the major contributing cause of the 1996 disc herniation was the 1992 disc herniation with tearing and permanent weakening of the annulus at L5-S1. (Ex. 67-7).

The other physicians disagreed with Dr. White's conclusion that claimant's 1996 disc herniation occurred through the same defect as the 1992 herniation. Dr. Church explained that the September 1992 MRI showed more protrusion in the left field than in the mid field. (Ex. 78-22). The 1992 MRI showed a left, rather small herniation impinging upon the exiting nerve root and there was only a slight amount of disc material protruding in the central area. (*Id.*) Based on the 1992 surgical report, Dr. Church opined that claimant had a localized disc herniation on the left. (*Id.*) The 1992 MRI did not show any extrusion on the right side of the disc. (Ex. 105-35). In contrast, the 1996 MRI showed a defect in the right side of the disc and no such loss in continuity on the left side. (Ex. 78-23). Dr. Church disagreed with Dr. White's conclusion that the left herniation in 1992 and the right herniation in 1996 were produced through the same weak place in the annulus. (Ex. 78-23).

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[1] If we assume that claimant's 1996 right-sided L5-S1 disc herniation involved a condition that was previously processed as part of the 1992 compensable claim, ORS 656.308(1) would apply and Boise Cascade would be presumptively responsible for claimant's current L5-S1 disc herniation. However, because the persuasive medical evidence establishes that claimant's 1996 injury was the major contributing cause of the right-sided L5-S1 disc herniation, we would find that claimant sustained a "new compensable injury" and responsibility for his L5-S1 disc herniation would shift to SAIF.

Alternatively, if ORS 656.308(1) does not apply, this is an initial claim for the right-sided L5-S1 disc herniation. *See SAIF v. Yokum*, 132 Or App 18, 23 (1994) (for ORS 656.308 to be triggered, there must be an accepted claim for the condition, for which some employer is responsible). Under those circumstances, we turn to the last injurious exposure rule to determine responsibility. *See Barrett Business Services v. Williams*, 148 Or App 1, 5 (1997) (ORS 656.308(1) did not apply to determine initial responsibility for a new compensable condition; the Board properly applied the last injurious exposure rule).

As a rule of assignment of responsibility, the last injurious exposure rule imposes responsibility on the last carrier that contributed to the worker's condition. *Roseburg Forest Products v. Long*, 325 Or 305, 310 (1997); *see Bracke v. Baza'r*, 293 Or 239, 245 (1982) (the rule assigns liability for the entire aggregate disability to the carrier at the time of the last injury). Here, claimant was working for SAIF's insured at the time of the January 1996 injury and the persuasive medical evidence establishes that claimant's 1996 injury was the major contributing cause of the 1996 disc herniation. Under these circumstances, SAIF would be responsible for claimant's right-sided L5-S1 disc herniation.

Dr. Donahoo also disagreed with Dr. White's conclusion that the midline herniation was the principal problem. Dr. Donahoo reviewed the September 14, 1992 MRI and found a very small, midline bulge or herniation and a small, left-sided disc protrusion or herniation. (Ex. 83-2). The 1996 MRI showed the small midline area virtually unchanged, but there was a large, right-sided herniated nucleus pulposus. (*Id.*) Dr. Donahoo concluded that the right-sided event in 1996 did not occur through the midline area, which was unchanged. (*Id.*) Drs. Dixon, Gilmore, Eyre and Frank also felt that the 1996 herniation was a new and separate herniation. (Exs. 81, 87, 89, 93).

We are persuaded by Dr. Church's opinion, as supported by the opinions of Drs. Dixon, Donahoo, Gilmore, Eyre and Frank that claimant's 1996 injury with SAIF's insured was the major contributing cause of his disability and need for treatment of the right-sided L5-S1 disc herniation. Dr. Church concluded that claimant had a new injury in 1996 with a new anatomic failure event on a new side at the same L5-S1 level. (Ex. 78-21, -24, 105-21). Although he felt the 1992 event could have a minor effect in accelerating the degenerative process, he did not believe the 1992 injury was a significant or major cause of the 1996 injury. (Ex. 105-21, -22). Dr. Church explained that the L5-S1 disc maintained its height between 1992 and 1996. (Ex. 105-36). He said that if there had been further degenerative change, further progression would have been demonstrated by a loss of more height, which there was not. (Ex. 105-37).

SAIF argues that Dr. Church's opinion is unpersuasive because he mistakenly believed that Dr. Louie's surgery was confined to the left side. However, Dr. Church was aware that Dr. Louie's 1992 surgery addressed both the ipsilateral and contralateral sides of the L5-S1 disc. (Ex. 105-33). He explained that the 1996 herniation was a different condition entirely from the 1992 herniation because it occurred at the other location and it was not only extruding, but sequestrating. (Ex. 105-36). Dr. Church said that studies indicated that approximately seven percent of people with previous disc surgeries have a second disc protrusion at the same level and sixty percent of those recurrences occur within the first year. (Ex. 105-40, 42). Based on the studies, Dr. Church concluded that it was medically probable that a person with a diskectomy would *not* have a second one. (Ex. 105-43). Dr. Church agreed that claimant's 1996 injury with SAIF was the major contributing cause of the right-sided disc herniation at L5-S1. (Ex. 105-41)

Dr. Church's conclusion is supported by the opinions of Drs. Dixon, Donahoo, Gilmore, Eyre and Frank. Dr. Dixon concluded that the 1996 herniation was a new disc herniation secondary to the second injury and it was not an exacerbation of the earlier smaller left-sided herniation. (Ex. 81). Dr. Donahoo concluded that the 1996 herniation was a "new event" and the 1996 injury was the major cause of his need for treatment in 1996. (Ex. 83-1, 4). Dr. Gilmore reviewed the MRI scans from 1992 and 1996 and concluded that it was "obvious" that the herniation on the left and on the right represented two separate events. (Ex. 87). Similarly, Dr. Eyre reviewed the MRI's from 1992 and 1996 and concluded that the signal disturbance on the 1996 MRI together with the shape of the posterior longitudinal ligament indicated the 1996 injury was a "fresh event" superimposed upon a chronic process. (Ex. 89-2).

Dr. Frank also agreed that claimant had sustained a "new compensable injury" in 1996. He concluded that the 1996 injury was the etiology of the fragments in the axillae and formina. (Ex. 93-2). He explained that the annulotomy that was done in 1992 was at the area of the left nerve root and, while there was some central herniation in 1996, the fragments were far to the right side in the axillae and foramina. (*Id.*) Dr. Frank concluded that it would be "extremely rare" to find fragments this far on the right side coming from an annular defect on the left. (*Id.*)

SAIF relies on the opinion of Dr. Louie to argue that the 1992 injury and surgery were the major contributing cause of the 1996 disc herniation. Dr. Louie relied on a "biomechanical" argument that claimant's L5-S1 disc was "severely distorted" by the 1992 surgery. (Ex. 90-1). He opined that the disc was "markedly abnormal" and unable to respond to stresses and strains as a normal disc, which results in "accelerated injury to the annulus cracking and in [claimant's] case, a tear in the opposite contralateral annulus." (*Id.*) In a later report, Dr. Louie said that the previous surgery resulted in increased stress on the remaining annulus fibers, collapse of the disk innerspace and contributed to the subsequent disc herniation. (Ex. 99).

Although Dr. Louie indicates that claimant had a "severely distorted" L5-S1 disc after 1992 that was unable to respond to normal stresses and strains, Dr. Donahoo noted that claimant had interim events of significance after 1992 that indicated claimant had a fairly stable spine after the first surgery. (Ex. 83-3, -4). Dr. Donahoo referred to claimant's motor vehicle accident on December 20, 1994, in

which he drove his pickup at a high speed into the back of a chip truck. (Ex. 83-3). He referred to claimant's injuries, including missing teeth, a large, right-sided mandible laceration, left pneumothorax, fractured left clavicle, and a right patellar fracture as indicating that claimant had a "significant event." (*Id.*) Dr. Donahoo noted that claimant did not appear to have back problems resulting from that injury and he felt that claimant had a fairly stable and "non-fragile" spine after 1992. (Ex. 83-4). He did not believe that claimant's L5-S1 disc was a "fragile situation" waiting for the "inevitable" recurrent herniation. (*Id.*) In light of Dr. Donahoo's report, we do not find Dr. Louie's conclusory "biomechanical" argument on causation persuasive. We conclude that Dr. Louie's opinion that the 1992 injury and surgery were the major contributing cause of the 1996 disc herniation is not persuasive.

Based on the opinions of Drs. Church, Donahoo, Dixon, Gilmore, Eyre and Frank, we conclude that SAIF is responsible for claimant's current right-sided L5-S1 disc herniation.

Claimant submitted a respondent's brief on review in which he argued that SAIF should be found responsible for his condition. Claimant's attorney requests an attorney fee for services on review. The only issue at hearing and on review was responsibility. The Department issued an order pursuant to ORS 656.307(1) designating Boise Cascade as the paying agent. (Ex. 84). ORS 656.307(5) makes no provision for an attorney fee for services on review. *Lynda C. Prociw*, 46 Van Natta 1875 (1994).

Furthermore, claimant is not entitled to an attorney fee pursuant to ORS 656.382(2). As established by the Department's "307 order," claimant's weekly wage under his SAIF claim ($664.61) was greater than his weekly wage under the claim with Boise Cascade ($528.00). (Ex. 64). Because compensability was not litigated at hearing and claimant's compensation was 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); *Vance T. Ferguson*, 50 Van Natta 320, 322 (1998).

ORDER

The ALJ's order dated February 19, 1998 is reversed. Boise Cascade's denial of responsibility is reinstated and upheld. The SAIF Corporation's denial of claimant's right-sided L5-S1 disc herniation is set aside and the claim is remanded to SAIF for processing according to law. The ALJ's $1,000 attorney fee award shall be paid by SAIF.

August 26, 1998 Cite as 50 Van Natta 1665 (1998)

In the Matter of the Compensation of
PATRICK J. CALLOW, Claimant
WCB Case No. 97-08869
ORDER ON RECONSIDERATION
Coughlin, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

The insurer requests reconsideration of our June 8, 1998 Order on Review. In that order, we adopted and affirmed the order of the Administrative Law Judge (ALJ) which affirmed an Order on Reconsideration award of scheduled permanent disability. We also cited to *Justeen L. Parker*, 49 Van Natta 334 (1997) and OAR 438-035-0007(27) to support our conclusion that claimant's impairment should be rated according to the arbiters' range of motion measurements. In order to address the insurer's contentions and to grant claimant an opportunity to respond, we abated our prior order. Having received claimant's response, we proceed to our reconsideration.

The insurer contends that the medical arbiters did explain why their findings were invalid, as they noted that claimant had a "nonanatomical examination." (Ex. 16-2). However, as claimant argues, the "nonanatomical examination" comment pertained to the arbiters' findings regarding claimant's sensory examination. (Ex. 16-2). With respect to the range of motion findings, the arbiters provided no comments regarding a nonanatomical examination. Consequently, we do not find the insurer's argument to support its contention that the arbiters' report contains a "written opinion, based on sound medical principles, explaining why the findings are invalid." *See* OAR 436-035-0007(27). Accordingly, we find this case to be distinguishable from the cases cited in the insurer's request for reconsideration.

The insurer also contends that we have altered claimant's burden of proof in this case. However, we note that this matter involves a request for hearing filed by the insurer to challenge the additional award of permanent disability granted to claimant by the Order on Reconsideration. Claimant did not seek an increased award. Under such circumstances, we have previously held that the employer has the burden of proving that claimant's permanent disability award should be reduced. *See Roberto Rodriguez*, 46 Van Natta 1723 (1994); *Barbara Barber*, 49 Van Natta 1923 (1997). Consequently, we continue to adhere to our decision in *Rodriguez* and we find that, in this case, the employer has not met its burden of proving that claimant's award should be reduced.

Moreover, notwithstanding the issue of burden of proof, we find that the ALJ's order satisfactorily explains why she relied on the arbiters' opinion. It is evident from the ALJ's order that the medical opinions were weighed and the ALJ relied on the most persuasive opinion, rather than automatically relying on the arbiters' report. *See Patricia M. Johnson*, 49 Van Natta 1084, 1085 (1997); ORS 656.726(3)(f)(B). Consequently, we continue to adhere to our decision.

Accordingly, our June 8, 1998 order is withdrawn. On reconsideration, as supplemented herein, we republish our June 8, 1998 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

Board Member Moller dissenting.

On reconsideration, I would decide this case differently than does the majority. The majority accepts the impairment findings made by the medical arbiters even though the arbiters expressly found those findings to be invalid. In reaching its conclusion, the majority relies on OAR 436-035-0007(27) and finds that the arbiters' note that claimant had a "nonanatomical examination" did not constitute a "written opinion, based on sound medical principles, explaining why the findings are invalid." The majority apparently finds the arbiters' opinion to be an insufficient explanation under the rule in order for the findings to be invalid. Consequently, pursuant to the rule, the majority has used the arbiters' range of motion findings to award impairment.

The insurer contends that the application of the aforementioned rule is, in this case, inconsistent with several statutes. Specifically, the insurer argues that, pursuant to ORS 656.266, ORS 656.726(3)(f)(B) and ORS 656.214(2), claimant must establish, by a preponderance of the medical evidence based upon objective findings, permanent impairment due to a compensable injury or disease.

I agree that, even assuming that the arbiters' explanation is insufficient under the rule, the application of the rule is inconsistent with the statutes cited above. In this regard, it is claimant's burden to establish, by a preponderance of the evidence, permanent impairment due to the injury. ORS 656.214(2). The adequacy of the explanation regarding invalidity affects the persuasive weight to be given to the report. Consequently, the Department's rule, to the extent it mandates use of findings for rating purposes, absent specific explanation, conflicts with our statutory duty to weigh the evidence. In other words, although the rule promotes a laudatory goal of well-reasoned medical reports, it goes too far here when it mandates use of any impairment findings despite the unequivocally stated opinion of the medical arbiters that their examination findings were invalid.

Finally, the majority relies on Board cases which have held that, when a hearing is requested by a carrier seeking a reduction of a claimant's permanent disability award, it is the carrier's burden of proof. Although I acknowledge that those cases are controlling, I believe that the holdings are incorrect and that the cases should be disavowed.

With respect to the burden of proof issue, I agree with former Board Member Westerband's special concurrence in the *Rodriguez* case. Specifically, I would find that, pursuant to ORS 656.266, a worker has the burden of proving the nature and extent of any disability throughout the proceedings on the initial claim. As noted by Member Westerband, in most appeals of a reconsideration order the Board is asked to review the same evidence that was considered by the Department. Consequently, to prevail, the insurer is not required to offer new evidence showing a change in circumstances, and the

insurer is not the party who would be unsuccessful if no evidence were introduced on either side. *Rodriguez*, 46 Van Natta at 1726, citing *Harris v. SAIF*, 292 Or 683, 690 (1982).[1]

Accordingly, under the facts of this case, *i.e.*, where an attending physician finds normal range of motion and the arbiters opine that the examination is invalid, I would conclude that claimant has not established entitlement to range of motion impairment by a preponderance of the evidence.

[1] *Also see Daquilante-Richards v. CIGNA*, 149 Or App 682 (1997) (The claimant had the burden of proving that her condition was not medically stationary at the time of closure, even though the insurer was the party appealing the Department's Order on Reconsideration).

August 26, 1998 Cite as 50 Van Natta 1667 (1998)

In the Matter of the Compensation of
RONALD R. DART, Claimant
WCB Case No. 96-03619
ORDER ON REMAND
Doblie & Associates, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Pursuant to the court's August 6, 1998 order, we have been directed to consider the parties' settlement. The parties have submitted a proposed "Disputed Claim Settlement," which is designed to resolve all issues raised or raisable between them in this case, in lieu of all prior orders, as well as any issues raised or raisable that were pending between them in WCB Case No. 98-00353, a case pending before the Hearings Division. Those portions of the settlement that pertain to the case pending before the Hearings Division have received ALJ approval.

Pursuant to the settlement, the parties agree that the insurer's denial, as supplemented in the agreement, "shall be reinstated and remain in full force and effect." The agreement further stipulates that the Board's prior order "shall be rescinded and held for naught" and "withdrawn in its entirety." Finally, the settlement provides that "claimant hereby withdraws the Request for Hearing," which "shall be dismissed with prejudice."

We have approved those portions of the parties' settlement that pertain to issues pending in this case, 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.

[1] A provision in the parties' settlement states that a portion of claimant's share of the proceeds shall be provided to a "HMO Oregon / Blue Cross" and to "Dept. of Human Resources Recovery Services Section" in partial satisfaction of their outstanding bills. Inasmuch as the parties' compensability dispute is being resolved by means of a Disputed Claim Settlement, only medical service providers may be directly reimbursed from the settlement proceeds. ORS 656.313(4)(c). (Health insurance providers may be directly reimbursed by the workers' compensation carrier when "the services are determined to be compensable." ORS 656.313(4)(b).) Nonetheless, because proceeds from a Disputed Claim Settlement are not considered "compensation," a claimant's assignment of all or a portion of his share of the proceeds is not prohibited by ORS 656.234. *Robert D. Surina*, 40 Van Natta 1855 (1988); *Theodule Lejeune, Jr.*, 40 Van Natta 493 (1988).

Here, we do not interpret the aforementioned settlement provisions to represent that non-medical service providers will receive reimbursement *directly* from the workers' compensation carrier. Rather, in granting our approval of the settlement, we have interpreted the settlement as stating that claimant has assigned a portion of his share of the settlement proceeds to the aforementioned non-medical service providers. Likewise, our approval should not be viewed as a Board determination that this assignment of proceeds to the non-medical service providers fully satisfies claimant's outstanding obligations with these entities. Rather, our approval should merely be interpreted as a conclusion that, pursuant to *Lejeune* and its progeny, such an assignment is not contrary to ORS 656.234. Finally, because the settlement also includes a list of medical service providers with outstanding billings on the date the settlement terms were agreed on, as well as claimant's express acknowledgment that the proposed reimbursement exceeds the statutory formula prescribed by ORS 656.313(4)(d), the agreement is approvable. *See* ORS 656.313(4)(c); OAR 438-009-0010(2)(g), (h); *Charles E. Munger*, 46 Van Natta 462 (1994).

In the Matter of the Compensation of
KENNETH G. FRASIER II, Claimant
WCB Case No. 97-06847
ORDER ON REVIEW
Mitchell & Associates, Claimant Attorneys
Sather, et al, Defense Attorneys

Reviewed by Board Members Hall and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Lipton's order that set aside its denial of claimant's left knee condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

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). The employer argues that ORS 656.802(2)(b) applies and, therefore, claimant must establish that his employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease. For the following reasons, we conclude that this case should be analyzed as an injury claim.

In determining the appropriate standard for analyzing compensability, we focus on whether claimant's left knee condition was an "event," as distinct from an ongoing condition or state of the body, and whether the onset was sudden or gradual. *Mathel v. Josephine County*, 319 Or 235, 240 (1994); *James v. SAIF*, 290 Or 343, 348 (1981); *Valtinson v. SAIF*, 56 Or App 184, 187 (1982). The 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 testified that he did not have any left knee problems before working for the employer. (Tr. 8). He had been working for the employer for approximately two weeks when he first noticed left knee symptoms. (Tr. 7). He finished his shift on July 11, 1997 without any problems, but when he woke up the next morning, he had difficulty extending his knee and he could barely walk on it. (Tr. 7, 11).

We find that claimant's left knee condition arose over a discrete time period, approximately two weeks after he began working for the employer. The record supports the occurrence of an injury in July 1997. The injury was unexpected, as claimant had not had previous problems with his left knee. Moreover, claimant's left knee condition was "sudden in onset" in that it occurred over a discrete, identifiable period of time. *See Donald Drake Co. v. Lundmark*, 63 Or App at 266. Therefore, we analyze the claim as an accidental injury, rather than an occupational disease.

The medical evidence establishes that claimant has a preexisting left patella condition that constitutes a "preexisting condition." Dr. Gritzka reported that claimant's left patella was "somewhat teardrop-shaped with an elongated or narrow inferior pole[.]" (Ex. 15-6). He explained that the teardrop-shaped patella could influence claimant's tendency to develop bursitis and he felt it was a contributing factor to the left knee condition. (Ex. 17-16). Thus, the medical evidence establishes that the compensable injury combined with the preexisting patella condition to cause or prolong claimant's disability or need for treatment. Under these circumstances, claimant must prove that his compensable injury was the major contributing cause of his current disability or need for treatment of his left knee condition. ORS 656.005(7)(a)(B).

Claimant relies on the opinion of Dr. Gritzka to establish compensability. Dr. Gritzka provided a detailed report of claimant's work activities as a floor selector in the employer's warehouse. (Ex. 15). He reported that claimant drove a cart up and down aisles and retrieved products. (Ex. 15-1). Claimant would lean his knees against a safety rail in order to brace himself and after retrieving a box, he would

"push off" primarily with his left knee. (Ex. 15-1, -2). Dr. Gritzka found that a McMurray's test was positive for the lateral knee joint compartment and there was swelling of the bursa between the patellar tendon and anterior proximal tibia. (Ex. 15-5). Claimant was tender over the inferior pole of the left patella and the left patellar tendon, as well as the left anteromedial knee joint line. (*Id.*) Dr. Gritzka diagnosed probable left retropatellar tendon bursitis, "[r]ule out" left lateral meniscal tear. (Ex. 15-6). He concluded that claimant's condition was due, in major part, to his work exposure at the employer. (*Id.*) Dr. Gritzka was later deposed and adhered to his earlier opinion. (Ex. 17-33). There are no contrary medical opinions.

The employer argues that Dr. Gritzka's opinion is not persuasive for several reasons. First, the employer contends that Dr. Gritzka did not have an accurate understanding of claimant's work activities. According to the employer, Dr. Gritzka believed that claimant spent his entire shift leaning on his knee and lifting 50 to 60 pounds. We disagree with the employer's characterization of Dr. Gritzka's opinion.

Dr. Gritzka reported that claimant was lifting products "weighing *up to* 50 or 60 pounds." (Ex. 15-1; emphasis added). Claimant testified that the products weighed 40 to 60 pounds. (Tr. 6). He said that, on average, the products weighed 20 to 25 pounds. (Tr. 23). We find that Dr. Gritzka's understanding of the weight of products claimant lifted was consistent with his testimony. In any event, although Dr. Gritzka considered the weight of the product as a factor, he felt the primary factor in determining causation was that claimant leaned his knees on a rail and pushed off with his knees when picking product. (Exs. 17-26, -29).

The employer also asserts that Dr. Gritzka understood that claimant spent his "entire shift" leaning on his knee. We disagree. Dr. Gritzka reported that claimant drove a cart up and down the aisles. (Exs. 15-1, 17-10). He was aware that claimant used his knees only when picking from the upper or fourth level. (Ex. 15-1). Thus, contrary to the employer's assertions, we find that Dr. Gritzka had an accurate understanding of claimant's work activities.

Next, the employer contends that claimant's testimony that his knee was swollen on July 12, 1997 was not credible and Dr. Gritzka's opinion based on claimant's testimony is not persuasive.

At hearing, claimant testified that his left knee was "real swollen" when he woke up on July 12, 1997. (Tr. 7, 12). His girlfriend and father also testified that his left knee was swollen on or about July 12, 1997. (Tr. 34, 37). However, Dr. Stahl examined claimant on July 13, 1997 and reported that claimant's knee "has not been hot or swollen" and his knee was "not swollen or red on inspection." (Ex. 1A-1). Claimant testified that Dr. Stahl's report was "incorrect." (Tr. 12). When Dr. Gritzka examined claimant on October 23, 1997, he said claimant told him that he "hasn't noticed any swelling." (Ex. 15-2). Based on the medical reports from Drs. Stahl and Gritzka, we are not persuaded that claimant's left knee was "real swollen" on July 12, 1997. In any event, Dr. Gritzka's testimony indicates that whether or not claimant's left knee was swollen when he was first symptomatic is not particularly important. Dr. Gritzka testified that the swelling may develop later as the bursitis condition persists. (Ex. 17-18, 27). He also explained that the swelling may be relatively subtle and may not necessarily be recognized by a physician other than an orthopedic surgeon. (Ex. 17-26, -27).

The employer argues that Dr. Gritzka provided an inadequate analysis of causation. We disagree.

Dr. Gritzka based his opinion on causation on the described mechanism of repetitive use and his examination findings. (Ex. 15, 17-26, -29). He explained:

> "[Claimant's] description of his work activity of leaning against a railing with his patellar tendon, leaning forward and picking up a box weighing up to 50 to 60 pounds from the back of a bin and then pulling the box toward him and 'pushing off' with his left patellar tendon, is a description of an activity that could reasonably be expected to cause a retropatellar tendon bursitis or other internal derangement of the knee." (Ex. 15-6).

Dr. Gritzka found no evidence of any other activity or injury that might have caused claimant's left knee condition. (*Id.*)

On this record, we find that Dr. Gritzka evaluated the relative contribution of the different causes for claimant's left knee condition in the process of identifying the work activity as the major contributing cause. We further find that his opinion is sufficient to sustain claimant's burden under ORS 656.005(7)(a)(B). Dr. Gritzka's opinion of causation was based on claimant's medical history, his clinical examination of claimant and his expertise as an orthopedic surgeon regarding the mechanism of claimant's left knee condition. *See Bronco Cleaners v. Velazquez*, 141 Or App 295 (1996) (evidence of causation that goes beyond a chronological connection is legally sufficient to sustain claimant's burden under ORS 656.266).

Finally, we address the employer's argument that we should reject Dr. Gritzka's opinion because he is biased in favor of compensability. The employer's argument is not well-taken. Dr. Gritzka testified that the fact that he had examined other clients of claimant's attorney had not affected his opinion with regard to claimant. (Ex. 17-33). In any event, "the contribution of one expert's opinion to the preponderance of evidence in one case has no bearing on the relative weight of the same expert's opinion in another case with a different mix of medical opinions." *Giesbrecht v. SAIF*, 58 Or App 218 (1982); *Dina M. Oldfield*, 50 Van Natta 885 (1998).

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 May 1, 1998 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the self-insured employer.

August 26, 1998 Cite as 50 Van Natta 1670 (1998)

In the Matter of the Compensation of
KEITH A. JOHNSON, Claimant
WCB Case No. C8-01693
ORDER ON RECONSIDERATION APPROVING CLAIM DISPOSITION AGREEMENT
Welch, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

On August 4, 1998, the Board approved the parties' claim disposition agreement (CDA) in the above captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant released his rights to future workers' compensation benefits, except medical services, for the compensable injury.

On August 14, 1998, we received an August 7, 1998 letter from the carrier's attorney forwarding corrected pages one, two and three of the previously approved CDA. The letter accompanying the corrected pages indicated that the corresponding pages in the approved CDA contained an inaccurate date of injury and should be replaced with the corrected pages. A copy of the August 7, 1998 letter was mailed to claimant's attorney. We treat the letter and corrected pages as a motion for reconsideration of the approved CDA.

In order to be considered, a motion for reconsideration of the approved CDA must be received by the Board within 10 days of the date of mailing of the final order. OAR 438-009-0035(1),(2). Because the request for reconsideration was received on August 14, 1998, within 10 days of the mailing of the order of approval, it is timely. OAR 438-009-0035(1). Moreover, based on the circumstances surrounding this request, we find good cause for allowing the additional submission. Accordingly, we reconsider the CDA. OAR 438-009-0035(3).

The corrected pages indicate that the date of injury is *August 16, 1996*, rather than November 19, 1997 as stated in the previously approved CDA.

In the absence of an objection, we find that the agreement, as amended by corrected pages one, two and three, is in accordance with the terms and conditions prescribed by the Board. ORS 656.236(1). We do not find any statutory basis for disapproving the agreement. *Id.* Accordingly, by this order, the CDA is approved, as amended by the corrected pages submitted with the carrier's attorney's August 7, 1998 letter.

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
CHERYL MOHRBACHER, Deceased, Claimant
WCB Case No. 96-08566
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Scheminske, 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) Menashe's order that: (1) declined to admit into evidence a hearsay statement regarding the cause of the decedent's death; (2) set aside the employer's denial of claimant's claim for survivor's benefits pursuant to ORS 656.204; and (3) awarded an assessed fee. In its reply brief, the employer objects to claimant's request for a $20,000 fee for services on review. On review, the issues are evidence, compensability, and attorney fees.

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

The ALJ declined to admit into evidence the hearsay statement of the decedent's 11-year old son regarding the cause of his mother's death. The ALJ reasoned that, considering the extreme emotional circumstances under which it was given, the statement could not be considered probative and given weight as substantive evidence.

On review, the employer contends that the ALJ abused his discretion in declining to admit the statement into evidence. The employer asserts that the statement is admissible as an "excited utterance."

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

We need not decide whether or not the ALJ abused his discretion in declining to admit the hearsay statement of the decedent's 11-year-old son regarding the cause of his mother's death. That is, even if we considered the disputed statement, we would still agree with the ALJ's reasoning and conclusions regarding the compensability issue.

Finally, the employer objects to counsel's request for a $20,000 fee for services rendered on review, arguing that such a fee is excessive. We agree.

We determine the amount of claimant's counsel's attorney fee for services on review by applying the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the 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); *compare Russell L. Martin*, 50 Van Natta 313 (1998) (in the absence of a fee request or argument on the rule-based factors, the ALJ was not obligated to make specific findings regarding the rule-based factors in order to have a reviewable order).

Our review of the record reveals the following information. The issue in dispute was whether the major contributing cause of the decedent's death was work exposure to latex. Approximately 110 exhibits were received into evidence, many of which were generated by claimant's counsel. The hearing lasted two days and the transcript consists of approximately 312 pages. There were three depositions of medical experts and nine depositions of hospital personnel. Ten witnesses, including one medical expert, testified at hearing. Counsel submitted a respondent's brief 77 pages in length (of which approximately 7 pages were devoted to defending the ALJ's attorney fee award). The compensability issue presented factual and medical questions of a complexity much greater than those generally submitted to this forum for resolution. The claim's value and the benefits secured are significant because survivor's benefits are involved. No frivolous issues or defenses were raised. Finally, considering the conflicting medical and lay evidence, there was a substantial risk that claimant's counsel's efforts might have gone uncompensated.

After considering and applying the factors in OAR 438-015-0010(4) to the case on review, we find that a reasonable fee for claimant's counsel's services on review concerning the compensability issue is $15,000, 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 and after reviewing claimant's counsel's statement of services and the employer's objections), the complexity of the issue, and the value of the interest involved. In determining claimant's counsel's fee, we have also 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 December 10, 1997 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $15,000, to be paid by the employer.

In the Matter of the Compensation of
JOHN E. PATTERSON, Claimant
WCB Case No. 97-09658
ORDER ON REVIEW
Rasmussen & Tyler, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Hall and Bock.

Claimant requests review of Administrative Law Judge (ALJ) McWilliams' order that: (1) affirmed an Order on Reconsideration in all respects; and (2) declined to award temporary disability benefits for the period of October 3, 1996 to November 20, 1996. On review, the issue is entitlement to substantive temporary disability for the period of October 3, 1996 to November 20, 1996. We reverse.

FINDINGS OF FACT

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

Claimant compensably injured his low back in an October 1992 motor vehicle accident. The claim was reopened in November 1993 and Dr. Hacker assumed claimant's care. Later that same month, Dr. Hacker performed surgery on claimant's back, including a discectomy and interbodyfusion with BAK instrumentation at L4-5. The aggravation claim was closed by a June 17, 1994 Determination order which awarded temporary disability and 17 percent unscheduled permanent disability.

In July 1995, claimant returned to Dr. Hacker complaining of back and leg pain. Dr. Hacker referred claimant to Dr. Karasek for a selective nerve root block at the left L5 level, which was administered on August 17, 1995. Claimant also saw Dr. Karasek on October 11, 1995 and November 29, 1995. Meanwhile, on October 26, 1995, Dr. Hacker completed an attending physician's palliative care request (form 2215) for selective root blocks on an as needed basis.

Claimant sought follow up treatment with Dr. Karasek and received additional nerve blocks on February 2, 1996 and March 4, 1996. In an April 3, 1996 letter to the claims adjuster, Dr. Hacker indicated that he had "not continued to monitor claimant's treatment course with Dr. Karasek since November 15, 1995," and that Dr. Karasek had been generally managing claimant and sending copies of his chart notes on claimant. In an April 19, 1996 letter to the claims adjuster, Dr. Karasek reported that he was "managing [claimant's] case temporarily" while claimant proceeded with conservative pain treatment.

Dr. Karasek continued to monitor claimant's progress, seeing him in May, June and September 1996. On September 25, 1996, Dr. Karasek suggested that Dr. Hacker reevaluate claimant to determine the appropriate treatment for his still-symptomatic iliac crest. On October 3, 1996, claimant reported increased low back pain and Dr. Karasek released claimant from work until October 7, 1996.

On October 7, 1996, Dr. Karasek performed another selective root block. On October 9, 1996, Dr. Karasek placed claimant on light duty for four weeks. He advised the claims adjuster that he was in the process of a diagnostic evaluation to determine whether claimant had experienced an aggravation. On October 18, 1996, Dr. Karasek conferred with Dr. Hacker concerning claimant's treatment plan. On November 5, 1996, Dr. Karasek performed a discography, which showed a severely disrupted disc at L5-S1.

On November 13, 1996, claimant returned to Dr. Karasek, who released him from work until his November 21, 1996 appointment with Dr. Hacker. Following his November 21, 1996 evaluation of claimant, Dr. Hacker completed an aggravation claim form and authorized continued time loss.

On December 13, 1996, Dr. Hacker performed a second discectomy and fusion surgery. He continued to monitor claimant's recovery and treatment until April 7, 1997, when he declared claimant medically stationary. The aggravation claim was then closed pursuant to a June 16, 1997 Determination Order which awarded temporary disability benefits from November 21, 1996 through April 7, 1997 and 23 percent unscheduled permanent disability for the low back. A November 6, 1997 Order on Reconsideration affirmed the Determination Order in all respects.

CONCLUSIONS OF LAW AND OPINION

At hearing, the only issue in dispute was claimant's entitlement to substantive temporary disability benefits from October 3, 1996 to November 20, 1996, the time period in which Dr. Karasek had authorized claimant's release from work. The ALJ determined that, considering the record as a whole, Dr. Hacker remained claimant's attending physician during this period, and therefore Dr. Karasek's time loss authorizations did not trigger claimant's entitlement to temporary disability benefits. In so finding, the ALJ affirmed the Order on Reconsideration which awarded claimant temporary disability as of November 21, 1996.

On review, claimant argues that Dr. Karasek was his attending physician between October 3, 1996 and November 20, 1996 because he was primarily responsible for claimant's treatment, whereas Dr. Hacker only monitored claimant's progress during this time. We agree that claimant is substantively entitled to temporary disability for the time period in dispute based on the following analysis.

Although the parties' arguments (and the ALJ's order) focused on whether claimant had an "attending physician's" authorization for temporary disability benefits between October 3, 1996 and

November 20, 1996, we do not find the attending physician issue dispositive. As we confirmed in *John P. Daugherty*, 50 Van Natta 1368 (1998), a worker's *substantive* entitlement to temporary disability is not contingent on an attending physician's authorization.[1] *See also Michael C. Leggett*, 50 Van Natta 226, 228 (1998); *Linda K. Holcomb*, 49 Van Natta 1491 (1997); *Kenneth P. Bundy*, 48 Van Natta 2501 (1996). Rather, on claim closure, a claimant's substantive entitlement to temporary disability benefits 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. *Id.*; *see also* ORS 656.210; *SAIF v. Taylor*, 126 Or App 658 (1994); *Lebanon Plywood v. Seiber*, 113 Or App 651 (1992).[2]

In this case, because the parties' dispute concerns claimant's entitlement to temporary disability upon claim closure, the pertinent inquiry is whether the evidence in the record establishes that claimant was in fact at least partially disabled during this time due to his compensable injury. In other words, it is not determinative whether Dr. Karasek was the physician primarily responsible for claimant's treatment when he authorized time loss for the period of October 3, 1996 to November 20, 1996,[3] so long as claimant has shown that his inability to work during this time was due to his compensable condition. As explained below, we find that the record supports such a conclusion.

Dr. Karasek released claimant from work on October 3, 1996 for one week because of his worsened low back pain. On October 9, 1996, pending diagnostic evaluation and the results of the nerve block treatment, Dr. Karasek released claimant to light duty work for four weeks. Later, in his chart notes and his correspondence with the claims adjuster, Dr. Karasek explained that claimant was restricted because of low back pain, which he attributed to claimant's BAK fusion device or the disc above or below the device. (Exs. 64, 67, 68). After his November 21, 1996 evaluation of claimant, Dr. Hacker confirmed that claimant was experiencing a discogenic syndrome related to the 1993 surgery for his compensable injury. In addition, Dr. Hacker reported that although claimant could pursue light work activities, he could not return to full work duties on a full-time basis until he underwent further treatment and surgery on his lumbar disc.

In light of this evidence and, in the absence of any evidence linking claimant's uncontested disability during this period to any other, noncompensable condition, we are persuaded that, between October 3, 1996 and November 20, 1996, claimant was at least partially disabled due to his compensable back condition. We therefore modify the Order on Reconsideration accordingly.

ORDER

The ALJ's order dated March 27, 1998 is reversed. In addition to the temporary disability awarded by the Order on Reconsideration, claimant is awarded temporary disability for the period of October 3, 1996 through November 20, 1996, less amounts already paid and any time worked. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney by the employer.

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[1] A worker's procedural entitlement to temporary disability for all periods of time during an open claim remains contingent upon authorization of temporary disability by the attending physician. ORS 656.262(4)(f).

[2] In fact, as we noted in *John P. Daugherty*, 50 Van Natta at 1368, n. 3, to the extent the Director's rule, OAR 436-060-0020(6), requires an attending physician's authorization for a substantive award of temporary disability, the rule is inconsistent with the statutes.

[3] An "attending physician" is the physician who is primarily responsible for the treatment of the worker's compensable injury. ORS 656.005(12)(b).

In the Matter of the Compensation of
CHRISTINE M. WESTMAN, Claimant
WCB Case No. 97-10294
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Lipton's order that upheld the insurer's *de facto* denial of claimant's disc lesions at L4-5 and L5-S1. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" except that we change the ALJ's reference to "March 10, 1995" on page 4 to "March 10, 1998."

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for lumbosacral strain/contusion as a result of a work injury on October 2, 1995. Claimant subsequently asked the insurer to accept the conditions of disc lesions at L4-5 and L5-S1. The ALJ found that claimant did not prove compensability because the opinion of his treating physiatrist, Dr. Long, was not persuasive. Claimant challenges this conclusion, asserting that Dr. Long's opinion is reliable and persuasive.

Dr. Long first concurred with a letter written by claimant's former attorney stating that claimant's October 1995 work injury had combined with a preexisting back condition to produce the disc herniations. (Ex. 29-1). The letter further stated that the work injury was the major contributing cause of the disc herniations, based on "the lack of evidence that [claimant] suffered from herniated discs prior to October 2, 1995, and the great increase in problems since that incident." (*Id.* at 1-2).

Dr. Woodward, orthopedic surgeon, after reviewing the medical records, found that "claimant has a chronic back problem which may have been temporarily aggravated by an incident at work on 10/02/95 and further aggravated by a fall in the bath in later October 1995 but that these aggravations would have been expected to recover within a few weeks with simple conservative measures to the usual status of chronic back problems." (Ex. 41-10). Dr. Woodward also believed that the spinal changes on the MRI reflected "aging" and, in the absence of radicular symptoms, had no "clinical significance." (*Id.* at 11).

Dr. Long then responded to Dr. Woodward's report. Dr. Long reiterated that claimant did have preexisting lumbar disc disease. (Ex. 43-2). Although acknowledging that claimant had prior low back symptoms, he also stated that there was no evidence that her "lumbar symptoms were significantly disabling during 1994 and 1995." (*Id.*) He also stated that the October 2, 1995 injury involved "rather significant forces" and the "combination of rising from a squatting position, rotating abruptly to the right after being struck by a substantial force from the left all combine to produce the sort of lumbar injury that could easily produce annular tearing and disc herniation." (*Id.*) Based on the history of the incident and the absence of significant symptoms before the injury, Dr. Long continued to conclude that the injury was the major contributing cause of the "disc injuries at L4-5 and L5-S1." (*Id.*)

Absent persuasive reasons to the contrary, we generally defer to the treating physician's opinion. *See Weiland v. SAIF*, 64 Or App 810, 814 (1983). Here, we find no persuasive reasons not to defer to Dr. Long's opinion that the October 1995 injury was the major contributing cause of claimant's need for treatment and disability of the disc herniations at L4-5 and L5-S1. He based his opinion on an accurate history that, although intermittent, claimant's low back symptoms became progressively worse following the October 1995 incident. He also accurately understood the accident itself and explained how the mechanism of injury resulted in disc herniations. Furthermore, in comparison to Dr. Woodward's examination of only the medical record, Dr. Long regularly examined claimant.

For these reasons, we find Dr. Long's opinion persuasive. Based on that opinion, claimant showed that the injury was the major contributing cause of her need for treatment and disability of her disc herniations at L4-5 and L5-S1. Consequently, she proved compensability of those conditions. *See* ORS 656.005(7)(a)(B).

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $4,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated April 13, 1998 is reversed in part. The insurer's *de facto* denial of claimant's disc herniations at L4-5 and L5-S1 is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $4,500, to be paid by the insurer. The remainder of the order is affirmed.

In the Matter of the Compensation of
DEAN L. WATKINS, Claimant
WCB Case No. 97-05601
ORDER ON RECONSIDERATION
Bradley P. Avakian, Claimant Attorney
Scheminske, et al, Defense Attorneys

On July 6, 1998, we withdrew our June 5, 1998 order that had affirmed an Administrative Law Judge's (ALJ's) order that: (1) set aside the insurer's denial of claimant's right knee suprapatellar plica and chondromalacia conditions; and (2) awarded an assessed attorney fee of $3,500. We took this action to retain jurisdiction to consider the parties' proposed settlement. The parties have now submitted a proposed "Disputed Claim Settlement," which is designed to resolve all issues raised or raisable between the parties, in lieu of all prior orders.

Pursuant to the settlement, the parties agree that the insurer's denial, as supplemented in the agreement, "shall forever remain in full force and effect." The agreement further provides that "claimant hereby withdraws all Requests for Hearing," which "shall be dismissed with prejudice."

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

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN M. MIOSSEC, Claimant
WCB Case No. 97-06583
ORDER ON REVIEW
Bradley P. Avakian, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Herman's order that set aside its denial of claimant's aggravation claim for a low back condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, but offer the following summary of the relevant facts. On January 19, 1995, claimant, a route salesman, sustained a compensable low back injury. An April 5, 1995 MRI revealed protruding discs at L4-5 and L5-S1. The employer accepted the claim as a "protruding disc at L5, S1 right with sciatica." The claim was closed by Notice of Closure dated September 21, 1995. It awarded no permanent disability.

Claimant sought treatment from a chiropractor, Dr. Platt, in April 1997 for low back, right thigh, and right calf pain. Dr. Platt opined that claimant had suffered an aggravation of his lumbar discs at L4-5 and L5-S1. (Exs. 18-2, 19).

Claimant changed attending physicians to Dr. George on May 2, 1997. (Ex. 22). Dr. George diagnosed a post acute lumbosacral strain with right radiculopathy and recommended continued chiropractic treatment and consideration of a neurosurgical referral. (Ex. 23-4, 5).

On May 30, 1997, an MRI was interpreted as showing no change from the April 1995 study. (Ex. 26). A neurologist, Dr. Woods, performed an EMG study that same day which he interpreted as consistent with an underlying peripheral neuropathy with a superimposed right S1 radiculopathy. (Ex. 27-3).

A neurosurgeon, Dr. Parsons, performed a consulting examination on July 2, 1997. Recommending a lumbar myelogram, Dr. Parsons diagnosed a possible protruded lumbosacral disc with S1 radiculopathy. (Ex. 31-3).

After a July 22, 1997 report by a panel of examining physicians, consisting of Drs. Zivin and Marble, the employer denied the aggravation claim on July 31, 1997. (Ex. 38). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the employer's aggravation denial, finding that claimant's current low back condition was compensably related to his accepted January 1995 low back injury claim and that claimant had experienced an "actual worsening" of his compensable low back condition. *See* ORS 656.656.273(1). In concluding that claimant had proved a compensable aggravation claim, the ALJ acknowledged that medical experts had been unable to make a definitive diagnosis with respect to the precise nerve root and level of the lumbar spine involved in claimant's current condition. However, the ALJ concluded that, regardless of the diagnosis, the evidence established that the condition from which claimant currently suffered was the same condition that he had in 1995 and that was accepted by the employer. We disagree and reverse.

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. If the allegedly worsened condition is not a compensable condition, compensability must first be established under ORS 656.005(7)(a). *Gloria T. Olson*, 47 Van Natta 2348, 2350 (1995); *see also Douglas G. Abbott*, 50 Van Natta 1156, 1157 (1998).

As a result of the January 1995 injury, the employer accepted a disabling claim for a protruding disc at L5-S1 with sciatica. As the ALJ noted, the medical evidence is unclear whether claimant's current low back problems stem from L5-S1 or L4-5. Claimant's nerve root at L4-5, however, is not an accepted condition. Therefore, in order to establish a worsened condition resulting from the original injury, we find that claimant must first establish that his current low back condition is a compensable condition. *Gloria T. Olson*, 47 Van Natta at 2350.

As a fact finder, it is our obligation to apply the appropriate legal standards to determine the compensability of a worker's claim. *Daniel S. Field*, 47 Van Natta 1457 (1995) (citing *Hewlett-Packard v. Renalds*, 132 Or App 288 (1995)). The medical evidence shows that claimant had degenerative disc disease and a congenitally shallow spinal canal in his lumbar spine before the January 1995 injury. (Ex. 49). Although no physician directly opined that claimant's 1995 injury "combined" with the preexisting conditions, Dr. Woods opined that claimant suffered from "chronically acquired conditions with superimposed acute injuries" (Ex. 52); Dr. Zivin opined that claimant's significant preexisting developmental and degenerative changes rendered him, on an expected basis, to develop radiculopathy (Ex. 55); and Dr. Howieson opined that, in the context of claimant's preexisting conditions, the 1995 injury may have been the precipitating event for the symptoms at that time, but that the 1995 injury was not the cause of the recurrent symptoms in 1997 (Ex. 58). *See* ORS 656.005(7)(a)(B). Thus, we conclude that the major causation standard applies. Further, we conclude that claimant has failed to prove a compensable condition under that standard. Therefore, we find that claimant has not established the compensability of his current condition. We base this conclusion on the following reasoning.

The ALJ relied on the opinions of Drs. Woods, George, Parsons and Platt in finding the aggravation claim compensable. Because of the multiple possible causes of claimant's disability or need for treatment, this issue presents a complex medical question that must be resolved on the basis of expert medical evidence. *Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279 (1993). In evaluating the medical evidence concerning causation, we rely on opinions that are well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986). We generally give greater weight to the opinion of a claimant's treating physician, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810, 814 (1983). For the following reasons, we find persuasive reasons not to give greater weight to the opinions of Drs. Platt and George, the treating physicians.

Dr. Platt opined that claimant had suffered an aggravation of his lumbar discs. (Ex. 18-2). Dr. Platt also concurred with Dr. Woods' July 22, 1997 report in which the latter physician concluded that claimant suffered a pathological worsening of his work-related injury. (Ex. 46). However, we give little weight to Dr. Platt's opinions inasmuch as they contain no reasoning. *See Moe v. Ceiling Systems*, 44 Or App 429 (1980) (rejecting conclusory medical opinion).

Dr. George, claimant's attending physician who authorized Dr. Platt's treatment, examined claimant on only two occasions: May 2, 1997 and July 9, 1997. Because greater familiarity with a claimant's condition is one of the primary considerations underlying the general policy of deferring to an attending physician, such considerations are obviously not present here when Dr. George has had limited contact with claimant. *See Weiland v. SAIF*, 64 Or App at 814.

Dr. George concurred with Dr. Woods' July 22, 1997 report and also opined that claimant' work injury in January 1995 was the major contributing cause of claimant's need for treatment. (Ex. 37). However, this conclusion was based largely on the temporal relationship between the 1995 injury and the onset of low back problems. *See Allie v. SAIF*, 79 Or App 284, 288 (1986) (finding medical opinion based on chronology of events unpersuasive); *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). Dr. George later reiterated his causation opinion in which he concluded that claimant's work injury was the major contributing cause of claimant's condition, as opposed to degenerative disc disease and congenital spinal abnormalities identified as the primary factors by various examining physicians. (Ex. 54). We do not find that opinion persuasive because it does not contain an adequate explanation of why claimant's current low back condition is related to his compensable injury.

As previously noted, a panel of examining physicians (Drs. Zivin and Marble) evaluated claimant's low back condition. In addition, a diagnostic radiologist and neurologist, Dr. Howieson, performed a records review. The examining physicians opined that the major contributing cause of claimant's need for treatment were preexisting conditions that included degenerative disc disease, congenital lumbar canal stenosis and foraminal compromise due to facet hypertrophy. (Ex. 36-5, 6). Dr.

Howieson concluded that the underlying degenerative disc disease and congenital narrowing of the spinal canal at L4-5 are the major factors in claimant's symptomatology. (Ex. 48-2). Neither of these opinions assist claimant in establishing the compensability of his current low back condition. Moreover, we find Dr. Zivin's February 16, 1998 analysis of the medical record and rebuttal of Dr. Woods' opinion to be thorough, well-reasoned and based on complete information. (Exs. 55, 56). Therefore, we find it persuasive. *Somers*, 77 Or App at 263.

The remaining opinions are from the consulting physicians, Drs. Parsons and Woods. Dr. Parsons' opinion is not persuasive because it consists of only an unexplained concurrence with Dr. Woods' report. (Ex. 44). This leaves Dr. Woods' opinion.

Dr. Woods examined claimant one time on May 30, 1997 on referral from Dr. Platt. He opined that claimant's low back condition had worsened primarily on the basis of an EMG abnormality. (Exs. 35, 52). However, Dr. Woods never explained how the EMG abnormality was related to the original compensable injury in January 1995. (Ex. 35). Accordingly, we do not find Dr. Woods' opinion persuasive.

Based on our *de novo* review of the medical evidence, we find that it does not persuasively establish a causal connection between claimant's injury and his current condition under the major causation standard. Thus, we reverse the ALJ's decision to set aside the employer's denial.

ORDER

The ALJ's order dated March 24, 1998 is reversed. The employer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

August 31, 1998 Cite as 50 Van Natta 1679 (1998)

In the Matter of the Compensation of
JOANNE DENZER, Claimant
WCB Case No. 97-01660
ORDER ON REVIEW
Willner & Associates, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Hall, Bock and Moller.

The self-insured employer requests review of Administrative Law Judge (ALJ) Otto's order that set aside its denial of claimant's aggravation claim for a current low back condition.[1] On review, the issue is aggravation.

We adopt and affirm the ALJ's order.

Claimant is entitled to an assessed attorney fee for services on review. *See* ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $900, 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 March 31, 1998 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $900, payable by the self-insured employer.

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[1] Claimant filed a cross-request for Board review but expressly withdrew it in her respondent's brief.

Board Member Moller dissenting.

In this case, the majority has adopted the ALJ's order finding that claimant has established a compensable aggravation claim based on Dr. Verzosa's opinion. I would find Dr. Verzosa's opinion unpersuasive on the basis that the doctor is equivocal regarding whether there has been a worsening of claimant's *condition*, as opposed to her *symptoms*. *See SAIF v. Walker*, 145 Or App 294,. 305 (1996) (in order for a symptomatic worsening to constitute an "actual worsening," a medical expert must conclude that the symptoms have increased to the point that it can be said that the *condition* has worsened).

In Exhibits 25-1, 37 and 38-10, Dr. Verzosa has indicated that claimant had sustained a "waxing or waning" or "flare-up" of *symptoms*. Dr. Verzosa also stated in her deposition, that there was a worsening of claimant's low back *condition*. Earlier in the deposition testimony, Dr. Verzosa had appeared to agree that there was no worsening of claimant's underlying condition. At best, Dr. Verzosa's opinion is unclear and confusing regarding whether the compensable condition has worsened.

Further, Dr. Verzosa did not examine claimant during the crucial period of time when claimant contends that her condition acutely worsened. In this regard, claimant reported by telephone an acute worsening of her *symptoms* of pain on November 1, 1996. However, Dr. Verzosa did not examine claimant until November 15, 1996, at which time claimant was "improved" with "minimal" objective findings. Claimant was seen during this two-week period by Dr. Graffeo, chiropractor. In his report of November 15, 1996, Dr. Verzosa deferred to Dr. Graffeo, stating that "Dr. Graffeo saw [claimant] when she was in an acute condition, so his findings would be most helpful to evaluate her present condition." (Ex. 24). However, there is no report in the record from Dr. Graffeo that supports claimant's claim.

Because I find Dr. Verzosa's opinion insufficient to establish that the condition has worsened, and in light of Dr. Quarum's opinion to the contrary, I disagree with the majority's conclusion that claimant has established a compensable aggravation claim.

In the Matter of the Compensation of
ROBERT W. FAGIN, Claimant
WCB Case No. 97-01796
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Hall, Bock and Moller.

The self-insured employer requests review of Administrative Law Judge (ALJ) Thye's order that: (1) set aside its denial of claimant's occupational disease claim for right median nerve neuropathy/carpal tunnel syndrome; (2) found that claimant was entitled to interim compensation from December 13, 1996 through February 3, 1997; (3) assessed a penalty for an allegedly unreasonable failure to pay interim compensation; and (4) awarded an assessed attorney fee of $4,750 for counsel's services regarding the compensability denial. On review, the issues are compensability, entitlement to interim compensation, penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt the ALJ's reasoning and conclusion regarding compensability.

Attorney Fee

We adopt the ALJ's reasoning and conclusion regarding this issue with the following supplementation.

At the hearing, claimant requested an attorney fee of $6,500 for prevailing over the compensability denial, but offered no supporting documentation regarding the time spent on the case. Addressing the factors contained in OAR 438-015-0010(4),[1] the ALJ awarded a fee of $4,750.

On review, the employer argues that at least part of the time that claimant's attorney expended in representing claimant was in reference to a different WCB Case Number which was ultimately dismissed. The employer further argues that much of the time that claimant's attorney spent on this case was devoted to the interim compensation issue for which a separate "out-of-compensation" fee was awarded.

In awarding the $4,750 attorney fee, the ALJ made findings regarding each factor listed in OAR 438-015-0010(4), including the time devoted to the case. Contrary to the employer's argument, there is no indication that the ALJ considered time spent on any issue other than the compensability issue. Under such circumstances, we agree, for the reasons given by the ALJ that $4,750 is a reasonable attorney fee for claimant's counsel's services in overcoming the denial of the right carpal tunnel syndrome.

Interim Compensation

The ALJ found that the employer had notice of the claim for a new occupational disease by December 13, 1996 when Dr. Irvine released claimant to modified work. The employer argues that it did not have notice of a claim for an occupational disease until it began paying interim compensation on February 4, 1997. The claim was denied on April 3, 1997.

A worker is entitled to interim compensation if he has suffered a loss of earnings as a result of a work-related injury or disease. *See RSG Forest Products v. Jensen*, 127 Or App 247, 250-51 (1994). ORS 656.262(4)(a) provides that "the first installment of temporary disability compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim, if the attending physician authorizes the payment of temporary disability compensation." To trigger the worker's entitlement to interim compensation, the attending physician's authorization must relate the claimant's inability to work to a job-related injury or occupational disease. *See Rustee R. St. Jean*, 49 Van Natta 2161 (1997).

After our review of the record, we are persuaded the employer had notice of a new occupational disease claim by December 13, 1996. Dr. Irvine's October 29, 1996 chart note states that "claimant's work activities have led to a carpal tunnel syndrome on the right." The employer's risk manager testified that she received the October 29, 1996 chart note by late November 1996. (Tr. 70-71). In addition, on December 3, 1996, Dr. Irvine indicated that claimant had a work-related carpal tunnel syndrome and needed further work-up with EMG and nerve conduction velocities. The nerve conduction studies were approved by the employer on December 3, 1996. (Tr. 69). On December 13, 1996, Dr. Irvine restricted claimant to modified work "as pertains to R carpal tunnel syndrome." (Ex. 26). This release was reviewed by the employer's risk manager on December 13, 1996. (Tr. 70).

ORS 656.005(6) provides that a "claim" is "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." We conclude that the October 29 and December 3, 1996 chart notes from Dr. Irvine constitute a claim for a new occupational disease for right carpal tunnel syndrome. *See Garnet D. Toll*, 50 Van Natta 1346 (1998) ("new medical condition" requirements of "specific written request for formal written acceptance" are not applicable to "initial" claims.) In this regard, the October 29, 1996 chart note relates that condition to claimant's work activities and the December 3, 1996 chart note requests medical services for the right carpal tunnel condition. In addition, Dr. Irvine's December 13, 1996 modified work release gave the employer notice that claimant had an inability to work as a result of a job-related injury or disease. Under such circumstances, we agree with the ALJ that the employer had notice of a new occupational disease claim by December 13, 1996 and that claimant was entitled to interim compensation commencing on that date and continuing until the date of the denial.

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[1] OAR 438-015-0010(4) provides that the following factors are considered in determining a reasonable attorney fee: (a) The time devoted to the case; (b) The complexity of the issue(s) involved; (c) The value of the interest involved; (d) The skill of the attorneys; (e) The nature of the proceedings; (f) The benefit secured for the represented party; (g) The risk in a particular case that an attorney's efforts may go uncompensated; and (h) The assertion of frivolous issues or defenses.

Claimant's attorney is entitled to an assessed fee for services on review with regard to the compensability and interim compensation issues. 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 $2,480, 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 his counsel's statement of services), the complexity of the issues, and the values of the interest involved.

Penalties

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

ORDER

The ALJ's order dated November 21, 1997 is affirmed. For services on Board review, claimant's attorney is awarded $2,480, payable by the employer.

Board Member Moller dissenting in part.

For the following reasons, I disagree with the portion of the majority's decision that sets aside the employer's denial of claimant's claim for right carpal tunnel syndrome.

The record contains two medical opinions regarding the cause of claimant's right carpal tunnel syndrome/median neuropathy. Drs. Fuller and Radecki opined that claimant had a number of preexisting conditions that were the major contributing cause of claimant's right median nerve slowing in the carpal tunnel. These conditions were age, increased body mass index and family history. Although Drs. Fuller and Radecki believed that claimant's work activities may have provoked symptoms, they opined that it was not the major contributing cause of median nerve injury. In their initial report, Radecki and Fuller opined that claimant's gout was not a major factor in his right carpal tunnel syndrome.

At his deposition, Dr. Radecki explained that carpal tunnel syndrome was a symptom complex only. The symptoms include numbness, pain, weakness and nighttime awakening with numbness and pain. Dr. Radecki indicated that patients could have median nerve slowing without having symptoms of carpal tunnel syndrome. Dr. Radecki opined that, based on medical studies, median nerve slowing was not related to work activities.

During his deposition, Dr. Radecki reviewed chart notes that he had not previously seen regarding claimant's gout symptoms in September and October 1996. Dr. Radecki also reviewed chart notes indicating that steroids claimant received as treatment for gout improved his carpal tunnel syndrome. Dr. Radecki indicated that gout causes inflammation which causes pressure in the carpal tunnel, and that based on the improvement of claimant's carpal tunnel syndrome with the use of steroids, the gout could have contributed to claimant's carpal tunnel syndrome symptoms and the median nerve slowing in the carpal tunnel.

Dr. Fuller also reviewed the chart notes regarding claimant's gout and opined that gout was a factor in claimant's carpal tunnel syndrome.

Dr. Irvine treated claimant for his right carpal tunnel syndrome/median neuropathy. Dr. Irvine disagreed with the conclusion of Drs. Fuller and Radecki that claimant's carpal tunnel syndrome was not related to his work activities. Dr. Irvine acknowledged that claimant had preexisting factors which related to carpal tunnel syndrome, but he opined that the major contributing cause of claimant's right median nerve neuropathy was increased use of the right upper extremity after his left biceps tendon rupture and repair which created *symptoms* of right median neuropathy at the wrist.

Although claimant had a history of gout, Dr. Irvine opined that, in the absence of a gouty tophus or other mass lesions in the carpal canal, the gout was unrelated to the carpal tunnel syndrome. Dr. Irvine stated that claimant's age, obesity body mass index and familial history all have an effect on the development of carpal tunnel syndrome, but the major contributing cause of the onset of claimant's symptoms was his repetitive hand use at work.

Relying on Dr. Radecki's explanation that patients could have median nerve slowing without symptoms, the ALJ found that carpal tunnel syndrome was the occupational disease since it was the symptom complex that required medical treatment. On this basis, the ALJ upheld the denial of the median nerve slowing, but set aside the denial of the carpal tunnel syndrome.

Generally, a worsening of symptoms alone is not sufficient to prove an occupational disease. *See Weller v. Union Carbide*, 288 Or 27 (1980). However, if the medical evidence establishes that the symptoms are the disease, a worsening of symptoms that is caused, in major part, by work conditions may be compensable. *See Teledyne Wah Chang v. Vorderstrasse*, 104 Or App 498, 501 (1990); *Georgia Pacific Corp. v. Warren*, 103 Or App 275, 278 (1990), *rev den* 311 Or 60 (1991).

On this record, there is insufficient medical evidence from which to conclude that the symptoms of carpal tunnel syndrome are the disease. It is evident from Dr. Radecki's medical report and deposition that he and Dr. Fuller believed that claimant's carpal tunnel symptoms were caused by the underlying median nerve slowing. According to Drs. Radecki and Fuller, the median nerve slowing is caused, in turn, by personal factors such as age, heredity and body mass. Radecki and Fuller opined that the underlying median nerve slowing is not caused by work activities, although work may provoke symptoms. Thus, Drs. Fuller and Radecki do not believe that the carpal tunnel symptoms are the disease. Rather, these physicians believe that the underlying median nerve slowing is the disease and that this condition causes the carpal tunnel symptoms.

Similarly, Dr. Irvine does not opine that the carpal tunnel symptoms are the disease. His opinions are stated in terms of the work activities causing the onset of *symptoms*. Under such circumstances, I find insufficient medical evidence from which to conclude that claimant's right carpal tunnel syndrome/right median neuropathy condition is compensable as an occupational disease. Because there is no medical evidence that claimant's work activities are the major contributing cause of the right carpal tunnel syndrome/median neuropathy as opposed to the cause of right carpal tunnel symptoms, I would find that claimant has not established a compensable occupational disease. Alternatively, even assuming that Dr. Irvine's opinion could meet claimant's burden of proof, the opinion is lacking in explanation and medical analysis as compared to the better reasoned and better explained analysis of Drs. Fuller and Radecki. *See Moe v. Ceiling Systems*, 44 Or App 429 (1980) (poorly explained medical opinion found unpersuasive). Thus, Dr. Irvine's opinion is entitled to less weight than that of Drs. Fuller and Radecki. For these reasons, I disagree with the majority's conclusion that the claim is compensable and I would uphold the employer's denial.

September 1, 1998 Cite as 50 Van Natta 1683 (1998)

In the Matter of the Compensation of
DALLAS D. ADKINS, Claimant
WCB Case No. 97-07982
ORDER ON REVIEW
Glenn M. Feest, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that reduced claimant's scheduled permanent disability for loss of use or function of the left foot from 5 percent (6.75 degrees) to zero. On review, the issue is scheduled permanent disability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant, a roofer, was compensably injured when he fell 20 to 25 feet off a roof. The claim was closed by a Notice of Closure which awarded ten percent scheduled permanent disability award for the left arm and a 15 percent unscheduled permanent disability award.

Claimant requested reconsideration of the Notice of Closure and underwent a medical arbiter exam by Dr. Peterson, a neurologist. Among Dr. Peterson's findings was "hyperesthesia over the left plantar surface as compared to the right." Dr. Peterson also found that the hyperesthesia over the plantar surface of the left foot constituted a loss of sensation due to nerve-root injury.

Based on Dr. Peterson's finding, the September 5, 1997 Order on Reconsideration included an award of five percent scheduled permanent disability for sensory loss in the left foot pursuant to OAR 436-035-0200(1).

SAIF appealed that portion of the Order on Reconsideration which awarded 5 percent scheduled permanent disability for claimant's left foot based on Dr. Peterson's findings of "hyperesthesia." The ALJ took notice of the definition of hyperesthesia contained in Dorland's Illustrated Medical Dictionary, Twenty-fifth Edition. The medical dictionary defined hyperesthesia as an "abnormally increased sensitivity of the skin or of an organ of special sense." The ALJ noted that the Order on Reconsideration had awarded five percent scheduled permanent disability pursuant to OAR 436-035-0200 for a loss of plantar sensation in the foot. Finding, based on the dictionary definition, that Dr. Peterson found an increased sensitivity in the foot, rather than loss of sensation, the ALJ modified the Order on Reconsideration to eliminate the 5 percent award for loss of sensation of the left foot.

Claimant argues that the medical dictionary definition relied on by the ALJ constitutes post-reconsideration, extra-record evidence that is inadmissible under ORS 656.268(7)(g).

The medical arbiter was asked to describe sensation loss in the plantar surface of the foot/feet described as either partial or total due to nerve root injury. The arbiter responded: "Hyperesthesia was identified over the plantar surface of the left foot. This constitutes partial nerve root injury." (Ex. 16-9).

Even considering the dictionary definition utilized by the ALJ, we find that a "heightened" sensitivity does not necessarily lead to the conclusion that there is no sensation loss. In the absence of medical evidence establishing that hyperesthesia does not constitute a sensory loss, we find that the present record (even considering the dictionary definition) preponderates in favor of a finding that claimant suffered sensory loss due to the compensable injury.[1]

Based on the above reasoning, we find that claimant is entitled to an award of scheduled permanent disability for loss of plantar sensation. Accordingly, we reinstate the Order on Reconsideration's award of 5 percent scheduled permanent disability pursuant to OAR 436-035-0200(1).

Because our order results in increased compensation, claimant's counsel is entitled to an out-of-compensation attorney fee equal to 25 percent of the increased compensation (5 percent scheduled permanent disability) awarded by this order, not to exceed $3,800. ORS 656.386(2); OAR 438-015-0055.

Claimant's attorney is also entitled to an assessed fee for services at hearing regarding SAIF's challenge to the Order on Reconsideration's 5 percent scheduled permanent disability award for the left foot. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing regarding the scheduled permanent disability issue is $1,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record and claimant's attorney's statement of services), the complexity of the issue, and the value of the interest involved. In determining a reasonable fee, we have not considered time devoted to legal research regarding the unsuccessful motion to reopen the record for a supplemental arbiter report.

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[1] We note that it is questionable whether we may take administrative notice of "post-reconsideration" material that impacts our rating of the extent of permanent disability. *See Janet R. Christensen*, 50 Van Natta 1152 (1998) (Board took official notice of an order finding certain conditions compensable subsequent to the Order on Reconsideration where the order had no impact on the rating of extent of permanent disability of the accepted conditions at claim closure). However, we need not decide that issue because even if we consider the dictionary definition used by the ALJ, we would still find that the record establishes impairment for loss of normal plantar sensation.

ORDER

The ALJ's order dated March 5, 1998 is reversed. The Order on Reconsideration is affirmed. Claimant's attorney is awarded an attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney. For services at hearing, claimant's attorney is awarded $1,500, payable by SAIF.

In the Matter of the Compensation of
FELIZ CONTRERAS, Claimant
WCB Case No. 97-05514
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that upheld the insurer's denial of claimant's injury claim for right ear and neck conditions. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings."

CONCLUSIONS OF LAW AND OPINION

On May 24, 1997, a coworker pulled claimant's hair. On June 3, 1997, claimant sought treatment for right ear and neck pain. She was diagnosed with a cervical strain and right ear pain/strain. (Exs. 30, 32).

On June 12, 1997, claimant saw Dr. Magilke, ear, nose and throat specialist. He noted that claimant had undergone right ear surgery in February 1995 and that she had "done well" since that date until the altercation at work. (Ex. 34). With regard to this incident, Dr. Magilke noted that claimant "got in a fight with another employee at her work" and "she had some head trauma, and someone pulled on her ear, and has had severe ear pain." (*Id.*) Dr. Magilke diagnosed "left-sided fluid collection" and tympanic membrane perforation. (*Id.*)

On June 30, 1997, Dr. Magilke treated claimant for a postauricular abscess by draining it. (Ex. 35). Following resolution of the abscess, Dr. Magilke recommended surgery to repair the tympanic membrane perforation. (Ex. 36).

The ALJ first found that, with regard to the cervical strain, there was an absence of objective findings and no evidence to show that claimant had been treated for the condition. The ALJ further found that there was no medical opinion supporting a causal relationship between the abscess and the May 1997 incident. Finally, after noting that he was persuaded by testimony that claimant experienced right ear symptoms before the altercation, the ALJ decided that there was insufficient medical opinion to support compensability of the tympanic membrane perforation.

Claimant first challenges the ALJ's conclusions that there were no objective findings to support a cervical strain condition or that claimant was not treated for such a condition. Claimant further contends that there is a temporal relationship between the abscess and the altercation.

When the causation issue is a complex medical question, expert medical opinion is required to prove compensability. *Uris v. Compensation Department*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279, 283 (1993). In particular, the following factors for determining whether expert testimony of causation is required include: (1) whether the situation is complicated; (2) whether symptoms appear immediately; (3) whether the worker promptly reports the occurrence to a superior; (4) whether the worker was previously free from disability of the kind involved; and (5) whether there was any expert testimony that the alleged precipitating event could not have been the cause of the injury.

Here, we find that causation is a complex medical question. According to claimant's testimony, her symptoms did not appear immediately after the altercation but arose the following day; consistent with such testimony, claimant did not seek treatment for more than a week following the incident.

Furthermore, although claimant promptly reported the incident to her supervisor, according to her supervisor's testimony, claimant was present and did not object to the coworker's report that she only reached out with her right hand and pulled on claimant's hair. (Tr. 111). This is in contradiction to claimant's reports to medical examiners and her testimony at hearing that the coworker used both hands to grab her hair and then forcefully shook her head three times. There also was contradictory testimony concerning whether claimant complained of right ear pain and demonstrated loss of hearing before the May 1997 incident; several coworkers, including claimant's supervisor, testified that claimant complained of her pain and at times wore cotton in her ear while other coworkers denied that claimant complained of any symptoms until after the altercation.

In light of the contradictory evidence concerning key points of the claim, we find the situation to be complex. Although there is no evidence that claimant had a history of neck pain or ear abscess before the incident and there is no medical evidence that the incident could not have caused the conditions, we conclude that the complexity of the situation, as explained above, and the absence of immediate symptom onset requires expert medical opinion supporting a causal relationship. Because the record contains no such evidence concerning a neck condition and the right ear abscess, we agree with the ALJ that claimant failed to prove compensability of these conditions.

With regard to the tympanic membrane perforation, we adopt the relevant portion of the ALJ's order addressing this issue. We note a further reason for not finding Dr. Magilke's opinion unpersuasive. Dr. Magilke had an inaccurate understanding of the altercation because his record shows that claimant sustained "head trauma" and that the coworker pulled claimant's ear. Although, as explained above, there was contradictory evidence concerning the details of the altercation, there was no evidence showing that claimant's ear was pulled. Furthermore, like the ALJ, we are persuaded by the testimony at hearing that claimant experienced symptoms in her right ear before the incident. Thus, in the absence of persuasive medical opinion, we agree with the ALJ that claimant did not carry her burden of proving the compensability of her tympanic membrane perforation.

ORDER

The ALJ's order dated April 21, 1998 is affirmed.

In the Matter of the Compensation of
RAYMOND A. GRAVES, Claimant
WCB Case No. 97-06634
ORDER OF ABATEMENT
Starr & Vinson, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

On August 3, 1998, we issued an Order on Review that, among other decisions, directed the SAIF Corporation to amend its Notice of Acceptance to include acceptance of claimant's urinary dysfunction condition. Contending that claimant has not established the compensability of the alleged urinary dysfunction, SAIF seeks reconsideration of our decision.

In order to allow sufficient time to consider SAIF's motion, our August 3, 1998 order is withdrawn. Claimant is granted 14 days from the date of this order to submit a response. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
JEFFREY N. DAVILA, Claimant
WCB Case No. 97-02700
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Hall and Bock.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Marshall's order that: (1) held that claimant's injury claims for lumbar spondylosis, central disc herniation at L5-S1, left disc herniation at L4-5, and a bulging disc at L3-4 were barred by a prior Stipulation and Disputed Claim Settlement (DCS); and (2) upheld the SAIF Corporation's denial of those conditions. On review, the issues are the preclusive effect of a stipulation/DCS order and compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant worked as a truck driver for a farming operation. In August 1996, claimant stepped off a corn picker ladder into a hole, injuring his low back. He was diagnosed with "low back and radicular left leg pain, suspect back sprain versus HNP." Claimant filed a claim for a low back strain. On October 9, 1996, SAIF denied a lumbar strain on the basis that there was insufficient evidence that it was the result of either a work-related injury or disease. (Ex. 9).

On October 10, 1996, the parties executed a DCS, which was approved by an ALJ on October 15, 1996. The agreement provides, in relevant part:

> "[A] bona fide dispute exists between [the parties] as to the compensability of the condition(s) and/or services which have been denied. All parties have substantial evidence to support their contentions and each desires to settle all issues raised or raisable at this time by entering into a disputed claim settlement under the provisions of ORS 656.289(4) for the total sum of $7,000.00."

The DCS also provides that SAIF's denial "as supplemented by the contentions of the employer/SAIF Corporation stated in this agreement, shall remain in full force and effect;" and that "[c]laimant shall have no further entitlement to compensation or any other legal right related to the denied treatment or condition(s) or to the denied injury or occupational disease." The DCS further provides that "the parties agree that the Request for Hearing shall be dismissed with prejudice and that payment shall be accepted in full settlement of all issues raised or raisable." (Ex. 12-3).

On October 11, 1996, MRI and x-rays revealed degenerative changes, disc herniations, and a disc bulge in the low back. (Exs. 10, 11, 11A, 11B). Claimant was informed of the results of the studies about one week later, after the ALJ had approved the DCS. (Tr. 23, 24, 28).

In February 1997, claimant sought treatment from Dr. Golden, neurosurgeon, for persistent low back and left leg pain. Dr. Golden noted that the MRI showed that claimant had a significant amount of degenerative disease in his low back, but attributed claimant's current symptomatology to the August 1996 work injury. On March 3, 1997, claimant filed a claim for lumbar spondylosis, herniated discs at L5-S1 and L4-5, and a bulging disc at L3-4, as related to the August 1996 injury.

In March 1997, as amended in May 1997, SAIF denied the claim on the basis that the new conditions flowed from the initial claim that had been settled by the DCS and that the newly claimed conditions were raised or raisable at the time the DCS was entered. SAIF also denied claimant's low back strain. Claimant requested a hearing, which is the subject of this review.

The ALJ concluded that, although the "raised or raisable" language of the parties' agreement may not preclude claimant from asserting a claim for the new conditions, the denial, which was upheld by the parties' agreement, and the stipulation state that claimant did not sustain a work-related injury

on August 21, 1996. Thus, because the compensability of claimant's spondylosis and herniated discs were contingent on claimant having sustained a compensable injury, the ALJ reasoned that claimant's current low back conditions are not compensable.

On review, claimant contends that *Trevisan v. SAIF*, 146 Or App 358 (1997), controls. In *Trevisan*, the court held that a DCS does not preclude a claim for a condition not denied at the time of settlement. In other words, claimant is contending that the only claim resolved by the DCS was his low back strain claim, whereas SAIF's position is that the DCS unambiguously encompasses claimant's low back injury claim, no matter what the diagnosis. We agree with claimant for the following reasons.

In *Trevisan*, the court analyzed whether a DCS precluded the claimant from asserting a headache claim, which was denied after the claimant and the carrier entered into a DCS that upheld a denial for bilateral temporomandibular joint (TMJ) problems. After examining the statutory and administrative requirements for a DCS, the court held that, as a matter of law, "the DCS did not settle [the] claimant's headache claim, because the headache claim was not denied at the time that the parties entered into the DCS." 146 Or App at 361-62.

The court further disagreed with the carrier's argument that the "raised or raisable" language in the DCS precluded the headache claim because that condition had been diagnosed and treated before the parties entered into the DCS. Explaining that, by statute, a DCS could be "used only to settle denied claims," the court explained that the "raised or raisable" language referred only to conditions associated with TMJ. *Id.* at 362-63.

Based on *Trevisan*, we conclude that, as a matter of law, the scope of the DCS in this case concerned only the denied low back strain claim. The compensability of claimant's spondylosis, herniated discs and disc bulge was not denied at the time of the DCS; SAIF did not issue the denial of those conditions until after the parties entered into the DCS. Consequently, we conclude that the DCS has no preclusive effect on the spondylosis, herniations and bulge, whether or not they had been diagnosed at the time of the DCS. *Trevisan*, 146 Or App at 362.

We next turn to whether, by entering into the DCS, the parties intended to resolve claimant's initial injury claim for a low back condition, no matter what the diagnosis. To resolve this issue, we must ascertain the parties' intent by applying standard rules of contract construction. *See Taylor v. Cabax Saw Mill*, 142 Or App 121, 124 (1996); *Trevitts v. Hoffman-Marmolejo*, 138 Or App 455, 459 (1996). Generally, that application consists of two steps, beginning with a determination whether, as a matter of law, the terms of the agreement are ambiguous and, if so, proceeding to a determination of the "objectively reasonable construction of the terms" in the light of the parties' intentions and other extrinsic evidence. *Taylor*, 142 Or App at 125; *Williams v. Wise*, 139 Or App 276, 281 (1996). A contract is not ambiguous if it has only one sensible and reasonable interpretation. *P & C Construction Co. v. American Diversified*, 101 Or App 51, 56 (1990); *D & D Co. v. Kaufman*, 139 Or App 459 (1996).

The parties' agreement states in part:

"IT IS HEREBY STIPULATED by [the parties] as follows:

"Claimant filed a claim for an injury to his low back sustained on or about August 21, 1996. SAIF Corporation denied lumbar strain on October 9, 1996. Claimant filed a Request for Hearing to appeal the denial and raise other issues.

"[SAIF] contend[s] that there is insufficient evidence that claimant's industrial exposure and work activities on or about August 21, 1996 at the employer are the major or material contributing cause of his lumbar strain and his need for related medical treatment. [SAIF] contend[s] that claimant's lumbar strain and need for medical treatment was caused by claimant's off-the-job nonwork related activities.

"The parties agree that a bona fide dispute exists between them as to the compensability of the condition(s) and/or services which have been denied. All parties have substantial evidence to support their contentions and each desires to settle all issues raised or raisable at this time by entering into a disputed claim settlement under the provisions of ORS 656.289(4) for the total sum of $7,000.

> "Claimant understands that if the administrative law judge approves this agreement, SAIF['s] denial, as supplemented by the contentions of [SAIF] stated in this agreement, shall remain in full force and effect. Claimant shall have no further entitlement to compensation or any other legal right related to the denied treatment or condition(s) or to the denied injury or occupational disease.
>
> "In consideration of the promise to pay the agreed sum, the claimant withdraws the Request for Hearing, and the parties agree that the Request for Hearing shall be dismissed with prejudice and that payment shall be accepted in full settlement of all issues raised or raisable." (Ex. 12).

The first two quoted paragraphs state that claimant filed a claim for a low back injury and SAIF denied a lumbar strain.[1] The third and fourth paragraphs specifically refer to "lumbar strain and need for related medical treatment." The fifth paragraph states that there was a bona fide dispute as to the compensability of the conditions and/or services which have been denied, *i.e.*, the lumbar strain and need for related medical treatment. The last quoted paragraph states that it was the parties' intention to resolve all issues relating to claimant's hearing request. We conclude that the issues relating to claimant's hearing request, as set forth above, are limited to a denial of the low back strain, as claimant filed the hearing request to contest the employer's denial of his low back strain.

In the last paragraph, the parties agreed that, in consideration for SAIF's payment of monies to claimant, claimant's hearing request "shall be dismissed with prejudice and [] payment shall be accepted in full settlement of all issues raised or raisable." According to SAIF, the last paragraph states the parties' intention to settle all issues that were raised or could have been raised prior to the date of the agreement, including claimant's subsequent claim for spondylosis, herniated discs and disc bulges, not just the issues relating to claimant's hearing request. We disagree for the following reason.

The agreement does not specify what "raised or raisable" issues are deemed settled under the agreement. While SAIF asserts that the parties intended to settle all issues that could have been raised prior to the date of the agreement, including issues not related to claimant's hearing request, the agreement itself does not state that intention.[2]

The "raised or raisable issues" language, when read harmoniously with the provisions addressing claimant's hearing request, could reasonably be interpreted as stating an intention to settle all "raised or raisable" issues relating to claimant's hearing request, i.e., issues arising from the denial of claimant's low back strain that predated claimant's March 3, 1997 claim for spondylosis, herniated discs and disc bulges. Because the agreement does not clarify whether the parties intended to settle only "raised or raisable" issues relating to the hearing request or whether they intended to settle all "raised or raisable" issues that arose prior to the date of the agreement, we find that the language of the agreement is ambiguous.

Therefore, we look to extrinsic evidence of the parties' intentions to determine the "objectively reasonable construction" of the terms of the agreement. *See Taylor*, 142 Or App at 125; *Williams*, 139 Or App at 281. There is extrinsic evidence that claimant entered into an agreement to settle SAIF's denial of a lumbar strain. Moreover, although the MRI and x-ray studies were performed between the date of the parties' agreement and the date the agreement was signed by the ALJ, there is no evidence that either claimant or SAIF had been informed of the results of the studies prior to claimant's hearing request. Therefore, the issue of the compensability of spondylosis, herniated discs and disc bulges was not raisable at time of the hearing request. Moreover, the evidence indicates that the parties had no knowledge of these conditions until after the ALJ approved the agreement on October 10, 1996. Thus, because the parties reached their settlement agreement prior to their knowledge of the spondylosis, herniated discs and disc bulge, we conclude that the existence of the claim for those conditions was unknown to either claimant or SAIF at the time they entered their agreement.

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[1] We note that SAIF's contentions state that work on or about August 21, 1996 was not the *cause* of claimant's lumbar strain. SAIF did not deny that there was no injury, only that such was not the cause of claimant's diagnosed condition.

[2] We note that the concise statement that defines the "bona fide" dispute as the "compensability of the conditions and/or services which have been denied" (which satisfies the requirement of ORS 656.289(4)(a) in order to DCS a claim) is evidence that the parties themselves defined the dispute and what it was that the "raised or raisable" language applied. Thus, alternatively, the agreement may be reasonably construed that the "raised or raisable" language was limited to that dispute.

Because the disc claim was not in existence at the time of the parties' October 10, 1996 agreement to settle, and neither party knew of the diagnosed disc condition prior to the ALJ's approval of the agreement, we conclude that the disc condition claim was not among the "raised or raisable issues" that were contemplated by the parties' settlement agreement. Accordingly, we conclude that the February 1997 disc claim was not barred by the terms of the agreement.

SAIF, however, argues that because *claimant* was aware of the disc claim prior to approval of the written agreement and therefore knew of a "potential dispute" concerning the claim, it was a "raisable" issue that was settled under the terms of the written agreement. SAIF's proposed analysis was expressly rejected by the court in *Pollock v. Tri-Met, Inc.*, 144 Or App 431 (1996), *on remand* 49 Van Natta 1419, 1421 (1997). In *Pollock*, the court instructed us to "construe the parties' settlement in such a way as to carry into effect *their* express purpose and intent at the time of the agreement." *Pollack*, 144 Or App at 435-436. (Emphasis supplied). By focusing our attention to "their" (i.e., the parties') intent, the court was presumably reiterating the general principle of contract law that an agreement, such as the stipulation in question, is a "negotiated, signed, meeting of the minds, based on a weighing of choices and the exercise of judgment as to the most beneficial outcome for each party." *Fimbres v. Gibbons Supply Co.*, 122 Or App 467, 471 (1993).

Here, because the disc claim was not in existence at the time the parties agreed to settle, and SAIF did not receive notice of the disc claim prior to approval of the written settlement, we conclude there could not have been a "meeting of the minds" to resolve that issue pursuant to the agreement. Having determined that claimant's disc claim was not precluded by the parties' stipulation, we turn to the merits of the claim.

Dr. Golden, who began treating claimant in February 1997 for persistent low back pain with radiation into the left leg, noted that the October 1996 MRI demonstrated the characteristics of lumbar spondylosis with a central disc herniation at L5-S1, with impingement on the left S1 nerve root, an L4-5 disc herniation on the left in the lateral recess and into the neuroforamen, and a bulging disc on the right. He also noted that claimant has a significant amount of degenerative disease in his back with the diskogenic lesions, and that it was likely that both levels were making some contribution toward his pain syndrome. Dr. Golden opined that claimant's spondylosis preexisted and combined with his injury, and that claimant's injury was the major contributing cause of his current combined condition, namely the central disc herniation at L5-S1, left disc herniation at L4-5 and a bulging disc at L3-4. Based on Dr. Golden's unrebutted opinion, we conclude that claimant's disc herniations at L5-S1 and L4-5 and disc bulge at L3-4 are compensable.

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

ORDER

The ALJ's order dated September 11, 1997 is reversed in part and affirmed in part. That portion of the order that upheld the SAIF Corporation's denial to the extent that it that denied herniated discs at L5-S1 and L4-5 and a disc bulge at L3-4 is reversed. The denial of those conditions is set aside and the claim for those conditions is remanded to SAIF for processing according to law. The remainder of the order is affirmed. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $4,000, to be paid by SAIF.

In the Matter of the Compensation of
MINH Q. HAN, Claimant
WCB Case No. 97-00584
ORDER ON RECONSIDERATION
Alice M. Bartelt (Saif), Defense Attorney

Claimant, *pro se*, requests reconsideration of our August 6, 1998 Order on Review, which affirmed the Administrative Law Judge's (ALJ's) order that upheld the SAIF Corporation's "de facto" denial of claimant's injury claim for a post-traumatic inner ear concussion syndrome condition.[1] With her reconsideration request, claimant submits copies of medical records pertaining to "post-hearing" medical treatment provided by Dr. Epley. We treat this submission as a motion for remand to the ALJ for further development of the hearings record. *Judy A. Britton*, 37 Van Natta 1262 (1985).

At the outset, we note that our review is limited to the record developed at hearing. ORS 656.295(5). However, we may remand to the ALJ should we find that the hearings record has been "improperly, incompletely or otherwise insufficiently developed." *Id.* Remand is appropriate upon a showing of good cause or other compelling basis. *Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988); *Bernard L. Osborn*, 37 Van Natta 1054, 1055 (1985), *aff'd mem*, 80 Or App 152 (1986).

Here, the medical records claimant has submitted pertain to treatment provided after the February 26, 1998 hearing. Thus, they may not have been obtainable with due diligence at the time of the hearing. However, the medical records do not address the causation issue. Therefore, we find that they are unlikely to affect the outcome of the case. Thus, we find no compelling basis for a remand.

Accordingly, we withdraw our August 6, 1998 order. On reconsideration, as supplemented herein, we adhere to and republish our order.[2] The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] Although we have treated claimant's submission as a request for reconsideration, we note that her letter states that she wished to "appeals the order on August 6, 1998." We emphasize to claimant the importance of the notice of appeal rights attached to this order. If claimant desires court review of our decision, she must make sure she complies with the instructions contained within that notice.

[2] In other words, we continue to find that claimant is not entitled to compensation for her alleged post-traumatic inner ear concussion syndrome. If claimant disagrees with that decision, she may seek review with the Court of Appeals in the manner described in the notice of appeal rights attached to this order.

In the Matter of the Compensation of
JERI L. ALLEN, Claimant
WCB Case No. 97-08579
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) set aside its denial of claimant's occupational disease claim for her left ganglion cyst; and (2) awarded claimant's counsel an assessed attorney fee of $3,600. On review, the issues are compensability and attorney fees. We affirm.

FINDINGS OF FACT

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

Claimant first began working for the employer in August 1993. In the fall of 1996, claimant was working for the employer in the option department. In that area, claimant worked tailing off the primer, which required her to turn boards as they came down a belt to see if the boards were fully primed on each side. Once the boards were fully primed, claimant pulled the boards off with her left hand and used her right hand to steady them as they were stacked.

A few days after starting the primer job, claimant's left wrist became sore. After several days, while claimant's wrist was still bothering her, she noticed a bump on her left wrist. Claimant advised her supervisor of the bump, but did not seek medical treatment.

Claimant quit working for the employer in late 1996, and returned to school to finish her degree. Claimant's left wrist symptoms went away, but the bump on her wrist remained.

On May 1, 1997, claimant returned to work for the employer. Claimant returned to the same type of work she had previously performed. On July 15, 1997, claimant's left hand hurt after she had worked for several hours tailing off primer.

On August 8, 1997, claimant treated with Dr. McKellar for her left wrist condition. Dr. McKellar diagnosed a ganglion (synovial cyst). Claimant was subsequently referred to Dr. Casey.

On August 11, 1997, claimant filled out an 801 form which provided that the date of injury was July 16, 1997. Claimant also indicated that the body part had never been injured before.

On August 20, 1997, Dr. Casey reported that claimant stated that her left wrist pain began after she was tailing off the primer in November, and that it again happened while doing the same job last month.

On October 1, 1997, Dr. Casey surgically removed the ganglion cyst.

On September 12, 1997, the employer denied claimant's claim.

CONCLUSIONS OF LAW AND OPINION

Compensability

On review, the employer argues that claimant provided an inconsistent history which undermines the persuasiveness of the medical opinions supporting compensability. Specifically, the employer contends that, although claimant testified and told her doctors that her first wrist problems occurred in the fall of 1996, she indicated on forms that her condition first occurred on July 16, 1997, and that she had never injured the body part before. The employer also argues that claimant gave a statement to an investigator in which she told him that she was first injured in July 1997.

We agree with the ALJ that the inconsistencies in the record are minor and we find that such minor discrepancies are resolved by the ALJ's credibility finding, which was based on demeanor. Moreover, although claimant noted on the 801 form that she had not injured that body part before, she also described the July 1997 incident as "aggrivated (sic) wrist while tailing off the primer." (Ex. 3). As claimant argues, the description of the incident is consistent with her testimony that the wrist had been previously injured. Additionally, claimant credibly testified that she misunderstood the investigator's questions regarding a prior injury and that she previously had problems with her wrist at work.

Finally, the employer argues that claimant's supervisor testified that he was first advised of claimant's wrist problems in July 1997. The employer also contends that the supervisor's testimony is supported by the fact that the supervisor kept a daily log in which every accident or injury mentioned was written down. However, the employer argues that the only notations regarding claimant's complaints were in July 1997.

In light of the ALJ's credibility finding, we do not find the supervisor's testimony dispositive. Moreover, the supervisor conceded that he was unable to recall whether claimant was injured in 1996. In addition, although the supervisor testified that he wrote down every single incident (including slivers), and that there was approximately one accident per week, no accident reports appeared in the supervisor's log from the period of August 1996 through December 1996. Consequently, we do not find the supervisor's testimony to be persuasive.

Under the circumstances, we agree with the ALJ that claimant has established compensability. We therefore affirm the ALJ on the issue of compensability.

Attorney fees

The employer contends that the ALJ's attorney fee award of $3,600 is excessive. The employer argues that the hearing was short and the cyst involved only simple surgery and no time loss.

On *de novo* review, we consider the amount of an 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 proceeding; (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 frviolous issues or defenses.

Our review of the record reveals the following information. The issue in dispute was compensability of claimant's left wrist condition. Eleven exhibits were admitted, with one exhibit generated by claimant's counsel. One physician was deposed, with a deposition transcript of 21 pages. The hearing was an hour in length, with claimant and the supervisor as the only witnesses.

When compared with other compensability disputes reviewed by this forum, we find that the case involved issues of average legal and medical complexity. The claim's value and benefits are slightly above average as claimant's compensation will include reimbursement for surgery, as well as the benefits that arise from such a procedure. The parties' respective counsels presented their positions in a thorough manner. No frivolous issues or defenses were presented. Finally, considering the employer's contentions regarding the accuracy of claimant's medical histories, there was a risk that claimant's counsel's efforts might have gone uncompensated.

Based upon our applicaton of each of the previously enumerated factors and considering the parties' arguments, we conclude that $3,600 is a reasonable and appropriate attorney fee for services at hearing. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the record), the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $1,200, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue and the value of the interest involved. Claimant is not entitled to an attorney fee for services related to the attorney fee issue. *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated May 6, 1998 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,200, to be paid by the employer.

In the Matter of the Compensation of
PATTI E. BOLLES, Claimant
WCB Case No. 97-08548
ORDER ON REVIEW
Pozzi, et al, Claimant Attorneys
Cummins, 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 an Order on Reconsideration on the basis that claimant's psychological condition claim was prematurely closed. On review, the issues are premature closure and, if the claim was not prematurely closed, extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

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

Claimant suffered a compensable occupational disease, which was diagnosed as "adjustment disorder with mixed anxiety and depression." Dr. Paulsen, claimant's attending psychiatrist, declared claimant medically stationary without permanent impairment as of November 7, 1996 and released her to regular work on the same date.

A May 12, 1997 Notice of Closure awarded temporary disability only. Claimant requested reconsideration, disputing, inter alia, the medically stationary date and the impairment findings used to rate her impairment. A medical arbiter examination was performed on August 28, 1997 by Dr. Bennington-Davis, psychiatrist.

On September 29, 1997, the Department issued an Order on Reconsideration that did not consider the medical arbiter report on the basis that the arbiter's report indicated that claimant's condition had changed subsequent to claim closure. Because the insurer did not consent to postpone the reconsideration, claimant's impairment was based on the record developed at the time of claim closure. The Order on Reconsideration declared claimant medically stationary on November 7, 1996 and awarded no unscheduled permanent disability. Claimant requested a hearing on the issues of premature claim closure and, if the claim was not prematurely closed, unscheduled permanent disability.

CONCLUSIONS OF LAW AND OPINION

Premature Claim Closure

The ALJ concluded that claimant was not medically stationary on the date the Notice of Closure issued and set aside the Order on Reconsideration on the basis that the claim was prematurely closed. On review, the employer challenges this conclusion, asserting that claimant failed to prove that she was not medically stationary at closure. We agree.

In order to prove that her claim was prematurely closed, claimant must demonstrate that she was not medically stationary on the date of closure. *Scheuning v. J. R. Simplot & Company*, 84 Or App 622, 625 (1987). "'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 question of claimant's medically stationary status is primarily a medical question requiring competent medical evidence. *Harmon v. SAIF*, 54 Or App 121 (1981); *Austin v. SAIF*, 48 Or App 7 (1980). In determining whether claimant is medically stationary, we examine medical evidence available

at the time of closure, as well as evidence submitted after closure. Medical evidence generated after claim closure, which refers to claimant's post-closure condition, may be considered in determining whether claimant was medically stationary at closure if the evidence establishes that claimant's condition has either not changed or has improved since closure. *Scheuning v. J. R. Simplot & Co.*, 84 Or App at 622 (1987); *Utrera v. Department of General Services*, 89 Or App 114 (1987).

On April 23, 1997, Dr. Paulsen found that claimant's psychological condition was medically stationary without permanent impairment as of her last medical examination on November 7, 1996, the date she released claimant to regular work. She continued claimant on anti-depressant medication, with the expectation that, after three months, tapering off and discontinuing the medication would be appropriate. (Exs. 18, 21). Claim closure took place on May 12, 1997.

On August 28, 1997, claimant underwent a medical arbiter examination by Dr. Bennington-Davis. (Ex. 27). The arbiter reported that claimant had voluntarily stopped taking her medication in May 1997, as "[s]he was doing 'okay' mood wise and she had gained 20 pounds on the medication and so she felt it would be safe to go off of it." The arbiter also noted that, during the month prior to the arbiter examination, claimant reported increased symptoms of depression. The arbiter opined that claimant experienced an episode of major depression that had lasted for several weeks. The arbiter also opined that claimant was not medically stationary in regard to her depression.

Because the arbiter rendered this opinion after claimant's claim was closed, and because it pertained to a change in claimant's condition that took place subsequent to the May 12, 1997 closure[1], we do not consider this evidence. Therefore, because the evidence regarding claimant's condition at the time of claim closure establishes that claimant was medically stationary at that time, we conclude that claimant has failed to prove that her claim was prematurely closed.

Extent of Unscheduled Permanent Disability

If a treating physician or medical arbiter makes impairment findings consistent with a claimant's compensable injury and does not attribute the impairment to causes other than the compensable injury, we construe the findings as showing that the impairment is due to the compensable injury. *Kim E. Danboise*, 47 Van Natta 2163, 2364, *on recon* 47 Van Natta 2281 (1995), *aff'd SAIF v. Danboise*, 147 Or App 550 (1997). However, where the medical arbiter attributes the claimant's impairment to causes other than the compensable injury, the medical arbiter's opinion is not considered persuasive evidence of injury-related impairment. *Julie A. Widby*, 46 Van Natta 1065 (1994).[2]

Here, the medical arbiter attributes his rating of "Class II, Mild" to claimant's episode of major depression that began several weeks prior to his examination, and not to claimant's accepted adjustment disorder. In addition, Dr. Bennington-Davis stated that she did not believe that claimant's current episode of major depression represented permanent impairment. (Ex. 24-5, -6, -7). Accordingly, the medical arbiter's opinion is not considered persuasive evidence of impairment related to the accepted condition.[3] Finally, we rely on the opinion of the attending physician, Dr. Paulsen (the physician more

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[1] Unlike the ALJ, we find no evidence that claimant's increased depression began prior to claim closure in May 1997. Rather, the medical evidence establishes that claimant's worsened symptoms of depression began around the end of July 1997, about two months after the May 12, 1997 claim closure.

[2] Evaluation of a worker's disability is as of the date of issuance of the reconsideration order. ORS 656.283(7). Where a medical arbiter is used, impairment is determined by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. *Orfan A. Babury*, 48 Van Natta 1687 (1996). This "preponderance of the evidence" must come from the findings of the attending physician or other physicians with whom the attending physician concurs. *See Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, 670 (1994). We have previously held that we do not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment but, rather, rely on the most thorough, complete, and well-reasoned evaluation of the claimant's injury-related impairment. *See Kenneth W. Matlack*, 46 Van Natta 1631 (1994). In this case, we find Dr. Paulsen's report provides the most persuasive medical opinion addressing claimant's permanent impairment.

[3] Unlike the ALJ, we find this case distinguishable from *Kim E. Danboise*. In *Danboise*, the medical arbiter did not give any reasons for the claimant's ongoing disability aside from the compensable condition. 47 Van Natta at 2282. In the current case, the medical arbiter discussed non-compensable causes of claimant's episode of depression in some detail. (Ex. 24). Given the arbiter's diagnosis of claimant's current condition as an episode of major depression, and the reasons therefore, we do not presume that claimant's depression is necessarily related to her accepted adjustment disorder.

familiar with claimant's condition), who opined that claimant had no permanent disability as a result of her adjustment disorder. Therefore, we find that claimant has not established entitlement to any unscheduled permanent disability.

ORDER

The ALJ's order dated May 12, 1998 is reversed. That portion of the order that set aside the September 29, 1997 Order on Reconsideration and awarded an "out of compensation" attorney fee is reversed. The Order on Reconsideration that awarded no permanent disability is reinstated and affirmed.

In the Matter of the Compensation of
BONNIE G. BOOM, Claimant
Own Motion No. 98-0188M
OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our August 18, 1998 Own Motion Order in which we declined to reopen her 1978 industrial injury claim for the payment of temporary disability compensation because she failed to establish that her compensable condition required surgery or hospitalization now or in the near future.

In seeking reconsideration, claimant submits no evidence that surgery or hospitalization has been recommended. Therefore, the record fails to demonstrate that claimant requires *surgery* or *hospitalization* for treatment now or in the near future. As a result, we continue to find that claimant's compensable condition has not worsened requiring surgery or hospitalization, and therefore, no temporary disability compensation is due.[1]

Accordingly, our August 18, 1998 order is withdrawn. On reconsideration, we adhere to and republish, as supplemented herein, our August 18, 1998 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 her request for reconsideration, claimant seems focused on what she perceives as SAIF's failure to notify her of the expiration of her aggravation rights. She asserts that she was therefore prejudiced by this "lack of notice." To begin, claimant does not contend that she did not receive a copy of the March 10, 1980 Determination Order, which initially closed her claim. Inasmuch as that closure order was statutorily required to inform claimant of her "aggravation rights," any "lack of notice" concerns would have been resolved by the Determination Order. In any event, the aggravation date is established by statute regardless of any notice from the carrier. ORS 656.273(4)(a). In light of these circumstances, we are without statutory authority to "extend" claimant's aggravation rights as she requests.

Finally, claimant is again raising her need for physical therapy and palliative treatment. As we noted in our previous order, her request for medical treatment lies solely with the Director. Under ORS 656.327(1), the Director has exclusive jurisdiction over all pending and future disputes arising under ORS 656.327. Consequently, assuming that this is a "327" medical services dispute, exclusive jurisdiction over this case rests with the Director. *Travis J. Thorpe*, 47 Van Natta 2321 (1995); *Thomas L. Abel*, 47 Van Natta 1571 (1995).

In the Matter of the Compensation of
RAYMOND J. BUCKNO, Claimant
Own Motion No. 97-0475M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE

Claimant, *pro se*, requests review of the self-insured employer's July 6, 1998 Notice of Closure which closed his claim with an award of temporary disability compensation from December 12, 1997, through January 20, 1998. The employer declared claimant medically stationary as of June 25, 1998.

In an August 6, 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 employer submitted its response on August 7, 1998. Claimant has not submitted a response to the employer's submission. Therefore, 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 entitlement to additional temporary disability compensation during the time the claim was open.

Here, in his request for review, it is not apparent on which ground claimant is contesting the employer's notice of closure. Rather, in his August 5, 1998 letter, claimant states that "The surgery from Dec. 97 would have to be considered a success that area is major improvement - However the shoulder blade area and that area of my back has been in constant pain and muscle spasms. *** I delayed in writing hoping that the spasms and tightness in my back would get better *** but it hasn't." We assume that claimant is contending that he was not medically stationary at claim closure.[1]

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 July 6, 1998 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980).

On June 25, 1998, claimant underwent a closing medical examination performed by Dr. Weintraub, claimant's attending physician. Dr. Weintraub opined that claimant was medically stationary insofar as his shoulder was concerned. He concluded "no treatment recommended at this time. Return prn." This opinion is unrebutted.

Based on the uncontroverted medical evidence, we find that claimant has not met his burden of

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[1] 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).

proving that he was not medically stationary on the date his claim was closed. Therefore, we conclude that the employer's closure was proper.[2]

Accordingly, we affirm the employer's July 6, 1998 Notice of Closure in its entirety.

IT IS SO ORDERED.

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[2] From our review of the record, it would appear that claimant is seeking review of his closure because of his belief that his condition has worsened. If claimant's compensable condition has worsened to the extent that surgery and/or inpatient hospitalization is eventually required, he may again request reopening of his claim for the payment of temporary disability. *See* ORS 656.278(1).

Further, it appears from claimant's request that he is unclear as to his rights and benefits under the Workers' Compensation laws. The Workers' Compensation Board is an adjudicative body that addresses issues presented to it by disputing parties. Because of that role, the Board is an impartial body and cannot extend legal advice to either party. However, since claimant is unrepresented, he may wish to contact the Workers' Compensation Ombudsman, whose job it is to assist injured workers regarding workers' compensation matters:

Workers' Compensation Ombudsman
Dept. of Consumer & Business Services
350 Winter St NE
Salem, OR 97310
Telephone: 1-800-927-1271

In the Matter of the Compensation of
NGA H. BURSON, Claimant
WCB Case Nos. 97-08998 & 97-02515
ORDER ON RECONSIDERATION
Cole, Cary, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys
Sheridan & Bronstein, Defense Attorneys

The Hartford Insurance Company (Hartford) requests reconsideration of that portion of our August 13, 1998 Order on Review which found that the Administrative Law Judge (ALJ) did not abuse his discretion in admitting Exhibit 87, a "check-the-box" report from Dr. Kaye. In renewing its objection to the admission of the report, Hartford inquires as to whether we received its reply brief and the argument contained within it regarding the admissibility of the report.

In response, we confirm that we did receive and consider Hartford's arguments on the evidentiary issue. Moreover, our response to its contentions are contained in footnote 1 of our order. Apparently, Hartford disagrees with our reasoning, a position to which it is entitled. However, we have nothing more to add to our order. We continue to find that the ALJ did not abuse his discretion in admitting the disputed exhibit.

Accordingly, we withdraw our August 13, 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.

In the Matter of the Compensation of
GRACIELA KASPRZYK, Claimant
WCB Case No. 97-07598
ORDER ON RECONSIDERATION
Michael B. Dye, Claimant Attorney
Mannix, Nielsen, et al, Defense Attorneys

Claimant requests reconsideration of our August 7, 1998 Order on Review that reversed an Administrative Law Judge's (ALJ's) order directing the insurer to recalculate claimant's temporary disability compensation based on a full-time work week. Specifically, claimant contends that we did not specifically comment on certain inconsistencies and conflicting testimony in the record and that we erred in concluding that claimant failed to prove that she was hired to work a regular, full-time schedule of five days a week, seven and a half hours a day.

After considering claimant's motion, we continue to find that she has failed to sustain her burden of proof. *See* ORS 656.266. As set forth in our original order, although we are persuaded that claimant desired full-time work when she accepted employment with the employer, she has not established by a preponderance of the evidence that the employer agreed or intended to hire her on such a basis. Rather, considering the record as a whole (including the information on the 801 form as well as the testimony at hearing) we find it more likely than not that claimant was hired to work at the employer's new restaurant location on a part-time, as needed basis.[1]

Consequently, we withdraw our August 7, 1998 order. On reconsideration, as supplemented herein, we adhere to and republish our August 7, 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] Specifically, we find no persuasive reason to reject the uncontroverted testimony of Mrs. Beaulaurier, that insofar as claimant had limited availability, limited experience and capabilities and no seniority, she was not a candidate for full-time employment. Ms. Beaulaurier explained that only her shift managers or employees with seniority would be given full-time schedules, and even these employees could not be guaranteed a particular schedule every week because the restaurant's sales and needs changed depending upon the time of year. (Tr. 24-27).

In the Matter of the Compensation of
CINDY M. MOUNT, Claimant
WCB Case No. 97-08823
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Biehl, Bock, and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that: (1) admitted the medical arbiter's report and a "post-reconsideration" letter from the SAIF Corporation to claimant; (2) declined to admit claimant's testimony at hearing; (3) affirmed an Order on Reconsideration awarding 1 percent (1.5 degrees) scheduled permanent disability for loss of use or function of the left forearm (wrist); and (4) authorized an offset against future awards of permanent disability. On review, the issues are evidence, offset, and extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Admissibility of medical arbiter's report and claimant's testimony

As she did before the ALJ, claimant asserts that, because she was not given the opportunity to cross-examine the medical arbiter, the medical arbiter's report should be excluded from evidence. Claimant also contends that her testimony at hearing is admissible and excluding such evidence contravenes her constitutional rights.

We adopt the relevant portions of the ALJ's order concerning these issues.

Admissibility of Exhibit 18A and Offset

Claimant further contends that the ALJ erred in admitting a letter from SAIF to claimant advising claimant of an overpayment (Exhibit 18A). SAIF sent the letter to claimant following the issuance of the Order on Reconsideration, which reduced claimant's permanent disability award from 21 percent to 1 percent. The overpayment was based on the difference between the amount awarded by the Order on Reconsideration and that paid pursuant to the Determination Order. At hearing, SAIF requested that the ALJ authorize an offset of the overpayment.

The ALJ first concluded that, because any overpayment was created by the Order on Reconsideration, the offset issue arose out of the reconsideration order and, thus, SAIF could raise the matter at hearing. The ALJ further found that, because SAIF was entitled to raise the issue at hearing, it could also offer evidence concerning the matter. Because Exhibit 18A related to the offset issue, the ALJ admitted the document.

We agree with the ALJ's conclusion that SAIF could raise, and the ALJ could address, the offset issue, but our reasoning differs from the ALJ's in the following respect. Rather than finding that the offset issue arose out of the reconsideration order, we find that the offset issue was not an "issue regarding a . . . determination order" within the meaning of ORS 656.283(7). We held in *Adam J. Delfel*, 50 Van Natta 1041, 1044 (1998), that if the issue of an offset was not manifest in the closure order (*i.e.*, notice of closure or determination order) itself, then ORS 656.283(7) did not bar the carrier from raising the issue at hearing, even though it had not raised the issue at the reconsideration proceeding.

The facts of this case are very similar to those in *Delfel*. The July 1997 Determination Order did not mention the existence of an overpayment of *permanent* disability benefits that SAIF later asserted at hearing. In fact, the alleged overpayment *did not exist* at the time of the Determination Order. SAIF alleged that the overpayment was created when it paid the 21 percent scheduled permanent disability awarded by the Determination Order and the award was later reduced to 1 percent by the Order on Reconsideration. Thus, the alleged overpayment of permanent disability came into existence after issuance of the closure order in this case. Because the overpayment/offset issue was not manifest in the closure order itself, the offset issue was not subject to the limitation in ORS 656.283(7) on closure-related issues that may be raised at hearing. *See Delfel*, 50 Van Natta at 1044. For this reason, it was unnecessary for the ALJ to proceed to the question of whether the offset issue "arose out of the

reconsideration order itself." In other words, our conclusion that ORS 656.283(7)'s limitation on closure-related issues that may be raised at hearing did not apply to the offset issue in this case, effectively moots the question of whether the issue met the exception to that limitation (for issues arising out of the reconsideration order).

Our analysis regarding the admissibility of Exhibit 18A follows the same reasoning. Because the offset issue is not subject to the limitation on closure-related issues that may be raised at hearing, it likewise is not subject to ORS 656.283(7)'s limitation on "post-reconsideration" evidence that may be admitted at hearing.

Turning to the offset issue, we conclude that SAIF is entitled to an offset for overpaid permanent disability. As we held in *Delfel*, when an Order on Reconsideration reduces permanent disability and authorizes the carrier to offset any overpayment of permanent disability, the carrier is entitled to do so under ORS 656.268(15)(a).[1] 50 Van Natta at 1045. Furthermore, although the carrier is not required to request prior authorization for an offset from an ALJ or the Board, it may raise the issue of the specific amount of its overpayment and we have authority to resolve that matter. *Id.* In *Delfel*, because the parties did not dispute the amount of the overpayment, we found that the carrier's overpayment was established. *Id.*

Here, the Order on Reconsideration authorized SAIF to deduct any overpaid temporary disability benefits or previously paid permanent disability benefits from the permanent disability awarded by the Order on Reconsideration. Thus, pursuant to ORS 656.268(15)(a), SAIF is entitled to offset any overpaid permanent disability.

Claimant's argument against SAIF's request for authorization of the offset concerns the evidence necessary to show that claimant actually received the overpayment; according to claimant, SAIF must provide canceled checks or some other evidence that establishes claimant's actual receipt of the money. We understand claimant as challenging the proof necessary to establish an overpayment and not the specific amount of the overpayment sought to be offset by SAIF. Consequently, consistent with *Delfel*, we conclude that SAIF is entitled to its offset.

Extent of Scheduled Permanent Disability

We adopt that portion of the ALJ's order regarding this issue. In particular, we agree with the ALJ that the medical arbiter provided the most persuasive opinion. In addition to the ALJ's reasoning, we further note that the treating orthopedic surgeon, Dr. Butters, provided inconsistent opinions in that he first attributed claimant's grip strength weakness to deconditioning (Ex. 7), and then indicated that the weakness was not due to deconditioning (Ex. 9). In short, we find persuasive reasons not to defer to Dr. Butters' opinion. *See Weiland v. SAIF*, 77 Or App 810 (1983).

ORDER

The ALJ's order dated February 20, 1998 is affirmed.

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[1] ORS 656.268(15)(a) provides:

"An insurer or self-insured employer may offset any compensation payable to the worker to recover an overpayment from a claim with the same insurer or self-insured employer. When overpayments are recovered from temporary disability or permanent total disability benefits, the amount recovered from each payment shall not exceed 25 percent of the payment, without prior authorization from the worker."

Board Member Moller specially concurring.

I agree with the majority's ultimate conclusions that the ALJ properly admitted Exhibit 18A and that SAIF is entitled to an offset. Because I disagree with its reasoning, however, I specially concur.

In deciding that the ALJ could address the offset issue, the majority relies on *Adam J. Delfel*, 50 Van Natta 1041 (1998). In *Delfel*, an overpayment was created when the carrier paid the permanent disability awarded by an Order on Reconsideration and that order subsequently was set aside on the basis that the claim was prematurely closed. Relying on *Blaine P. Hosey*, 50 Van Natta 360 (1998), we found that, because the Determination Order "did not address the issue of offset of overpaid *permanent* disability in any manner, * * * the issue of offset of permanent disability is not manifest in the closure order itself, [thus], the insurer is not precluded from raising that issue at hearing under ORS 656.283(7)." 50 Van Natta at 1044. (Emphasis in original.)

Hosey and *Delfel*, however, do not explain the statutory basis that allows a party to raise, and the Board to address, an issue when it is not "manifest in the closure order itself." Moreover, the relevant statute explicitly provides that "issues that were not raised by a party to the reconsideration may not be raised at hearing[.]" ORS 656.283(7). The only exception contained in the statutes are issues that arise out of the reconsideration order itself. ORS 656.283(7), 656.268(8).

I agree with the ALJ that the offset issue "arises out of the reconsideration order itself." The overpayment was created by the Order on Reconsideration because it reduced the permanent disability awarded by the Determination Order. Because the statutes specifically provide that issues arising out of the Order on Reconsideration can be raised and addressed at hearing, and the offset issue in this case fits that definition, I believe the better approach is to address it on this basis. This is more consistent with the statutes than determining whether or not the issue is "manifest in the closure order itself."

Furthermore, although "post-reconsideration" evidence, Exhibit 18A is admissible. In interpreting ORS 656.283(7) and 656.268(8), our first task is to discern what the legislature intended when it enacted the statutes. ORS 174.020. We begin by examining the text and context of the statute. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610 (1993). Only if those sources do not reveal legislative intent do we resort to legislative history and other extrinsic aids. *Id.* at 611-12.

ORS 656.283(7) states that "[e]vidence on *an issue regarding a notice of closure or determination order* that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing[.]" (Emphasis added.) Under the terms of the statute, any evidence, including vocational evidence, not submitted during the reconsideration process is inadmissible at a subsequent hearing. *E.g., Rogue Valley Medical Center v. McClearen*, 152 Or App 239 (1998).

Such language, however, expressly limits itself to evidence concerning an issue relating to the Notice of Closure or Determination Order. Both ORS 656.283(7) and 656.268(8) then address "issues arising out of the reconsideration order." Thus, I see a distinction in the statutes between evidence "on an issue regarding a notice of closure or determination order" and issues that "arise[] out of the reconsideration order itself." For that reason, I find an intent to treat evidence relating to issues first arising out of the Order on Reconsideration in a different manner than "[e]vidence on an issue regarding a notice of closure or determination order." That is, evidence relating to an issue first arising out of the Order on Reconsideration does not come within the category of "[e]vidence on an issue regarding a notice of closure or determination order."

Therefore, having found that the legislative intent underlying the statutes is to allow "post-reconsideration" evidence relating to "issues arising out of the reconsideration order," such evidence comes within the remaining rules of admissibility. That is, if the evidence is otherwise discoverable and admissible under statutes and our rules, then the ALJ properly can admit the proffered documents.

Thus, I would hold, first, that we can address the offset issue because it "arises out of the reconsideration order itself." Furthermore, I would hold that the admission of Exhibit 18A is not prohibited by ORS 656.283(7) and 656.268(8). Here, because Exhibit 18A is relevant to the offset issue and no other grounds have been raised for disputing its admission, I would find that the ALJ properly admitted the document.

In the Matter of the Compensation of
JOHN M. MORLEY, Claimant
WCB Case No. 97-09751
CORRECTED ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

It has come to our attention that our August 17, 1998 Order on Review contains a clerical error. Specifically, the "Order" portion of our decision incorrectly provides that the attorney fee shall be paid by the "self-insured employer," rather than the SAIF Corporation.

To correct this error, we withdraw our August 17, 1998 order. We republish our August 17, 1998 order, replacing the "Order" portion of our prior order with the following paragraph:

ORDER

The ALJ's order dated March 19, 1998 is modified in part and affirmed in part. That portion of the order that awarded a $5,148.50 assessed attorney fee is modified. In lieu of the ALJ's attorney fee award, claimant is awarded a $3,500 attorney fee, payable by the SAIF Corporation. For services on Board review, claimant's attorney is awarded $1,000, payable by SAIF. The remainder of the order is affirmed.

In the Matter of the Compensation of
SHARON L. PACKER, Claimant
WCB Case No. 97-09022
ORDER ON REVIEW
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Nichols' order that upheld the SAIF Corporation's denial of her low back injury claim. In her briefs, claimant submits additional documents to be admitted into evidence. We treat these submissions as a motion to remand for the taking of additional evidence. *See Judy A. Britton*, 37 Van Natta 1262 (1985). On review, the issues are remand and compensability.

We deny the motion to remand, and adopt and affirm the ALJ's order with the following supplementation.

Remand

In her briefs, claimant submits additional documents, including letters from Dr. Johnson dated October 23, 1997 and May 4, 1998, to be admitted into evidence. We treat these submissions as a motion to remand for the taking of additional evidence. *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, we are not persuaded that the proffered evidence was unobtainable with due diligence at the time of her January 29, 1998 hearing.[1] We also note that the record already contains the remaining evidence submitted by claimant on review. Moreover, we conclude that the proffered evidence, including the document dated May 4, 1998, will not likely affect the outcome of the case. Therefore, we deny claimant's request for remand.

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[1] We note that claimant's then-attorney was in possession of the document dated October 23, 1997 by at least November 7, 1997. *See* Ex. 17A.

Claimant also expresses concerns regarding her lack of a copy of the closing arguments that were apparently presented by telephone following the hearing. To begin, it is unclear whether these arguments were recorded. In any event, because neither the parties nor the ALJ ordered a transcript, these arguments are not part of the record. Finally, even if they were present in the record, such a submission would only supplement the arguments that parties have already presented on review. In other words, our decision has been based on all admissible evidence and relevant portions of the reviewable record.

Compensability

There is no dispute that claimant has preexisting degenerative disc disease (DDD), or that her work injury of July 3, 1997 combined with the DDD to cause a need for treatment. In order to establish compensability of her herniated disc[2] as a combined condition, claimant must prove that her work injury of July 1997 was the major contributing cause of the need for medical treatment or disability due to the combined condition. ORS 656.005(7)(a)(B);[3] *SAIF v. Nehl*, 148 Or App 101, *recon* 104 Or App 309 (1997), *rev den* 326 Or 389 (1998); *Gregory Noble*, 49 Van Natta 764 (1997), *aff'd mem Liberty Northwest Insurance Corp. v. Noble*, 153 Or App 125 (1998). Determination of the major contributing cause involves evaluating the relative contribution of different causes of claimant's need for treatment for the combined condition and deciding which is the primary cause. *Deitz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995). Thus, the quantitative contribution of each cause, including the precipitating cause and the preexisting DDD, must be weighed to establish the primary cause of claimant's need for treatment.

Four doctors offered causation opinions regarding claimant's disc herniation. We agree with the ALJ that the only opinion supporting compensability, that of Dr. Johnson, is not persuasive. Dr. Johnson checked a box on a letter prepared by claimant's former counsel in which he agreed with the statement that the major contributing cause of claimant's herniated disc and need for surgery was her "work activity and awkward position when she knelt down to open the safe on July 3, 1997." (Ex. 17A-2).

The ALJ correctly reasoned that Dr. Johnson's opinion was not persuasive because he failed to explain his conclusory opinion and did not weigh the relative contribution of claimant's preexisting DDD against that of the work injury in evaluating the major contributing cause of the need for treatment of the herniated disc.[4]

ORDER

The ALJ's order dated April 17, 1998 is affirmed.

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[2] Claimant was diagnosed with herniated discs at L4-5 and L5-S1. It is unclear from the record which disc required surgery.

[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."

[4] In reaching this conclusion, we acknowledge claimant's frustration with the workers' compensation system and the processing of her claim. We further recognize that it is undisputed that claimant's onset of pain arose while she was performing her work activities. Nonetheless, because her work injury combined with her preexisting degenerative condition, she is not entitled to benefits unless the persuasive medical evidence establishes that her work injury was the major contributing cause of her disability or need for treatment. For the reasons expressed by the ALJ, we conclude that the persuasive medical evidence demonstrates that her preexisting condition, rather than the work injury, is the major contributing cause of her need for medical treatment. This determination has been based on the substance of the medical opinions, not on which party "hired" these medical experts.

In the Matter of the Compensation of
JENNIFER BRADLEY, Claimant
WCB Case Nos. 95-10232 & 95-09669
ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Claimant requests reconsideration of those portions of our August 7, 1998 Order that: (1) declined to remand to the Administrative Law Judge (ALJ) for the consideration of additional evidence; and (2) affirmed an ALJ's order upholding the self-insured employer's denial of her injury claim for a right shoulder condition. Specifically, claimant asserts that we did not specifically address whether the proffered evidence (which, she contends, supports her testimony and tends to impeach the testimony of the employer's witness, Mr. Purdom), would be admissible under the circumstances of this case.

As set forth in our original order, we found that the proffered evidence, even if considered on review, would likely not affect the outcome of the case.[1] Given this determination, we need not specifically resolve whether the proffered evidence would be admissible on remand.

Claimant further contends that remand is appropriate because she did not reasonably anticipate that Mr. Purdom's testimony would conflict with her testimony concerning the nature of the job she was assigned on May 18, 1995. We note, however, that claimant did not seek to present rebuttal evidence from herself or other witnesses in response to Mr. Purdom's testimony. Rather, at the close of the hearing, claimant's counsel indicated that claimant had no additional evidence to be placed in the record. (Tr. 152).

In short, after considering claimant's contentions, we adhere to our determination that this case presents no compelling reason to remand. *See Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986) (to warrant remand, the moving party must show good cause or a compelling basis).

Accordingly, we withdraw our August 7, 1998 order. On reconsideration, as supplemented herein, we adhere to and republish our August 7, 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] The proffered evidence consists of pictures of "u-racks" allegedly similar to the one which claimant was assigned to cut on May 18, 1995 and claimant's "daily production ticket" for that day. We explained that even if we assumed that claimant cut five boards (rather than three) and that this was her last task of the day, such evidence would not establish the compensability of her right shoulder condition. Rather, we agreed with the ALJ that claimant failed to prove by a preponderance of the evidence that her right shoulder condition was caused by her work activity on May 18, 1995.

In the Matter of the Compensation of
GARY P. BOWERS, Claimant
WCB Case No. 97-04210
ORDER ON REVIEW
Bryant, Emerson, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Baker's order that upheld the SAIF Corporation's denial of his aggravation claim for his current low back condition (L4-5 herniated disc). On review, the issue is compensability.

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

On review, claimant argues that his accepted September 29, 1995 lumbar strain is the major contributing cause of his current low back condition at L4-5. 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, SAIF accepted a lumbar strain as a result of claimant's September 1995 injury. Claimant's current condition has been diagnosed as an L4-5 herniated disc. Because claimant's herniated disc is not an accepted condition, in order to establish a worsened condition resulting from the original injury, he must first establish that the herniated disc is a compensable condition.

Claimant argues that the causation opinion of Dr. Norby, claimant's treating physician, is more persuasive than that of Dr. Dietrich. SAIF contends that the most persuasive argument has been provided by Dr. Dietrich, who related claimant's current disc condition to preexisting and degenerative factors.

Here, the preponderance of the evidence indicates that claimant's degenerative disc disease and L4-5 disc condition preexisted and combined with the September 1995 injury. Therefore, he must prove that the September 1995 injury was the major contributing cause of the need for treatment and disability of his L4-5 herniated disc with radicular symptoms. ORS 656.005(8)(a)(B); *SAIF v. Nehl*, 148 Or App 101, *recon* 104 Or App 309 (1997), *rev den* 326 Or 389 (1998). (1997). The fact that a work injury is the immediate or precipitating cause of a claimant's condition does not necessarily mean that that injury was the major contributing cause of the condition. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995). Instead, determination of the major contributing cause involves evaluating the relative contribution of different causes of claimant's need for treatment of the combined condition and deciding which is the primary cause. *Id.*

The record shows that at the time of the September 1995 injury, claimant experienced low back pain with radiation into his left hip and anterior thigh and right posterior hip pain. (Exs. 32, 35, 36). A myelogram and CT scan showed a left-sided disc bulge at L4-5, but no nerve root amputation or herniation. (Exs. 36, 37). Claimant returned to modified work, but continued to experience intermittent low back aching and bilateral posterior thigh pain. (Exs. 44, 46, 50). On May 24, 1996, his claim was closed with 2 percent unscheduled permanent disability.

On January 27, 1997, claimant sought treatment for complaints of continual numbness of the left thigh and complaints of weakness, numbness and pain into the left leg and foot, which he had been experiencing for about six months. He was diagnosed with a probable disc herniation at L4-5 with radiculopathy. (Exs. 52, 53). A February 1997 MRI revealed a focal disc herniation at L4-5 on the left, which, Dr. Norby opined, showed a marked interval change since a May 1995 MRI, and which was consistent with claimant's complaints. Dr. Norby recommended disc surgery, which was performed on February 26, 1997. (Ex. 63).

Dr. Norby explained that claimant had herniated his lumbar disc in September 1995, which had improved by the time of closure and then subsequently worsened after claimant returned to work, which included heavy raking and twisting. (Ex. 66). Dr. Norby further explained that, although the September 1995 injury had combined with claimant's preexisting degenerative disc condition, the natural degenerative process was not playing a role in the disc herniation and need for treatment. (*Id.*)

In contrast, Dr. Reimer, who had examined claimant for SAIF on a number of occasions, opined that the September 1995 injury was a lumbar strain which had combined with claimant's preexisting multi-level degenerative disc disease which had been well-documented since 1989. Dr. Reimer opined that the most logical explanation for the cause of claimant's herniated disc was the natural progression of disc disease. (Ex. 70).

Initially, Dr. Dietrich, who performed a records review for SAIF, opined that the September 1995 injury was the major contributing cause of claimant's need for treatment. (Ex. 74A). During his deposition, however, he stated that his opinion was based on his need to distinguish between the September 1995 injury being the major contributing cause of the need for treatment of the combined condition as opposed to causation by some subsequent injury. He then opined that, looking at the entire picture of claimant's back troubles dating back to the early 1980's, claimant's preexisting condition may have been the major contributing cause of all of claimant's symptoms. Dr. Dietrich also stated that, if claimant had not been doing heavy work in September 1995, his herniated disk would not have progressed to the need for surgery at the time it occurred. Finally, he stated that claimant's major difficulty was his preexisting condition, and that claimant's preexisting condition included progressive annular tears and the herniated disk. (Ex. 77-45, 46).

Dr. Newby, the only physician who supports compensability, opined that the degenerative process was not playing a role in claimant's herniated disc. He offered no explanation of his opinion, and no evaluation of the relative contribution of the preexisting degenerative condition and claimant's work incident. Instead, it appears that Dr. Newby was simply relying on a precipitating cause, or a "but for" analysis, which, without the required *Dietz analysis*, is not sufficient to establish the work injury as the major contributing cause of the need for treatment or disability of the combined condition. *Georgia Barklow*, 49 Van Natta 1261 (1997); *Alec E. Snyder*, 47 Van Natta 838 (1995) (persuasive medical opinion must weigh the relative contribution of different causes; "but for" analysis not well reasoned).

Accordingly, like the ALJ, we find claimant has failed to meet his burden of proving a compensable L4-5 disc injury. Consequently, it follows that SAIF's Aggravation Denial must be upheld.

ORDER

The ALJ's order dated February 12, 1998 is affirmed.

In the Matter of the Compensation of
BETTY L. MARTINEZ, Claimant
WCB Case Nos. 96-01346, 96-00819 & 95-02012
ORDER OF ABATEMENT
Malagon, Moore, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys
Alice M. Bartelt (Saif), Defense Attorney

On August 25, 1998, we issued a Second Order on Remand that republished our August 4, 1998 Order on Remand that affirmed an Administrative Law Judge's (ALJ's) order that found Wal-Mart responsible for claimant's occupational disease claim for a right carpal tunnel syndrome condition. Contending that we neglected to award her counsel an attorney fee for services provided before the court and on remand before the Board, claimant seeks reconsideration of our decision.

In order to further consider claimant's request, we withdraw our prior orders. In addition, we implement the following supplemental briefing schedule. Claimant's opening brief must be filed within 14 days from the date of this order. Wal-Mart's and the SAIF Corporation's supplemental responses must be filed within 14 days from the date of mailing of claimant's brief. Claimant's reply must be filed

within 14 days from the date of mailing of Wal-Mart's and SAIF's briefs. In submitting their respective positions, the parties are requested to address the effect, if any, the following cases have on the issue posed by claimant's request: *Foster-Wheeler Constructors v. Smith*, 151 Or App 155 (1997); *Liberty Northwest Insurance Corporation v. Gordineer*, 150 Or App 136 (1997); *Burton I. Thompson*, 48 Van Natta 866 (1996). Following completion of this supplemental briefing schedule, we will take this matter under advisement.

IT IS SO ORDERED.

September 10, 1998 Cite as 50 Van Natta 1708 (1998)

In the Matter of the Compensation of
DEWEY C. HARVEY, Claimant
Own Motion No. 98-0369M
INTERIM OWN MOTION ORDER CONSENTING TO
DESIGNATION OF PAYING AGENT (ORS 656.307)
Ransom & Gilbertson, Claimant Attorneys
Saif Legal Department, Defense Attorney

The Benefits Section of the Workers' Compensation Division has notified the Board that it is prepared to issue an order designating a paying agent under ORS 656.307 and OAR 436-060-0180. Each insurer has provided its written acknowledgment that the only issue is responsibility for claimant's otherwise compensable claim. Claimant's aggravation rights under his 1991 injury claim with the SAIF Corporation expired on December 16, 1997. Thus, the claim is subject to ORS 656.278.

Under OAR 438-012-0032, the Board shall notify the Benefits Section that it consents to the order designating a paying agent if it finds that the claimant would be entitled to own motion relief if the own motion insurer is the party responsible for payment of compensation. The Board may exercise its own motion jurisdiction if there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, the Board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary. *Id.*

The record establishes that there has been a worsening of claimant's compensable injury requiring surgery. Inasmuch as claimant would be entitled to own motion relief if the own motion insurer is found responsible for claimant's current condition, the Board consents to the order designating a paying agent for temporary disability compensation under claimant's 1991 own motion claim, beginning the date claimant is hospitalized for the proposed surgery. ORS 656.278(1)(a).

The Board emphasizes that this is not a final order or decision authorizing a reopening of the claim under ORS 656.278 and the Board's rules. Instead, this is an interim order consenting to the designation of a paying agent under ORS 656.307.

When the responsible carrier has been determined, the Board will either: (1) issue an order reopening an own motion claim, if the own motion carrier is found to be the responsible carrier; and/or (2) issue an order denying reopening of an own motion claim, if the own motion carrier is not found responsible, or if a non-own motion carrier is found to be the responsible carrier. Furthermore, if the own motion carrier is determined to be responsible for claimant's current condition, the parties are requested to submit their respective positions regarding own motion relief.

IT IS SO ORDERED.

In the Matter of the Compensation of
CONRID J. PAXTON, Claimant
WCB Case Nos. 95-00537, 94-13809 & 94-10357
ORDER ON REMAND
Aller & Morrison, Claimant Attorneys
William J. Blitz, Defense Attorney
James B. Northrop (Saif), Defense Attorney
Hornecker, Cowling, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. *SAIF v. Paxton*, 154 Or App 259 (1998). The court has reversed our prior order, *Conrid J. Paxton*, 48 Van Natta 475, *on recon* 48 Van Natta 1045, *on recon* 48 Van Natta 1243 (1996), that held that the SAIF Corporation/Sun Studs was responsible for claimant's occupational disease claim for a hearing loss condition. The court concluded that, when viewed as a whole, the record permitted only one reasonable interpretation that all of claimant's hearing loss (either due to occupational exposure or non-work-related factors) occurred before he began work for Sun Studs. Because no hearing loss occurred while claimant was employed by Sun Studs, the court held that SAIF/Sun Studs could not legally be the responsible carrier on the claim. Consequently, the court remanded for further consideration. In accordance with the court's mandate, we now proceed with further consideration of the responsibility issue.

FINDINGS OF FACT

We continue to adopt the ALJ's findings of fact, with the following correction noted in our original February 29, 1996 order: claimant was employed by Sun Studs from October 1991 to present, not October 1990 to present.

CONCLUSIONS OF LAW AND OPINION

We begin by briefly recounting the procedural background of the claim. Claimant was employed as a heavy equipment maintenance worker by another SAIF insured, Woolley Enterprises, from 1977 to January 1981; by RLC from January 1981 to October 1991; and by Sun Studs from October 1991 forward. The ALJ held that SAIF/Sun Studs was responsible for claimant's hearing loss claim. We reversed in a February 29, 1996 order. *Conrid J. Paxton*, 48 Van Natta at 476. Applying the last injurious exposure rule (LIER), we explained:

> "That rule provides that when, as here, a worker proves that an occupational disease was caused by work conditions that existed when more than one carrier was on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. *Boise Cascade Corp. v. Starbuck*, 296 Or 238 (1984)."

We then explained that the last potentially causal employer (Sun Studs), could shift responsibility to a prior carrier by showing that claimant's work exposure while a prior carrier was on the risk was the sole cause of claimant's hearing loss condition, or that it was impossible for conditions while SAIF/Sun Studs was on the risk to have caused that condition. *See FMC Corp. v. Liberty Mutual Ins. Co.*, 70 Or App 370, 374, *mod* 73 Or App 223, *rev den* 299 Or 203 (1985). Applying those rules, we found, on the basis of Drs. Scott's and Hodgson's reports, that the sole cause of claimant's hearing loss was his work exposure before June 4, 1981, and that, therefore, Sun Studs was not the responsible employer.

We then addressed which carrier, as between RLC and SAIF/Woolley, was responsible for claimant's hearing loss claim. Because the preponderance of the medical evidence established that claimant's employment prior to June 4, 1981 caused his hearing loss, and because RLC was on the risk for six months of that time (from January to June 1981), we reasoned that RLC failed to meet its burden under the sole cause or impossibility tests. Consequently, we found RLC responsible for claimant's hearing loss. RLC requested reconsideration of our order on the ground that we erroneously assigned it responsibility for claimant's hearing loss claim.

In lieu of our prior decision, we concluded in a May 22, 1996 Order on Reconsideration that responsibility for claimant's hearing loss claim rested with SAIF/Sun Studs. 48 Van Natta at 1045. We

reasoned that neither Dr. Scott nor Dr. Hodgson specifically addressed whether claimant's pre-June 4, 1981 work was the sole cause of his hearing loss, or whether it was impossible for claimant's work conditions at Sun Studs to have caused that condition. We noted that Dr. Hodgson's statement that the major portion of claimant's hearing loss was due entirely to pre-1981 work noise exposure admitted, at least impliedly, that part of his hearing loss was due to post-1981 work noise exposure, which would include claimant's period of employment at Sun Studs.

Under the circumstances, we concluded that SAIF/Sun Studs was not entitled to shift responsibility to an earlier carrier under the "sole cause/impossibility" test. Therefore, we affirmed the ALJ's decision setting aside SAIF/Sun Studs' denial and upholding the denials on behalf of RLC and SAIF/Woolley.

The SAIF Corporation, on behalf of Sun Studs, requested reconsideration of our May 22, 1996 order. SAIF argued that Dr. Hodgson's opinion must be construed to mean that all of claimant's industrial hearing loss occurred prior to 1981.

Noting that SAIF/Sun Studs had the burden of proof, we found SAIF's argument that all of claimant's industrial noise exposure occurred prior to 1981 inconsistent with Dr. Hodgson's quantification of claimant's condition in terms of the "major" contributing cause. Accordingly, we concluded in a second reconsideration order of June 19, 1996 that SAIF's argument did not persuade us that claimant's work prior to his employment with Sun Studs was the sole cause of his hearing loss condition, or that it was impossible for employment conditions while SAIF/Sun Studs was on the risk to have caused that condition. Consequently, we adhered to our prior decision. 48 Van Natta at 1243. SAIF/Sun Studs requested appellate review by the Court of Appeals.

The court reversed. It found that the record, viewed as a whole, permitted only one reasonable interpretation: that all of claimant's hearing loss due to occupational exposure occurred before June 4, 1981; some of claimant's hearing loss was caused by non-work related factors, but that loss occurred before October 1991; and that claimant suffered no hearing loss after October 1991 or after he began to work for Sun Studs. Because no hearing loss occurred while claimant was employed by Sun Studs, the court ruled that SAIF/Sun Studs could not legally be the responsible employer, citing *Roseburg Forest Products v. Long*, 325 Or 305, 313 (1997). *SAIF v. Paxton*, 154 Or App at 265.

Finally, SAIF/Woolley requested a ruling that, if the court found that SAIF/Sun Studs was not responsible, then presumptive responsibility for claimant's occupational disease shifted to RLC Industries. However, the court rejected SAIF/Woolley's request, concluding that the issue was not before it to decide. Noting that the only order before the court was the second Order on Reconsideration, and that the order did not decide whether responsibility shifted to RLC if Sun Studs was not the responsible employer, the court remanded to us for further consideration.

Based on the court's decision, SAIF/Sun Studs has established that it was impossible for it to have contributed to or caused claimant's hearing loss. Thus, responsibility shifts to RLC. As we concluded in our February 29, 1996 order (a conclusion echoed by the court), the preponderance of the medical evidence establishes that the sole cause of claimant's occupational hearing loss was his work exposure before June 4, 1981. Because RLC was on the risk for six months of that time (from January to June 1981), we find that RLC failed to meet its burden under the sole cause or impossibility tests to shift responsibility to SAIF/Woolley. Consequently, we again find RLC responsible for claimant's hearing loss claim.

Accordingly, on remand, as supplemented herein, we republish our February 29, 1996 order. However, we again withdraw the attorney fee for services on Board review awarded in that order, because claimant's attorney did not file a brief with the Board. Moreover, as noted in our May 22, 1996 reconsideration order, the ALJ awarded a $2,800 attorney fee for services at hearing, whereas the Board's February 29, 1996 order referred to a $2,500 award. We, therefore, again modify the February 29, 1996 order to award $2,800, payable by RLC.

IT IS SO ORDERED.

In the Matter of the Compensation of
DIANN C. RICHARDS, Claimant
WCB Case No. 97-05381
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) upheld the insurer's denial of her intraoccular left lens dislocation/subluxation; and (2) upheld the insurer's denial of her myofascial pain syndrome. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation concerning the claim for myofascial pain syndrome.

Claimant was injured at work on September 11, 1996, when she attempted to sit down on a chair that rolled out from under her and she fell to the floor. She experienced some discomfort in her upper back, but was able to continue working. A few days later, however, she noted a considerable increase in her back pain while transferring patients. She sought emergency treatment and was diagnosed with lumbar and thoracic strains. On September 30, 1996, she began treating with Dr. Swena. In December 1996, the insurer accepted disabling lumbosacral and thoracic strains.

In early January 1997, claimant complained of worsening upper back pain despite conservative treatment. Dr. Swena referred her to Dr. Mundall, a neurologist. Meanwhile, on January 7, 1997, claimant was examined by Drs. Pettee and Snodgrass at the insurer's request. Drs. Pettee and Snodgrass diagnosed "ill-defined upper dorsal pain, etiology not apparent; possible early mild carpal tunnel syndrome; and functional overlay." (Ex. 26-5). They further found no objective findings to support claimant's upper back symptoms. (Ex. 26-6).

Three weeks later, when claimant was seen by Dr. Mundall, she was complaining of neck and upper thoracic pain (as well as symptoms of carpal tunnel syndrome). Dr. Mundall noted mild tenderness in the upper thoracic back, and diagnosed chronic lower cervical ligamentous pain, without any objective evidence of radicular involvement, and right carpal tunnel syndrome. (Ex. 34-3). Dr. Swena concurred with Dr. Mundall's assessment that claimant's symptoms were consistent with ligamentous pain. He also agreed with Drs. Pettee and Snodgrass that she had no objective neurologic changes. (Ex. 40).

In March 1997, claimant saw Dr. Englander, who noted that claimant's complaints remained the same, *i.e.*, pain in the upper thoracic region left of midline. Dr. Englander concluded that claimant had a soft tissue problem, with no evidence of nerve involvement. (Ex. 48). Claimant continued to complain of pain in the upper neck and thoracic spine in May 1997, after her bilateral carpal tunnel surgeries. (Ex. 33).

In August 1997, Dr. Swena diagnosed "chronic myofascial pain syndrome" secondary to the back strains incurred in September 1996. (Ex. 59). He noted that claimant had muscular pain from the cervical to the lumbar area, but that the primary problem was just to the right of the mid-thoracic spine. He also reported that claimant had "localized tender trigger points" of the paraspinal muscles. *Id.*

Seven months later, in March 1998, claimant was examined by Dr. Woodward. At that time, her primary complaints were spinal and extremity pain. Dr. Woodward noted limited spinal ranges of motion and tenderness along the thoracic spine, but concluded that claimant had no objective findings that would support an orthopedic diagnosis. Dr. Woodward further found that the strains claimant sustained in September 1996 likely resolved within three months without permanent impairment and that her present symptoms were not related to the September 1996 injury. (Ex. 61-10).

At hearing, claimant contended that her accepted lumbar and thoracic strains led to a consequential condition of myofascial pain syndrome. The ALJ found that claimant's ongoing complaints of ligamentous pain were not compensable due to a lack of objective findings. Alternatively, the ALJ concluded that claimant failed to show that her alleged myofascial pain syndrome was a distinct condition from the accepted thoracic and lumbar strains or that her recent symptoms were caused in major part by her September 1996 injury.

On review, claimant renews her contention that she has established a compensable consequential condition of myofascial pain syndrome. Claimant further argues that, insofar as Dr. Woodward documented reduced spinal motion, she has established objective findings. As set forth below, we need not decide whether claimant has established objective findings related to her chronic myofascial pain because, even if she has, we are not persuaded by a preponderance of the evidence that her current chronic pain condition is caused, in major part, by her compensable injuries.

Under ORS 656.005(7)(a)(A), when a worker contends that his or her current condition is a consequence of an compensable injury, the worker must prove that the compensable injury was the major contributing cause of the consequential condition. *See, e.g., Albany General Hospital v. Gasperino*, 113 Or App 411 (1992). In determining the "major contributing cause," the persuasive medical opinion must evaluate the relative contribution of the different causes and explain why one condition, activity or exposure contributes more to the claimed condition than all other causes or exposures combined. *See Dietz v. Ramuda*, 130 Or App 397 (1994) (the "precipitating" or immediate cause of an injury may or may not be the "major contributing cause"). Furthermore, where, as here, the medical evidence concerning causation is divided, we generally give more weight to those opinions that are well-reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263 (1986).

Although Dr. Swena has opined that the major cause of claimant's myofascial pain syndrome was the strains sustained in September 1996, he has provided no explanation or analysis for this conclusion. Dr. Woodward, on the other hand, opined that claimant's ongoing symptoms are not related to her September 11, 1996 injury. Dr. Woodward explained that the strains sustained in the September 1996 incident likely resolved within three months, and that her ongoing pain complaints could not reasonably be attributed to her compensable injury. Similarly, only four months after claimant's September 1996 injury, Drs. Pettee and Snodgrass opined that her compensable injury did not cause permanent impairment and was not the major contributing cause of her then-present complaints. Drs. Pettee and Snodgrass diagnosed ill-defined upper dorsal pain of unknown etiology.

After considering the above expert medical evidence, we find Dr. Swena's conclusory opinion insufficient to outweigh the contrary assessments of Drs. Woodward, Pettee and Snodgrass. *See Moe v. Ceiling Systems*, 44 Or App 429, 433 (1980) (conclusory and unexplained medical opinion rejected). Consequently, we agree with the ALJ that claimant has failed to prove that her September 1996 compensable injury is the major contributing cause of her current disability or need for treatment for her myofascial pain syndrome.

ORDER

The ALJ's order dated May 15, 1998, as corrected May 20, 1998, is affirmed.

In the Matter of the Compensation of
BARBARA J. OWENS-BOOKER, Claimant
WCB Case No. 97-03624
ORDER ON REVIEW
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Podnar's order dismissing claimant's request for hearing. On review, the issue is the propriety of the dismissal.

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

Claimant, through counsel, filed a request for hearing contesting the self-insured employer's January 21, 1997 denial. Claimant failed to appear at the hearing as initially scheduled because of transportation problems, and the hearing did not convene as rescheduled because of pending settlement negotiations. Claimant's counsel then informed the Board that he had lost contact with claimant and was withdrawing as counsel. The employer moved for dismissal of the hearing request under OAR 438-006-0071(1), which authorizes the dismissal of a hearing request if an ALJ finds that the party that requested the hearing has abandoned that request or has engaged in conduct that has resulted in an

unjustified delay in the hearing of more than sixty (60) days. The ALJ issued a May 4, 1998, Order to Show Cause why the request for hearing should not be dismissed as abandoned or for an unjustified delay. When claimant did not respond to the show cause order, the ALJ issued an Order of Dismissal on May 21, 1998. Claimant, *pro se*, then filed this request for Board review of the dismissal order. However, claimant did not submit a brief on review or otherwise provide any reason that the ALJ should not have dismissed claimant's hearing request.

In light of these facts, we conclude that the ALJ's dismissal order was appropriate and should be affirmed.

ORDER

The ALJ's order dated May 21, 1998 is affirmed.

In the Matter of the Compensation of
CAROL B. SHEAFFER, Claimant
WCB Case No. 97-10372
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Michael Johnson's order that set aside its partial denial of claimant's cervical spondylosis condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the second paragraph on page 2, we delete the seventh sentence. On page 3, we change the first full sentence to read: "Dr. Bert diagnosed 'spondylosis probably previously existing aggravated by a cervical strain.' (Ex. 5)." We change the first full paragraph on page 3 to read as follows:

> "Claimant missed one day of work and returned to light duty work. (Tr. 14). She was on light duty until November 1997. (Tr. 14-15, 19-20). On April 2, 1997, the employer accepted a nondisabling claim for acute cervical sprain. (Ex. 9)."

On page 3, we replace the fifth full paragraph with the following:

> "On July 21, 1997, Dr. Bert reported that claimant was not improving and he discussed the possibility of surgery. He opined that claimant had preexisting arthritis at C6-7, but 'her work injury, by history, is the major factor bringing her to the need for more aggressive approach.' (Ex. 10)."

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt and affirm that portion of the ALJ's order that found that claimant's injury was the major contributing cause of her need for medical treatment.

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 May 6, 1998 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
JILL E. LAMPSON, Claimant
WCB Case No. 97-07547
ORDER ON REVIEW (REMANDING)
Gloria D. Schmidt, Claimant Attorney
Schwabe, et al, Defense Attorneys

Reviewed by the Board *en banc*.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Crumme's order that: (1) found that her claim was not prematurely closed; (2) declined to award temporary disability; and (3) affirmed an Order on Reconsideration that eliminated claimant's awards of 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of her left forearm and 2 percent (3.84 degrees) scheduled permanent disability for loss of use or function of the right arm (as granted by a Determination Order). In her appellate briefs, claimant requests that we remand the claim for an evaluation of her unscheduled permanent disability. On review, the issues are premature closure, temporary disability, scheduled and unscheduled permanent disability, and remand. We affirm in part, vacate in part, and remand in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Premature Claim Closure

We adopt and affirm the ALJ's reasoning and conclusions on this issue with the following supplementation.

The ALJ determined that claimant's accepted occupational disease claim for her right arm and neck conditions was not prematurely closed. In doing so, the ALJ relied on the medical opinion of Dr. Jewell, whom the ALJ determined to be claimant's attending physician and who declared claimant medically stationary as of January 8, 1997. On review, claimant contends that Dr. Karasek, not Dr. Jewell, was her attending physician for her cervical condition and that he never declared that condition medically stationary prior to the May 21, 1997 Determination Order which found claimant medically stationary on January 8, 1997. Thus, claimant asserts that her claim was prematurely closed. We disagree.

A claim may not be closed unless claimant's condition is medically stationary. "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). 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 May 21, 1997 Determination Order, considering claimant's condition at the time of closure and not subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980).

In this case, we agree with the ALJ that Dr. Jewell was the attending physician for claimant's cervical condition. Based on our *de novo* review of the medical record, we find that Dr. Jewell provided diagnosis, treatment and assessment of claimant's compensable conditions, including the cervical

condition. (Ex. 10-8). Although the record contains evidence that Dr. Jewell provided copies of his chart notes to Dr. Karasek, the record does not establish that Dr. Karasek was more involved than Dr. Jewell in the treatment of the cervical condition. Thus, we conclude that Dr. Jewell was the physician primarily responsible for treatment of claimant's compensable conditions, including the cervical condition. Therefore, Dr. Jewell was the attending physician. *See* ORS 656.005(12)(b).

However, the medically stationary issue does not turn on whether Dr. Jewell was the attending physician. As previously noted, we determine the medically stationary issue on the basis of competent medical evidence. Given Dr. Jewell's familiarity with claimant's compensable conditions, we find that his unrebutted opinion constitutes the most competent and persuasive opinion regarding claimant's medically stationary status. Thus, we affirm the ALJ's finding that the Determination Order did not prematurely close the claim.

Temporary Disability

We adopt and affirm the ALJ's reasoning and conclusions.

Scheduled Permanent Disability

We adopt and affirm the ALJ's reasoning and conclusions.

Unscheduled Permanent Disability

The ALJ declined to award unscheduled permanent disability because the record did not prove that claimant had permanent impairment in an unscheduled body part as a result of the compensable injury. Thus, the ALJ affirmed the Order on Reconsideration which did not award unscheduled permanent disability.

On review, claimant seeks remand because the reconsideration order never evaluated her accepted cervical condition. For the following reasons, we find that remand to the ALJ is appropriate.

To begin, it is necessary to recount the procedural background of the claim. Claimant, a dental hygienist, filed an occupational disease claim in November 1995 for numbness in the right hand and arm and aching in her neck, upper back and right arm. Dr. Cordes diagnosed bilateral carpal tunnel syndrome on December 15, 1995. The insurer issued a Notice of Claim Acceptance on January 9, 1996, indicating that the accepted condition was a nondisabling "right upper extremity/cervical strain." (Ex. 5).

Claimant sought treatment from Dr. Karasek in June 1996, but Dr. Jewell provided the bulk of claimant's treatment, beginning with claimant's first office visit on June 24, 1996. (Ex. 7). Dr. Jewell diagnosed upper extremity musculoskeletal pain, rule out cervical disc disease and mild carpal tunnel syndrome. Dr. Jewell performed a right carpal tunnel release on October 15, 1996. (Ex. 9).

On January 8, 1997, Dr. Jewell declared claimant medically stationary, noting that claimant's carpal tunnel and musculoskeletal pain were improved. (Ex. 10-3, 15). Dr. Jewell also indicated that claimant was capable of "full, unrestricted work activity." (Ex. 10-3).

The insurer accepted bilateral carpal tunnel as a disabling claim on February 6, 1997, the same day a prior ALJ set aside an alleged "de facto" denial of the bilateral carpal tunnel condition. (Ex. 12). In response to claimant's request for reclassification of the previously accepted right upper extremity/cervical strain portion of the claim, the ALJ reserved the issue for later hearing.

On May 21, 1997, the claim was closed by Determination Order which awarded 5 percent scheduled permanent disability for claimant's left wrist and 2 percent scheduled permanent disability for her right arm. Claimant requested reconsideration of the Determination Order on June 3, 1997, alleging, among other contentions, that her right upper extremity/cervical strain had not been evaluated. (Ex. 17-3). In a subsequent letter of June 19, 1997, claimant informed the Department that she never agreed that her neck condition was nondisabling and that she was entitled to have all of her accepted conditions rated for permanent disability. (Ex. 19).

On July 31, 1997, the insurer amended its acceptance to indicate that all three accepted conditions (right upper extremity, cervical strain and bilateral carpal tunnel syndrome) were classified as "disabling." (Ex. 20). Subsequently, Dr. Tearse conducted a medical arbiter's examination on August 22, 1997, but did not evaluate claimant's cervical area. An Order on Reconsideration issued on August 29, 1997. (Ex. 23). Only claimant's carpal tunnel condition was evaluated for permanent disability, with the order stating that an updated acceptance notice had been requested but not received. The Department declined to evaluate the right upper extremity/cervical condition on the ground that only "disabling" conditions are subject to reconsideration, and classification had not been contested within one year of the date of injury. Based on Dr. Tearse's arbiter's report, claimant's scheduled permanent disability was reduced to zero.

In letters to the Department dated September 3, 1997 and September 5, 1997, claimant enclosed a copy of the updated acceptance notice and requested that an arbiter's examination be scheduled to evaluate permanent disability in the right upper extremity and cervical areas. (Exs. 24, 25). The record does not contain a response from the Department. Claimant requested a hearing before the Board's Hearings Division on September 17, 1997.

The ALJ declined claimant's request for remand to the Department for further consideration of the permanent disability issue, finding no persuasive basis for remand. The ALJ then determined that claimant was not entitled to an award of unscheduled permanent disability, concluding that the record did not prove that claimant had permanent impairment in an unscheduled body part due to the compensable injury.

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. *See Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986).

In this case, we find a compelling basis for remand. The Department referred the claim to a medical arbiter on July 18, 1997, but only listed bilateral carpal tunnel as the accepted condition. (Ex. 19A-4). However, the insurer had accepted right upper extremity/cervical conditions on January 9, 1996. Moreover, the insurer had reclassified those conditions to "disabling" prior to the August 22, 1997 arbiter examination. For reasons not readily apparent, the Department had not received the insurer's updated acceptance notice reclassifying the claim prior to issuing its reconsideration order.[1] (Ex. 23-1).

After issuance of the reconsideration order, which expressly evaluated only claimant's bilateral carpal tunnel condition, claimant submitted the updated acceptance notice along with a request for an evaluation of the right upper extremity and cervical areas. The record does not contain any response from the Department to claimant's request for reconsideration of the reconsideration order.

Under these particular circumstances, we conclude that there is a compelling basis to remand. In *Juan Ramirez*, 49 Van Natta 2117 (1997), we remanded to the ALJ for deferral of the extent of permanent disability issue so that the parties could contact the Director to make arrangements for preparation and submission of a medical arbiter report. In *Ramirez*, the claimant had been unable to attend the originally scheduled medical arbiter examinations due to his incarceration. Finding that claimant was entitled to a medical arbiter's report, we found it necessary to fashion a remedy that accommodated the claimant's right to a medical arbiter's report and *Pacheco-Gonzalez v. SAIF*, 123 Or App 312 (1993), which held that we do not have authority to remand to the Director for consideration of an arbiter report. A remand to the ALJ for deferral of the extent of permanent disability issue, while the parties arranged for an arbiter's report, was our "best remedy."

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[1] The Department stated that only "disabling conditions" are subject to reconsideration. (Ex. 23-1). However, once the "claim" is rated as disabling (as it was in this case), all accepted conditions should be rated. There is no statutory restriction to "disabling conditions." As a practical matter, if a particular accepted condition is "nondisabling," there will likely be no impairment for that condition. However, there is no statutory authority to limit evaluation of conditions to only those classified as "disabling." In any event, we need not expressly rule on this issue because, even if conditions must be classified as "disabling," the accepted conditions in this case were so classified prior to the medical arbiter's examination and issuance of the reconsideration order. Thus, the cervical/upper extremity conditions should have been evaluated by the medical arbiter.

Similarly, in this case, we must also fashion a remedy that accommodates claimant's right to have all her compensable conditions rated for permanent disability, but also does not violate *Pacheco-Gonzalez*. Just as we did in *Ramirez*, we conclude that a remand to the ALJ for deferral of the extent of unscheduled permanent disability issue pending receipt of a medical arbiter's report pursuant to ORS 656.268(6)(e) is the best remedy.[2] The parties shall then be responsible for contacting the Director to make arrangements for preparation and submission of a medical arbiter's report to address the extent of unscheduled permanent disability. When the parties are ready to proceed to hearing on the extent of permanent disability issue, they shall contact ALJ Crumme. Thereafter, ALJ Crumme shall conduct further proceedings in any manner that achieves substantial justice.

ORDER

The ALJ's order dated February 17, 1998 is affirmed in part and vacated in part. That portion of the ALJ's order that declined to award unscheduled permanent is vacated. This portion of the case is remanded to ALJ Crumme for further proceedings consistent with this order. The remainder of the ALJ's order is affirmed.

[2] In remanding, we emphasize that, under these particular circumstances, when the Department expressly limited the medical arbiter's examination/report to less than all of the accepted conditions, it was as though there was no medical arbiter's report evaluating the "omitted" upper extremity/cervical conditions.

In the Matter of the Compensation of
JEFFREY S. CHAPMAN, Claimant
WCB Case No. C8-01995
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Doblie & Associates, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

On September 2, 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 CDA indicates that claimant has received a third party settlement in the amount of $90,000. The CDA further provides that, after the statutory distribution of attorney fees and costs, claimant received his statutory one-third share of the remaining $59,829.50 balance. Claimant's statutory share equaled $19,943.16. Of the remaining balance of $39,886.34, the CDA indicates that the carrier has agreed to accept $25,000 in satisfaction of its third party lien. Finally, the CDA provides that $8,000 of the remaining $14,886.33, constitutes consideration for the CDA.[1]

Although the CDA does not explicitly state the amount of the carrier's third party lien, we interpret the agreement as providing that the carrier's third party lien equals or exceeds the $39,886.34 balance of the third party settlement after the attorney fees and costs and claimant's statutory share are deducted. Under such circumstances, we find that the consideration for the CDA is the carrier's waiver of recovery of $8,000 of its third party lien.

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.

[1] The remaining $6,886.33 represents consideration for agreements that are not subject to our statutory authority under ORS 656.236. Inasmuch as the parties do not seek our approval of those agreements, neither the agreements nor their accompanying considerations has been evaluated in our review of this CDA.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
CINDY M. PENTURF, Claimant
WCB Case No. 97-03618
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Bock.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Herman's order that: (1) declined to award temporary disability from March 19, 1996 through March 11, 1997; and (2) denied her motion to "reopen" the evidentiary record.[1] On review, the issues are the ALJ's ruling and temporary disability. We reverse.

FINDINGS OF FACT

On February 27, 1996, claimant filed a claim for a back injury that allegedly occurred on January 27, 1996. The insurer initially denied the claim on March 19, 1996, but a prior ALJ set aside the denial on January 29, 1997. As a result of the ALJ's order, the insurer accepted a disabling lumbar strain on March 6, 1997.

On May 5, 1997, the claim was closed by Determination Order, which awarded 17 percent unscheduled permanent disability and temporary disability from February 5, 1996 through April 11, 1997. Claimant requested reconsideration on June 6, 1997, raising all issues listed on the Department's request for reconsideration form, including temporary disability. (Ex. 48-3). The insurer also requested reconsideration, raising permanent disability as an issue and enclosing an affidavit from the employer alleging that claimant's employment was terminated on March 19, 1996 for reasons other than the injury. (Ex. 50-3). The insurer's request for reconsideration indicated that the affidavit was submitted in regard to the permanent disability issue. (Ex. 50-1).

An Order on Reconsideration issued on August 28, 1997. It reduced claimant's permanent disability to zero, but otherwise affirmed the May 5, 1997 Determination Order.

On September 7, 1997, claimant requested a hearing, raising extent of permanent disability, failure to pay temporary disability, penalties, and attorney fees. The insurer cross-requested a hearing, raising the issue of an offset in the amount of $3,209.32. The insurer responded to claimant's hearing request by denying that claimant was entitled to permanent disability or penalties and attorney fees. In addition, the insurer requested that the Order on Reconsideration be affirmed.

CONCLUSIONS OF LAW AND OPINION

Prior to the scheduled hearing on January 28, 1998, the parties moved to have the matter decided based on the documentary record and written argument. (Opinion and Order p. 1). The ALJ granted the motion. Claimant's closing arguments addressed extent of permanent disability and the alleged overpayment of temporary disability. In response, the insurer presented argument on those

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[1] We note that the "Order" portion of the ALJ's Opinion and Order did not make an adjustment in the temporary disability award in the May 5, 1997 Determination Order that was affirmed by the August 28, 1997 Order on Reconsideration. However, the parties on review have interpreted the ALJ's order as having modified claimant's temporary disability award. In accordance with the parties' expectations, we have also interpreted the ALJ's order as having reduced claimant's award of temporary disability in the Determination Order as affirmed by the Order on Reconsideration.

issues, but also disputed claimant's entitlement to temporary disability from March 19, 1996 through March 11, 1997. The insurer alleged that claimant was not entitled to the disputed temporary disability because her employment had been terminated on March 19, 1996 for reasons unrelated to the injury. Claimant objected to consideration of the "new issue," arguing that it was not properly raised.

The ALJ rejected claimant's argument, concluding that the issue was raised as part of the offset issue cited in the insurer's response to issues. In addition, the ALJ reasoned that a party is free to amend issues up to the date of the "hearing," which the ALJ determined consisted of the written arguments submitted by the parties. *See* OAR 438-006-0031. Turning to the merits, the ALJ held that claimant was not entitled to the temporary disability in dispute, relying on the employer's unrebutted affidavit that claimant was terminated from employment on March 19, 1996 for reasons unrelated to the claim.

Claimant requested reconsideration of the ALJ's order, seeking either reversal of the ruling on the timeliness of the insurer's challenge to her entitlement to temporary disability or an order "reopening" of the record to present additional evidence. The ALJ again rejected claimant's arguments, finding that the merits of the temporary disability issue was before the Department in the reconsideration proceedings and that claimant had raised temporary disability as an issue in her opening brief. Thus, the ALJ reiterated that the insurer was entitled to argue the temporary disability issue. Moreover, according to the ALJ, claimant could have submitted additional records from the reconsideration record or moved to have the record reopened during written arguments. Therefore, the ALJ denied claimant's request to reopen the record.

On review, claimant contends that the ALJ incorrectly allowed the insurer to raise a "new issue" during written argument. We agree.

Prior to the date of the hearing, the parties moved to have the case tried on the record. The ALJ granted the motion. The only record of the issues to be tried is contained in the request for hearing and the insurer's response to issues.[2] While claimant raised the issue of failure to pay temporary disability, extent of permanent disability, penalties and attorney fees, the insurer denied claimant's allegations and specifically stated that the Order on Reconsideration (which would include its award of temporary disability) should be affirmed. As an issue on cross-appeal, the insurer asserted a right to an offset to an overpayment in the amount of $3,209.32.

It was not until the insurer submitted its closing argument that it raised the issue of claimant's entitlement to temporary disability from March 19, 1996 through April 11, 1997. It is well-settled, however, that an issue raised for the first time in closing argument will not be considered.[3] *Lawrence E. Millsap*, 46 Van Natta 2112, 2112-13 (1995) ("We have consistently held that we will not consider an issue raised for the first time during closing argument." (citations omitted)); *see also Felipe A. Rocha*, 44 Van Natta 797 (1992); *Leslie Thomas*, 44 Van Natta 200 (1992); *Karel L. Nelson*, 42 Van Natta 1206 (1990). Considering that the insurer specifically requested that the reconsideration order be affirmed, which would include the award of temporary disability from February 5, 1996 through April 11, 1997, we find that the insurer untimely raised the issue of claimant's entitlement to temporary disability after March 19, 1996.

We acknowledge that the insurer submitted an affidavit during the reconsideration proceedings which stated that claimant's employment was terminated for reasons unrelated to the injury. (Ex. 50-3). However, that affidavit was submitted in regard to the extent of permanent disability issue. (Ex. 50-1). We also recognize that the insurer did raise the matter of an offset in response to issues. However, the

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[2] To avoid misunderstandings regarding the issues to be litigated in cases where no "transcribed" hearing is held and the issues are submitted for a decision based on the documentary record and written argument, we strongly encourage litigants and the ALJ to clarify matters such as the issues in dispute prior to submission of closing argument.

[3] We acknowledge that the *Millsap/Thomas* holdings involved cases where the closing arguments were preceded by an in-person hearing. Nonetheless, where, as here, the parties elect to present their case based on the written record, we consider it appropriate to interpret the presentation of that record as the "hearing." In this way, the closing arguments (whether written or closing) will be treated in the same consistent manner, regardless of whether an "in-person" hearing was convened.

majority of the alleged offset was related to permanent disability. The portion allocated to temporary disability concerned March 12, 1997 through April 1, 1997 ($471.96). This alleged overpayment had nothing to do with claimant's entitlement to temporary disability from March 19, 1996 through March 11, 1997.[4]

Accordingly, under these particular circumstances, we find that the issue of claimant's entitlement to temporary disability was untimely raised and should not have been considered. Therefore, we reverse the ALJ's reduction of claimant's award of temporary disability.

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. In the event that compensation resulting from this order has already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed in *Jane A. Volk*, 46 Van Natta 681 (1994), *on recon* 46 Van Natta 1017 (1994), *aff'd on other grounds Volk v. America West Airlines*, 135 Or App 565 (1995), *rev den* 322 Or 645 (1996). However, the total "out-of-compensation" attorney fee granted by our order shall not exceed $3,800.

ORDER

The ALJ's order dated March 24, 1998, as reconsidered on April 27, 1998, is reversed in part and affirmed in part. That portion of the order that reduced claimant's award of temporary disability is reversed. The award of temporary disability in the Order on Reconsideration is reinstated and affirmed. Claimant's attorney is awarded 25 percent of any increased compensation created by this order, payable directly to claimant's counsel. In the event that this compensation has already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed in *Jane Volk*. 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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[4] The ALJ stated that the parties are free to amend issues up to the date of the hearing and, thus, that the insurer could raise the issue of claimant's entitlement to temporary disability from March 19, 1996 through March 11, 1997 in its written argument. While we agree that the Board's rule (OAR 438-006-0031) and relevant case law allows free amendment of issues, *see Sandra M. Goodson*, 50 Van Natta 1116, (1998), we do not interpret the "hearing" in this case as consisting of the written "arguments." Instead, we find that the "hearing" was the written record upon which this matter was submitted. Thus, when the insurer raised the issue of entitlement to temporary disability for the first time in its closing argument, and claimant objected to the timeliness of the issue, the ALJ should have sustained claimant's objection to consideration of the issue.

In the Matter of the Compensation of
SUSAN A. DORNBUSCH, Claimant
WCB Case No. 97-07951
ORDER ON REVIEW
Steinman & Cooper, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

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

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact, with the following correction. Although the ALJ's order refers to claimant's age as "nearly thirty," claimant was actually 39 years of age at the time of hearing.

CONCLUSIONS OF LAW AND OPINION

We adopt the ALJ's "Opinion and Conclusions," with the exception of the ALJ's conclusion that Dr. Peters' opinion was an "attribution of exclusion," and thus, did not satisfy claimant's burden of proof pursuant to ORS 656.266. Opinion and Order, pg. 3. Rather, we find that Dr. Peters relied on the nature of claimant's work activities (although we agree with the ALJ that his understanding of those duties was inaccurate), as well as excluding other causes. However, for the remaining reasons discussed in the ALJ's order, we agree that Dr. Peters' opinion is not persuasive and does not meet claimant's burden of proof.

ORDER

The ALJ's order dated May 20, 1998 is affirmed.

September 14, 1998 Cite as 50 Van Natta 1721 (1998)

In the Matter of the Compensation of
DAVID L. DYLAN (fka David H. Hubbard), Claimant
Own Motion No. 98-0189M
OWN MOTION ORDER REFERRING FOR CONSOLIDATED HEARING
Cole, Cary, et al, Claimant Attorneys
Ronald W. Atwood & Associates, Defense Attorneys

The Board has received claimant's letter stating that "the employer's 90 days to process the claim have expired." We treat claimant's submission as a request for own motion relief.[1]

Claimant's April 1990 low back injury claim was accepted by the employer as a disabling injury on May 21, 1990. The claim was closed by a January 16, 1991 Determination Order that awarded temporary disability only.

On November 30, 1995, Dr. Lewis, orthopedic surgeon, performed an excision of claimant's L5, L6 disc on the left (claimant's spine has six lumbar vertebrae). On January 10, 1996, Dr. Lewis submitted a Director's aggravation claim form on claimant's behalf. However, 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.

On March 13, 1996, the employer issued a denial that denied claimant's aggravation claim, his current condition, and his need for medical services. That denial was ultimately litigated through Board review. Regarding the aggravation denial, the Board determined that, because no accompanying attending physician's report establishing that claimant suffered a worsened condition attributable to the compensable injury was submitted to the carrier within five years of the first closure of the claim, claimant failed to perfect a timely aggravation claim. Therefore, the Board concluded that it did not have jurisdiction to address the merits of claimant's aggravation claim. *David L. Dylan*, 50 Van Natta at 278. Thus, claimant's claim is within the Board's own motion jurisdiction.

However, the Board determined that it retained jurisdiction over the parties' dispute regarding compensability of claimant's current condition and medical services. Regarding those issues, the Board determined that claimant failed to prove the compensability of his disability and need for surgery in 1995. *David L. Dylan*, 50 Van Natta at 853.

Subsequently, on March 21, 1997, claimant underwent surgery to his L6-S1 disc space. It is this surgery that is the basis of the own motion claim currently before us.

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[1] Notwithstanding claimant's prior requests for own motion relief and the Board's May 12, 1998 letter seeking information, Willamette Industries, Inc., the self-insured employer in this case, has neither submitted an Own Motion Recommendation Form nor any supporting evidence as required by OAR 438-012-0020 and 438-012-0030. Because our record is scant, we provide the following background from our earlier decision. *See David L. Dylan (fka David H. Hubbard)*, 50 Van Natta 276, *on recon* 50 Van Natta 852 (1998).

On May 29, 1997, claimant sent a letter to the employer's attorney requesting workers' compensation benefits for the 1997 L6-S1 surgery. Receiving no response from the employer, on April 29, 1998, claimant petitioned the Board in its own motion jurisdiction for additional compensation under ORS 656.278 regarding the 1997 surgery. A copy of that petition was sent to the employer's attorney. In addition, on April 21, 1998, as amended on April 27, 1998, claimant submitted a request for hearing raising the following issues: (1) a "de facto" partial denial; (2) "[u]nreasonable refusal to process [a] claim and pay compensation as demanded in [a] May 29, 1997 to the employer's attorney;" and (3) penalties and attorney fees. That hearing request is presently pending before the Hearings Division. (WCB Case No. 98-03148).

Because claimant's aggravation rights regarding his 1990 back injury claim have expired, any additional compensation regarding the 1997 L6-S1 surgery as it relates to the 1990 back injury claim, falls under the Board's own motion jurisdiction pursuant to ORS 656.278. However, issues regarding compensability of claimant's current condition and need for treatment are within the jurisdiction of the Board's Hearing Division.

As litigation is pending regarding the compensability of claimant's current need for medical treatment, including the 1997 surgery, we conclude that it would be in the best interest of the parties to consolidate this own motion matter with the pending litigation.

At the consolidated hearing, if claimant's current condition and need for treatment is found to be causally related to the compensable injury, the assigned Administrative Law Judge (ALJ) shall make findings of fact and conclusions of law and opinion on the following issues: (1) the employer's failure to provide the required own motion recommendation; (2) claimant's request for penalties regarding the employer's failure to process his own motion claim; and (3) whether claimant was in the work force at the time claimant's condition worsened. *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990); *Dawkins v. Pacific Motor Trucking*, 308 Or 245, 258 (1989).

At the conclusion of the hearing, the ALJ shall forward to the Board a separate, unappealable recommendation with respect to the own motion matter and a copy of the appealable order issued in WCB Case No. 98-03148. 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
CLYDE E. KOSTRZEWSKI, Claimant
WCB Case No. C8-01671
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Bottini, et al, Claimant Attorneys
Ronald W. Atwood & Associates, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

On July 22, 1998, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for his compensable injury. We disapprove the proposed disposition.

On July 30, 1998, the Board wrote the parties noting that the agreement listed medical bills for unidentified (and possibly unaccepted) conditions. The Board's letter further noted that the agreement provided that the employer would pay the "audited" amount of the bills on a diagnostic basis. Noting that the "medical bill" provision could be interpreted as a limitation on claimant's rights to medical

services and that the function of a CDA was not to accomplish claim processing functions or resolve compensability issues, the Board's letter requested that the "medical bill" provision be removed from the agreement.[1]

Pursuant to OAR 438-009-0020(4)(b), the Board may disapprove the agreement as unreasonable as a matter of law if the deficiency noted in the Board's addendum letter is not corrected within 21 days. To date, the parties have not submitted the addendum as requested on July 29, 1998. Under the circumstances, we disapprove the proposed disposition as unreasonable as a matter of law. *See* OAR 438-009-0020(4)(b).

Inasmuch as the proposed disposition has been disapproved, the self-insured employer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-060-0150(4)(i) and (6)(e).

Should the parties wish to comply with our prior addendum letter, they may move for reconsideration. However, to do so, that motion for reconsideration must be filed within 10 days of the date of mailing of this order. OAR 438-09-035(1).

IT IS SO ORDERED.

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[1] The letter also pointed out that other procedural avenues were available to the parties for accomplishing claim processing objectives or settling compensability issues such as stipulations or disputed claim settlements. *See Frederick M. Peterson*, 43 Van Natta 1067 (1991).

In the Matter of the Compensation of
JAMES A. PERKINS, Claimant
Own Motion No. 66-0444M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Saif Corp Legal, Defense Attorney

Claimant requests review of the SAIF Corporation's June 30, 1998 Notice of Closure which closed his claim with an award of temporary disability compensation from December 9, 1997 through April 15, 1998. SAIF declared claimant medically stationary as of April 15, 1998. Claimant challenges SAIF's decision to "cut-off [his] benefit money." We interpret claimant's contention to be that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the June 30, 1998 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980).

In a July 31, 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 August 5, 1998, however, no further response has been received from claimant. Therefore, we will proceed with our review.

On April 15, 1998, claimant was examined by claimant's treating physician, Dr. Butler. He stated that "[claimant] has made about as much gain in his physical therapy as feasible.*** I don't think that more physical therapy is appropriate at this time, nor do I think that exploration of the knee would

add anything to the clinical picture. *** We will recheck him only on an annual basis." Furthermore, by letter dated June 10, 1998, Dr. Butler concurred that claimant was medically stationary as of April 15, 1998 and that no further treatment or improvement was expected. These opinions are unrebutted.[1]

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 SAIF's closure was proper.

Accordingly, we affirm SAIF's June 30, 1998 Notice of Closure in its entirety.

IT IS SO ORDERED.

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[1] In his request for review, claimant questions how SAIF could "cut-off" benefits "without someone from the State to see me." There are no statutory requirements for the "State" to see a worker before benefits can be terminated. In this case, the medical record establishes that claimant's condition was medically stationary at the time of closure. As he has done, claimant is entitled to request review of the carrier's decision to close his own motion claim. The request then causes the "State" i.e. the Board to review the closure and determine whether his benefits were properly terminated.

In the Matter of the Compensation of
JASON L. WINNETT, Claimant
WCB Case No. 98-01940
ORDER OF ABATEMENT
Meyers, Radler, et al, Defense Attorneys

Claimant, *pro se*, has requested reconsideration of our August 14, 1998 order that dismissed his request for Board review. Contending that he was misinformed regarding the procedure for requesting Board review, claimant seeks reconsideration of our order.

In order to allow sufficient time to consider claimant's request, we withdraw our August 14, 1998 Order of Dismissal. The self-insured employer is granted 14 days from the date of this order to submit a response. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
LINDA R. BAROCIO, Claimant
WCB Case Nos. 98-01494 & 98-00212
ORDER ON REVIEW (REMANDING)
Vick & Conroyd, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl, Bock, and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Myzak's order that upheld the SAIF Corporation's denial of claimant's right knee condition claim. In her brief, claimant also moves to remand the case to the ALJ. On review, the issues are remand and compensability. We remand.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

In her briefs on review, claimant asks that we remand the case to the ALJ for consideration of additional evidence generated after the hearing. In support of the motion, claimant provides reports showing that her treating orthopedic surgeon, Dr. Nonweiler, scheduled claimant for right knee surgery and that the surgery revealed a tear in the medial meniscus of the right knee. Claimant contends that such evidence provides a compelling reason to remand.

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 reasons 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).

Here, the evidence concerning claimant's surgery concerns claimant's disability and, because the surgery was performed after the hearing and revealed a new condition, was not obtainable at the time of the hearing. Furthermore, we find that such evidence is reasonably likely to affect the outcome.

The record developed at hearing contained two opinions concerning causation. Examining orthopedic surgeon, Dr. Vessely, thought that a preexisting condition was the major contributing cause of claimant's need for treatment of the right knee while Dr. Nonweiler, although conceding some contribution from the preexisting condition, attributed the need for treatment to claimant's work activities. Both physicians, however, rendered their opinions before the surgery; another document submitted by claimant on review indicates that Dr. Nonweiler considered the medial meniscus tear to be acute and probably no older than six months and that claimant's preexisting condition would not have contributed to the tear.

Inasmuch as neither physician provided an opinion based on the existence of an acute tear and such condition apparently caused Dr. Nonweiler to reconsider his opinion concerning claimant's need for treatment, we find that the evidence of the surgery is reasonably likely to affect the outcome.[1] Thus, we grant claimant's motion for remand. Inasmuch as we are remanding, we need not address the compensability issue.

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[1] Although we concede that, as noted by the dissent, Dr. Nonweiler also indicated that the meniscal tear "may have" been caused by claimant's work activities, we do not think this statement alone should decide the remand issue. Instead, we consider the discovery of the tear, and its effect on Dr. Nonweiler's opinion concerning contribution from the preexisting condition, to provide a sufficient showing of a reasonable likelihood of a changed outcome. In this regard, if the record shows that a preexisting condition did not contribute to the need for treatment, claimant's burden of proof may be reduced. In other words, we consider it more appropriate to allow the parties an opportunity to further develop the record concerning the medical opinions in light of the newly discovered knee condition.

Accordingly, the ALJ's order dated April 27, 1998 is vacated. This matter is remanded to ALJ Myzak for further proceedings consistent with this order. Following these further proceedings, ALJ Myzak shall issue a final, appealable order.

IT IS SO ORDERED.

Board Member Haynes dissenting.

I disagree with the majority that this claim should be remanded based on evidence of claimant's post-hearing right knee surgery. Although the surgery did reveal a condition that apparently had not been diagnosed until the surgery, the letter submitted by claimant's attorney containing Dr. Nonweiler's opinion also states: "It was your medical opinion to a reasonable degree of medical probability, based on the history as related to you and your surgical findings, specifically the acute appearance of the medial meniscus tear, that the medial meniscus tear may have occurred during the course of her squatting activities" while working on November 18, 1997.[1]

By stating that claimant's work activities "may have" occurred during her squatting activities, I would find that the submitted letter indicates only a possibility that claimant's work was the major contributing cause of any right medial meniscus tear. As such, it is not sufficient to prove compensability, whether under a major or material contributing cause standard. Consequently, I fail to understand how admission of the additional evidence submitted by claimant on review creates a reasonable likelihood of a changed outcome.

For these reasons, I would affirm the ALJ's order and deny claimant's motion for remand.

[1] The letter as originally drafted did not include the words "may have"; those words were added by hand, followed by Dr. Nonweiler's initials.

In the Matter of the Compensation of
SUSAN SCHWARTZ, Claimant
WCB Case No. 97-08602
ORDER ON REVIEW
Glenn M. Feest, Claimant Attorney
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Otto's order that: (1) declined to award "procedural" temporary disability; and (2) did not award a penalty-related attorney fee for the insurer's allegedly unreasonable claim processing. On review, the issues are temporary disability, penalties and attorney fees. We modify in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," but offer the following summary of the relevant facts which also contains additional findings. In June 1994, claimant developed left arm complaints for which she filed an occupational disease claim. The insurer denied the compensability of the claim on February 24, 1995. On June 19, 1995, a prior ALJ upheld the insurer's denial. We reversed the ALJ's order on February 15, 1996 and remanded the claim to the insurer for processing in accordance with law. *Susan Schwartz*, 48 Van Natta 346 (1996). The insurer requested appellate review by the Court of Appeals, but did not pay temporary disability pending its appeal. On March 12, 1997, the court affirmed our order without opinion. (Ex. 2).

On June 25, 1997, the insurer began seeking information regarding claimant's entitlement to temporary disability from the date of its February 24, 1995 denial to the date of the appellate judgment. (Ex. 3). On October 22, 1997, claimant requested a hearing, raising the issue of "procedural" entitlement to temporary disability from June 14, 1994 through September 2, 1997, penalties, and attorney fees. On January 23, 1998 (after the January 21, 1998 hearing, but before the ALJ's order issued), the insurer issued a Notice of Closure, which awarded temporary partial disability for the period from September 11, 1994 through April 9, 1996. (Ex. 12A).

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant sought an award of temporary disability commencing October 20, 1994. Rejecting claimant's request for an award of "procedural" temporary disability, the ALJ determined that the January 23, 1998 Notice of Closure had substantively determined claimant's entitlement to temporary disability. Thus, the ALJ held that the Hearings Division did not have authority to award such benefits under *Gerald F. Jaensch*, 50 Van Natta 66 (1998). In light of the insurer's stipulation that it unreasonably failed to calculate temporary disability and to timely close her claim, the ALJ assessed a 25 percent penalty pursuant to ORS 656.262(11). The ALJ, however, declined to award a separate attorney fee under ORS 656.382(1), reasoning that misconduct subject to a penalty under ORS 656.262(11) could not be the basis for an attorney fee award under ORS 656.382(1).

On review, citing *Victor Robles*, 48 Van Natta 1174 (1996), claimant contends that the ALJ should have awarded temporary disability from February 15, 1996 (the date of the Board's prior order) to January 23, 1998 (the date of claim closure) because ORS 656.313 required that temporary disability be paid pending the insurer's appeal of our order.[1] Claimant also asserts that he is entitled to penalties based on the insurer's failure to pay temporary disability during the above period and a separate attorney fee award under ORS 656.382(1) for the insurer's failure to close the claim in a timely manner.

Temporary Disability

In *Daniel W. Garris*, 50 Van Natta 941 (1998), we reviewed the relevant court cases regarding the distinction between "procedural" and "substantive" temporary disability benefits. In particular, we noted that the court in *Atchley v. GTE Metal Erectors*, 149 Or App 581, 585, *rev den* 326 Or 133 (1997), had continued to recognize the distinction between procedural and substantive benefits and had explained that "the general distinction between a substantive and procedural entitlement is that a substantive benefit is one that is made explicit and unconditional by statute, while a procedural benefit is conditional, arising solely from the vagaries of claim processing."

We further noted in *Garris* two other cases, *Roseburg Forest Products v. McDonald*, 116 Or App 448 (1992), and *Anodizing, Inc. v. Heath*, 129 Or App 352 (1994). In *Roseburg Forest Products* the court held that, because the claimant's right to temporary disability benefits during the pendency of appeal arose directly from an earlier version of ORS 656.313(1), his entitlement to such benefits was unconditional, and payment was required regardless of the outcome of the appeal. In *Anodizing, Inc.*, the court held that, because the current version of ORS 656.313(1)(a)(A) unconditionally entitles a claimant to temporary disability benefits that accrue during the pendency of an appeal, a claimant is entitled to those benefits regardless of the outcome of the appeal.

In accordance with the court's reasoning in *Roseburg Forest Products* and *Anodizing, Inc.*, 656.313(1)(a)(A) unconditionally entitles claimant in this case to temporary disability benefits that accrue during the pendency of an appeal. Claimant is entitled to those benefits regardless of the outcome of the appeal. Thus, claimant's benefits are "substantive" because they were made explicit and unconditional by ORS 656.313(1).[2]

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[1] ORS 656.313 provides, in part:

"(1)(a) Filing by an employer or the insurer of a request for hearing on a reconsideration order or a request for board review or court appeal stays payment of the compensation appealed, except for:

"(A) Temporary disability benefits that accrue from the date of the order appealed from until closure under ORS 656.268, or until the order appealed from is itself reversed, whichever event first occurs; and

"(B) Permanent total disability benefits that accrue from the date of the order, appealed from until the order appealed from is reversed."

[2] We have recently suggested that temporary disability paid pursuant to ORS 656.313(1)(a)(A) is "procedural." *See Gregory C. Noble*, 50 Van Natta 1575 (1998). However, unlike this case, the claim in *Noble* had not been closed. Moreover, *Noble* is consistent with the principle of this case that the Board can address the issue of temporary disability payments under ORS 656.313(1)(a)(A).

However, based on our reasoning in *Victor Robles*, we conclude that claimant is not precluded from seeking an ALJ order awarding those benefits, even though the claim was closed following his hearing request. In *Robles*, a prior ALJ found that the claimant's claim had been prematurely closed, set aside a Determination Order and an Order on Reconsideration, and remanded the claim to the insurer for processing. Thereafter, the insurer issued a Notice of Closure, awarding claimant temporary partial and temporary total disability. Citing *Lebanon Plywood v. Seiber*, 113 Or App 561 (1992), the ALJ found that it was "premature" to address the claimant's entitlement to a specific period of temporary disability benefits or to determine the degree of the claimant's temporary disability (total or partial), reasoning that such issues should first be raised with the Department pursuant to ORS 656.268. We reversed.

We reasoned that, pursuant to ORS 656.313(1)(a)(A), a carrier has a statutory obligation to pay temporary disability benefits that accrue from the date of an appealed reconsideration order. Moreover, we noted that a carrier is required to pay the temporary disability benefits that accrue during the pendency of the appeal, regardless of the outcome of the appeal. Therefore, we determined that, once the insurer appealed the prior ALJ 's order, it was required under the statute to resume paying the claimant temporary disability benefits accruing from the date of the order until such time as the claim was closed under ORS 656.268. We reasoned that, notwithstanding the insurer's appeal, the prior ALJ's order was effective and enforceable when it issued. *See Theodore W. Lincicum*, 40 Van Natta 1953, 1955 (1988), *aff'd mem Astoria Oil Service v. Lincicum*, 100 Or App 100 (1990). Although the insurer subsequently closed the claimant's claim, we concluded that the claim closure did not relieve the insurer of its obligation to pay benefits from the date of ALJ's order until it closed the claimant's claim. *Robles*, 48 Van Natta at 1175.

Like the carrier in *Robles*, pursuant to ORS 656.313(1)(a)(A), the insurer in this case had a statutory obligation to pay temporary disability benefits that accrued from the date of our order reversing the prior ALJ's order. It was required under the statute to resume paying the claimant temporary disability benefits accruing from the date of the order until such time as the claim was closed under ORS 656.268. Notwithstanding the insurer's appeal, our prior order was effective and enforceable when it issued. In accordance with our reasoning in *Robles*, we conclude that claimant is entitled to temporary disability during the disputed period, notwithstanding the fact that the claim was closed on January 23, 1998, when claimant's substantive benefits were initially determined.

Our decision is consistent with *Alfredo Martinez*, 49 Van Natta 67, 68 n. 1 (1997), where we stated that procedural temporary disability benefits that are owing pursuant to ORS 656.313 may be awarded regardless of whether or not a claimant's claim has been closed. We also emphasized in *Martinez* that *Seiber* prohibits creation of an overpayment of temporary disability benefits. 49 Van Natta at 69. However, we note that no overpayment is created by our order because claimant was substantively entitled to temporary disability benefits that accrued pending appeal of the ALJ's order, regardless of the outcome of that appeal. *See Roseburg Forest Products*, 116 Or App at 451, and *Anodizing, Inc.*, 129 Or App at 357.

We are mindful of *Gerald F. Jaensch.* In that case, we held that, because the claimant's entitlement to temporary disability benefits for the time period granted by the ALJ had been substantively determined by a final Order on Reconsideration, the Board was without authority to award procedural temporary disability benefits for the same time period. 50 Van Natta at 68. However, we do not find *Jaensch* controlling because it did not concern payment of temporary disability pending appeal pursuant to ORS 656.313.

Accordingly, because the ALJ determined that claimant must proceed with the reconsideration process in order to assert entitlement to the disputed temporary disability, and because we have held otherwise, we reverse.

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).

Penalties and Attorney Fees

Although satisfied with the ALJ's award of a 25 percent penalty pursuant to ORS 656.262(11), claimant also seeks a separate attorney fee under ORS 656.382(1). For the following reasons, we find that claimant is entitled to an attorney fee under that statute.

ORS 656.382(1) authorizes the assessment of an attorney fee if an insurer unreasonably resists the payment of compensation, provided that there are no amounts of compensation then due upon which to base a penalty or the unreasonable resistance is not the same conduct for which a penalty has been assessed under ORS 656.262(11). *Corona v. Pacific Resource Recycling*, 125 Or App 47 (1993); *Oliver v. Norstar, Inc.*, 116 Or App 333 (1993); *Martinez v. Dallas Nursing Home*, 114 Or App 453, *rev den* 315 Or 271 (1992).

Here, we agree with the ALJ's determination that the insurer's conduct in failing to calculate temporary disability and timely close the claim amounted to "unreasonable resistance to the payment of compensation." There are amounts due, but the ALJ already assessed a penalty on those amounts pursuant to ORS 656.262(11). We cannot assess another penalty on the same amount of compensation. However, a separate attorney fee award under ORS 656.382(1) may be granted for separate unreasonable conduct that relates to a different factual basis. *See, e.g., Oliver v. Norstar, Inc.*, 116 Or App at 336. Accordingly, since the insurer's conduct of unreasonably failing to calculate temporary disability and to timely close the claim constituted separate acts of unreasonable resistance to the payment of compensation, relating to different factual bases, we find that claimant is entitled to penalty-related attorney fees assessed under ORS 656.382(1). *See Lucille G. Major*, 47 Van Natta 617, 619 (1995) (where a penalty was already assessed on amounts due, an attorney fee under ORS 656.382(1) was assessed for separate unreasonable conduct).

After 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 unreasonable failure to timely close the claim 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.

ORDER

The ALJ's order dated February 19, 1998, as reconsidered on March 13, 1998, is modified in part, reversed in part, and affirmed in part. That portion of the order that declined to award temporary disability is modified. Claimant is awarded temporary disability from February 15, 1996 through January 23, 1998, less any temporary disability paid for this period. 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 addition, the portion of the order that declined to award an assessed fee pursuant to ORS 656.382(1) is reversed. Claimant is awarded an assessed fee of $500, to be paid by the insurer to claimant's attorney. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
CINDY K. CHRISTIAN, Claimant
WCB Case No. 97-10260
ORDER ON REVIEW
Linerud Law Firm, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that found that claimant's new occupational disease claim for carpal tunnel syndrome (CTS) and bilateral ulnar nerve conditions was barred by a Claim Disposition Agreement (CDA) regarding a prior accepted claim. On review, the issue is whether the CDA barred claimant's occupational disease claim.

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

Claimant asserts that her CTS and elbow conditions were caused by her repetitive work for the employer and are distinct from (and not a consequence of) her January 1996 neck injury. We find to the contrary.

ORS 656.236(1)(a) expressly provides that a CDA resolves all matters concerning the claim (except medical services) regardless of the conditions stated in the agreement. *See Jeffrey B. Trevitts*, 46 Van Natta 1767 (1994), *aff'd Trevitts v. Hoffman-Marnolejo*, 138 Or App 455 (1996) (the parties' CDA pertained to the claim as a whole and disposed of all conditions arising from claimant's compensable injury, not just the conditions listed in the agreement). Therefore, to the extent the medical evidence establishes claimant's current CTS and elbow conditions are the same conditions which were treated and diagnosed in connection with her January 10, 1996 claim, her occupational disease claim is barred by ORS 656. 236(1)(a). *See D&D Company v. Kaufman*, 139 Or App 459 (1996).

On January 10, 1996, claimant completed an 801 form identifying her neck *and arms* as the body parts affected. She reported a date of injury of January 4, 1996, and explained that she had been working on the french fry sorter and had washed off the belt to push the product through, and could not move her neck the next day. (Ex. 1). Dr. Dahl, who treated claimant on January 10, 1996, noted that claimant complained of neck pain as well as pain going down her right shoulder and into the hand, along with numbness and tingling in the hand. (Ex. 2). Thereafter, when he examined her on February 28, 1996, Dr. Dahl again noted claimant's complaints of pain in the arms, shoulder, wrist and elbows (Ex. 15). On March 5, 1996, claimant saw Dr. Lindholm, who found a positive Tinel's at the right elbow, and suspected ulnar nerve entrapment and mild CTS. (Ex. 16). Subsequent nerve studies confirmed this diagnosis. (Ex. 17, 17A).

On March 23, 1996, claimant was examined by Drs. Thomas and Wilson, who also found positive Tinel's and Phalen's test results on claimant's right arm, but diagnosed only a cervical strain based upon pain to palpation of the cervical paraspinal muscles and right trapezius and rhomboids. (Ex. 19). By mid-April 1996, claimant's major complaint was right arm numbness, along with neck and shoulder pain. She continued to relate her problems to her work activity in January. (Ex. 23). Due to her persistent neck, shoulder and arm pain, claimant stopped working for the employer on April 22, 1996. At that time, her doctor raised the possibility of thoracic outlet syndrome. (Ex. 23)

On August 23, 1996, the Board approved the parties' CDA, which covered "all compensable condition(s) and consequences arising out of the injurious exposure of January 4, 1996." By this time the employer had accepted a cervical strain. (Ex. 27-2).

On January 8, 1997, claimant returned for treatment of neck and arm pain, again relating her symptoms to her work activity on January 4, 1996. (Ex. 28). Dr. Lewis suspected C7 radiculopathy. (Ex. 28-4). Thereafter, on January 28, 1997, claimant was seen by Dr. Borman, who diagnosed chronic bilateral shoulder strain, cervical strain/sprain and thoracic strain/sprain. (Ex 31).

In October 1997, claimant completed a second 801, alleging an October 16, 1997 injury involving her arms and hands, even though she had stopped working for the employer in April 1996. Around this same time, she was also seen by Dr. Meier who, in a "check the box" letter, opined that claimant's CTS and elbow conditions were due to her repetitive work activity at the cannery. (Ex. 46). Dr. Meier also relied on Dr. Lindholm's nerve study results from March 1996 and recommended that claimant be evaluated by an orthopedic surgeon. (Ex. 46-3).

In December 1997, the insurer accepted claimant's right CTS and bilateral elbow conditions as part of her January 1996 claim. In January 1998, claimant was seen by another physician who noted that she had been having problems with her arms since 1996, when she injured her right arm pushing french fries off the production line. (Ex. 52-1). This doctor diagnosed "documented ulnar neuropathy of both elbows and mild CTS of the right wrist."

Considering the above medical evidence, we agree with the ALJ that claimant's current elbow and CTS conditions are the same conditions that were diagnosed and treated in connection with her January 1996 claim. Indeed, even claimant has consistently related the onset of these symptoms to her work activity on January 4, 1996 (*see, e.g.*, Exs. 23, 28, 52). The only evidence even suggesting the contrary is Dr. Meier's opinion that these conditions are due to "several years of performing repetitive work as a cannery worker," but this opinion is lacking in foundation, explanation and analysis and is therefore not persuasive.[1] On the other hand, none of the other doctors who treated and evaluated

[1] For example, Dr. Meier does not specifically address the mechanics of January 1996 incident nor explain why claimant's elbow and CTS conditions are separate and distinct from the claimed injury. In addition, Dr. Meier admits that he is not an expert in this area.

claimant in the first half of 1996 (*i.e.*, Drs. Dahl, Lindholm, Thomas and Wilson) gave any indication that claimant's arm complaints were unrelated to her work activity on January 4, 1996.

Consequently, the record establishes that claimant's CTS and ulnar nerve entrapment conditions were part of her claim for "neck and arm" pain arising out of her work activity on January 4, 1996. These conditions were therefore resolved by the parties' CDA. Insofar as the record also establishes that claimant's current CTS and ulnar nerve condition are the same conditions encompassed by the CDA, her subsequent occupational disease claim is barred pursuant to ORS 656.236(1)(a). *D&D Company v. Kaufman*, 139 Or App at 463.

ORDER

The ALJ's order dated April 10, 1998 is affirmed.

September 17, 1998 Cite as 50 Van Natta 1731 (1998)

In the Matter of the Compensation of
PAUL D. FIELD, Claimant
WCB Case No. 96-04437
ORDER ON REVIEW
Debbe Stein, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Livesley's order that dismissed his request for hearing regarding a Director's Order of Dismissal concerning claimant's request for reconsideration on the ground that it was untimely filed. On review, the issue is the propriety of the ALJ's dismissal order.

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

The ALJ concluded that claimant's request for hearing was untimely, also noting that there is no statutory provision excusing a late filing of a request for hearing on an Order of Reconsideration. Citing ORS 656.319(1)(b), claimant contends that he had good cause for his untimely request for hearing. The insurer contends that the "good cause" argument available through ORS 656.319 is not applicable to this case. We agree with the insurer.

ORS 656.319(1) establishes the time within which a hearing must be requested with respect to a claimant's objection to a *denial for a claim for compensation under ORS 656.262*. Moreover, ORS 656.319(2) and (3), which allow a hearing after the appeal period specified in ORS 656.319(1) if a claimant can show lack of mental competency, also refer to a hearing regarding a denial for a claim for compensation under ORS 656.262.

The issue in this case is the time within which a hearing must be requested if a party *objects to a reconsideration order under ORS 656.268*. This issue is governed by ORS 656.319(4), which provides for a 30-day appeal period. As noted by the ALJ, there is no provision for establishing "good cause" for untimely filing of a hearing request on an order on reconsideration. Consequently, because claimant's request for reconsideration was "deemed denied" as of January 6, 1996,[1] and claimant failed to request a hearing within 30 days of that date, claimant's hearing request was untimely and the ALJ properly dismissed the request for hearing. ORS 656.268(6)(d); 656.268(6)(f); *Jenny L. Boydston*, 50 Van Natta 691 (1998); *Cheryl A. Caldwell*, 49 Van Natta 1356 (1997).

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[1] Claimant's request for reconsideration was received by the Department on October 12, 1995. (Ex. R24). Eighteen working days from that date is November 7, 1995. Sixty calendar days from that date is January 6, 1996. Claimant's request for hearing was received on May 8, 1996, more than 30 days after January 6, 1996.

ORDER

The ALJ's order dated March 25, 1998 is affirmed.

In the Matter of the Compensation of
WILEY J. FORD, Claimant
Own Motion No. 97-0264M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
SAIF Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's July 30, 1998 Notice of Closure which closed his claim with an award of temporary disability compensation from June 11, 1997 through June 15, 1998. SAIF declared claimant medically stationary as of June 15, 1998. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the July 30, 1998 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980).

In an August 11, 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 August 13, 1998, however, no further response has been received from claimant. Therefore, we will proceed with our review.

On May 27, 1998, claimant was examined by claimant's treating physician, Dr. Eilers. He stated in a letter dated May 29, 1998 that "I am not going to do anything further for [claimant]. I don't think that there is anything that I have that is curative. It is all palliative at this point in time. I think he maintains medical stability." On July 29, 1998, Dr. Eilers submitted his responses to SAIF's July 27, 1998 letter wherein he concurred that claimant had reached medically stationary status on June 15, 1998. These 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 SAIF's closure was proper.

Accordingly, we affirm SAIF's July 30, 1998 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
RONALD D. FULLER, Claimant
Own Motion No. 96-0503M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Pozzi, Wilson, et al, Claimant Attorneys
Rick Dawson (Saif), Defense Attorney

Claimant previously requested reconsideration of our November 7, 1996 Own Motion Order in which we declined to reopen his 1983 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. Because a permanent total disability (PTD) issue was pending before the Hearings Division, we reasoned the decision in that matter may have an effect on claimant's "Own Motion" request. On December 13, 1996, we issued an order on reconsideration consolidating the own motion matter with the hearing and postponed action pending resolution of the aforementioned matter.

On August 4, 1997, Administrative Law Judge (ALJ) Crummé issued an order that: (1) found that a Determination Order was procedurally invalid (that disallowed claimant's PTD award); and (2) reinstated claimant's PTD benefits. SAIF requested review of ALJ Crumme's August 4, 1997 order. On May 28, 1998, we affirmed the "PTD" decision. Following reconsideration, on July 28, 1998, we continued to find that the Determination Order was procedurally invalid and that claimant was entitled to PTD benefits.

Having summarized the procedural history of this claim, we turn to claimant's current request for Own Motion relief.

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).

Here, we found the Determination Order which reversed claimant's permanent total disability award invalid. Thus, it follows that claimant was considered to be in the work force because he was unable to work due to a compensable injury. *William L. Halbrook*, 46 Van Natta 79 (1994). However, because claimant was found to be permanently totally disabled and is entitled to receive payments for that disability, then he cannot at the same time be temporarily totally disabled. *SAIF v. Grover*, 152 Or App 476 (1998). Under these circumstances, no temporary disability benefits are due for the worsening of his compensable condition.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our November 7, 1996 order, as reconsidered on December 13, 1996, in its entirety. The parties' rights of appeal and reconsideration shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT M. HADWEN, Claimant
Own Motion No. 98-0206M
OWN MOTION ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our May 28, 1998 Own Motion Order in which we declined to reopen his 1974 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 June 25, 1998, we abated our May 28, 1998 order, and allowed the SAIF Corporation 14 days in which to file a response to the motion. Having received SAIF's 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). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. *Id.* Claimant underwent surgery on May 13, 1998. Thus, we conclude 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).

We have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction,[1] is the date he enters the hospital for the proposed surgery. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). The relevant time period for which claimant must establish he was in the work force is the time prior to his May 13, 1998 hospitalization, 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 contends that he qualifies for temporary disability compensation because he was participating in an employment development program sponsored by Adult and Family Services (AFS), which is required to qualify for food stamps. Claimant has the burden of proof on this issue, and must provide persuasive evidence that he was in the work force at the time of disability.

Claimant provided an Employment Development Plan dated January 12, 1998. The plan outlined a program wherein claimant was to accomplish certain job search requirements in order to keep his Food Stamp benefits. In claimant's affidavit, he attests that in attempting to comply with the plan's requirements, he was registered to work with Cardinal Employment Services and had attended interviews with them on January 26 and February 3, 1998. However, claimant also attests that he was unable to continue with the program due to pain resulting from his compensable condition. On April 1, 1998, claimant's food stamp benefits were "closed" due to his non compliance with the Employment Development Plan.

We have previously found that a claimant who qualifies for unemployment benefits has met the second criterion of the *Dawkins* standards, in that the receipt of unemployment benefits establishes *prima facie* evidence that claimant was willing to work and was making reasonable efforts to obtain employment. *See Carol L. Conaway*, 43 Van Natta 2267 (1991); *John T. Seiber*, 43 Van Natta 136 (1991). Likewise, we have found an analogous conclusion can be reached regarding the "willing and seeking" requirements necessary to obtain AFS benefits. *Michelle Zamarron*, 49 Van Natta 577 (1997).

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

As noted above, claimant must show that he was in the work force prior to his May 13, 1998 surgery. Claimant had signed up for AFS benefits in January of 1998. He did not complete the interview process and discontinued his job search in February of 1998, because of pain in his right knee. Although claimant asserts that he sought treatment with Dr. Hayes in February of 1998, the medical documentation contained in the file, demonstrate his first return visit to Dr. Hayes since 1996, was on March 30, 1998, a full month after he discontinued his job search program due to "pain his right knee." Further, claimant's AFS benefits were cut off effective April 1, 1998 for his failure to complete the assigned work search, six weeks prior to his surgery on May 13, 1998. Thus, based on this record, we are not persuaded that claimant participated in the job search program in a manner which would demonstrate that he was "willing and seeking" work at the time of his current disability.

Further, claimant does not provide medical documentation supporting his affidavit nor does he submit a medical opinion supporting his contentions. The record does not contain medical evidence that claimant was taken off work in February 1998 due to his compensable injury. Further, the medical documentation contained in the record fails to establish that claimant was unable to work and that it would have been futile for him to seek work due to his compensable condition.

Accordingly, our May 28, 1998 order is abated and withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our May 28, 1998 order in its entirety. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
INGRID A. HANSEN, Claimant
WCB Case No. 97-10118
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Employers Defense Counsel, Defense Attorney

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Black's order that affirmed an Order on Reconsideration that awarded 35 percent (52.5 degrees) scheduled permanent disability for loss of use or function of the left forearm. Claimant cross-requests review of that portion of the ALJ's order that awarded a $1,800 attorney fee pursuant to ORS 656.382(2). On review, the issues are extent of scheduled permanent disability and attorney fees.

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

Claimant compensably injured her left hand/wrist on January 30, 1996. The claim was closed by a September 3, 1997 Notice of Closure that awarded 16 percent (24 degrees) scheduled permanent disability. An Order on Reconsideration dated November 25, 1997 increased claimant's scheduled award to 35 percent (52.5 degrees). The Order on Reconsideration award included impairment for the radial median and ulnar nerves, an award for loss of range of motion and an award for a chronic condition limiting repetitive use of the forearm. The ALJ affirmed the Order on Reconsideration.

On review, the insurer argues that the ALJ erred in affirming an award based on an impairment value for loss of strength pursuant to OAR 436-035-0110(8)(a) (WCD Admin. Order 96-072), where there was no evidence of an impaired peripheral nerve or a weakened muscle. In addition, the insurer argues that the Department's rule rates nerve impairment three times by giving a separate award for each potentially involved nerve.

To determine impairment due to loss of strength, the physician reports the worker's strength using a 0 to 5 grading system, which is converted into a percentage value pursuant to OAR 436-035-0007(18)(a). Loss of strength in the forearm or hand is valued *as if* the peripheral nerve innervating the weakened muscle(s) was impaired. OAR 436-035-0110(8)(a). The table at OAR 436-035-0110(8) provides the maximum percentage impairment values for each peripheral nerve in the upper extremity. After

identifying the peripheral nerve(s) involved, the percentage of loss of strength is multiplied by the maximum percent impairment allowed for the identified nerve(s). OAR 436-035-0110(8). If multiple nerves have impairment findings, those impairment values are combined. OAR 436-035-0007(20).

Contrary to the insurer's argument, OAR 436-035-0110(8)(a) does not require that a loss of strength be due to peripheral nerve injury. Rather, that rule states, in relevant part: "(a) Valid loss of strength in the arm, forearm or hand, substantiated by clinical findings, shall be valued *as if the peripheral nerve supplying (innervating) the weakened muscle(s) was impaired,* pursuant to this section." (Emphasis added). Thus, we agree with the ALJ that the Order on Reconsideration correctly made an award pursuant to OAR 436-035-0110(8)(a) for claimant's loss of strength.

In addition, the standards take into account that more than one nerve may be implicated in the strength loss. In this case, Dr. Butters identified three nerves that were involved in claimant's loss of strength. OAR 436-035-0007(20) provides that if multiple nerves have impairment findings, those impairment values are combined. Because multiple nerves were identified, the Order on Reconsideration correctly rated and combined the impairment attributable to each nerve. Thus, we reject the insurer's argument that claimant was triply compensated for a single nerve impairment.

Finally, in her cross-appeal, claimant argues that the attorney fee awarded by the ALJ under ORS 656.382(2) was insufficient because it was less than claimant's attorney would have received if the fee had been an out-of-compensation fee rather than an assessed fee. Claimant argues that, had the insurer succeeded in obtaining a reduction in the Order on Reconsideration award, she would have been entitled to an out-of-compensation attorney fee which could have been more than the assessed attorney fee awarded by the ALJ. On this basis, claimant seeks an attorney fee equal to 25 percent of the compensation at risk by virtue of the insurer's appeal of the Order on Reconsideration.

There is no rule or statute requiring an ORS 656.382(2) fee to be equivalent to an out-of-compensation attorney fee based on increased compensation and awarded pursuant to ORS 656.386(2) and OAR 438-015-0040(1). Rather, we determine the amount of a reasonable attorney fee for claimant's counsel's services at the hearing by applying the factors set forth in OAR 438-015-0010(4) to the circumstances of each case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

The issue in dispute was the extent of scheduled permanent disability for claimant's left forearm. Approximately 21 exhibits were received into evidence. Approximately four of the exhibits were generated or submitted by claimant's counsel. The matter was submitted on the record with written closing arguments. There was no formal hearing. Claimant's attorney submitted four pages of closing argument. The value of the interest involved and the benefit secured for claimant was the value of the additional 19 percent scheduled permanent disability awarded by the Order on Reconsideration. The parties' attorneys were skilled and presented their positions in a thorough, well-reasoned manner. No frivolous issues or defenses were presented. Finally, considering the conflicting legal arguments, there was a modest risk that claimant's counsel's efforts might go uncompensated. Considering all these factors, we find that $1,800 is a reasonable fee for claimant's counsel's services at hearing concerning the extent of scheduled permanent disability.

Claimant's attorney is also 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 scheduled permanent disability issue is $1,200, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review concerning the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated April 24, 1998 is affirmed. For services on Board review, claimant's attorney is awarded $1,200, payable by the insurer.

In the Matter of the Compensation of
THOMAS R. HERRINGTON, Claimant
WCB Case No. 98-00058
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) declined to award scheduled permanent disability; and (2) affirmed an Order on Reconsideration which affirmed a Notice of Closure's award of 29 percent (92.8 degrees) unscheduled permanent disability. On review, the issue is scheduled permanent disability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant sought an award of scheduled permanent disability based on a "chronic condition" limiting repetitive use of his forearms allegedly as a result of his compensable neck injury. The ALJ declined to make such an award, concluding that scheduled permanent disability for a "chronic condition" could not be granted in the absence of an accepted claim for injury to the hands.

On review, claimant contends that the ALJ incorrectly held that scheduled permanent disability cannot be awarded in a case of injury to an unscheduled body part. Moreover, claimant asserts that the impairment questionnaire supplied by his attending physician, Dr. Molitor, provides a sufficient basis for a bilateral chronic condition award for his forearms. In response, the insurer concedes that the ALJ's legal analysis was incorrect,[1] but argues that the medical record, nevertheless, does not support the "chronic condition" award claimant seeks. We agree with the insurer.

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 438-010-0010; OAR 436-035-0003(2). Here, the claim was closed by an October 3, 1997 Notice of Closure. Therefore, the applicable standards are found at WCD Admin. Order 96-072.

Claimant has the burden of proving the extent of his permanent disability. ORS 656.266. ORS 656.726(3)(f)(B) provides that "[i]mpairment is established by a preponderance of medical evidence based upon objective findings." Furthermore, with the exception of a medical arbiter, findings concerning a claimant's impairment can be made only by the attending physician at the time of claim closure or other physicians with whom the attending physician agrees. ORS 656.245(2)(b)(B); *Roseburg Forest Products v. Owen*, 129 Or App 442 (1995); *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, 670 (1994); *Dennis E. Conner*, 43 Van Natta 2799 (1991).

OAR 436-035-0010 provides, in relevant part:

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

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[1] We agree. *See Foster v. SAIF*, 259 Or 86 (1971); *Danny L. Fernandez*, 50 Van Natta 501, 502 (1998) (affirming ALJ's award of scheduled "chronic condition" impairment in arms in a case involving accepted injuries to neck, thoracic spine and right trapezius).

Here, no medical arbiter's examination occurred. The only medical evidence regarding potential scheduled permanent disability is provided by Dr. Molitor, the attending physician. That evidence consists of an impairment questionnaire in which Dr. Molitor responded "yes" when asked if claimant had a chronic and permanent medical condition significantly limiting repetitive use of his forearms with respect to pinching and grasping. (Ex. 26-10).

However, impairment must be based on "objective findings." ORS 656.726(3)(f)(B). As of the December 4, 1997 examination that provided the basis for Dr. Molitor's responses to the impairment questionnaire, Dr. Molitor indicated that claimant's strength and sensory findings in his arms and hands were normal. (Ex. 26: ppgs. 2-9). Nor does that report reference any other findings in support of a limitation on claimant's ability to repetitively pinch and grasp. Therefore, we agree with the insurer that there are no "objective findings" documented in the impairment questionnaire to support a chronic condition award based on Dr. Molitor's unexplained response to the "chronic" condition inquiry.

As objective evidence of impairment, claimant cites to Dr. Molitor's September 21, 1997 report that indicated that sensory testing showed decreased two-point sensory discrimination. (Ex. 21). However, we rely on Dr. Molitor's most recent examination on December 4, 1997, as it is much closer in time to the December 17, 1997 Order on Reconsideration. As of the date of that examination, claimant's sensory findings were reported as normal. Therefore, we conclude that there are no "objective findings" to support a bilateral scheduled chronic condition award.

Accordingly, while we disagree with the ALJ's reasoning in declining claimant's request for an award of scheduled permanent disability, we agree with his ultimate conclusion. Thus, we affirm.

ORDER

The ALJ's order dated April 16, 1998 is affirmed.

In the Matter of the Compensation of
DARYL D. McCLURE, Deceased, Claimant
WCB Case No. 97-05597
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by the Board *en banc*.

The self-insured employer requests review of Administrative Law Judge (ALJ) Nichols' order that set aside its denial of the deceased worker's widow's (claimant's) claim for death benefits.[1] On review, the issue is death benefits. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Decedent was compensably injured in 1976 and was granted permanent total disability status on July 6, 1981. (Ex. 3). Decedent and claimant had been married since 1965. (Ex. A). In 1996, decedent and claimant began having serious problems with their marriage that eventually culminated in claimant filing for divorce. In early November 1996, claimant left the family residence in Arizona and went to visit a friend in Florida. While she was in Florida, decedent, accompanied by his son, sought treatment at an emergency room for emotional problems. (Exs. 81, 85, 87). The medical records indicate that decedent was troubled because his wife was leaving him. (*Id.*)

[1] Although claimant filed a cross-request for review, she did not raise any additional issues in her brief.

After claimant returned to Arizona, the parties were unable to resolve their differences and claimant went to an attorney to file for divorce. Claimant testified that the parties had worked out the terms of the divorce and they had separated accounts. (Tr. 32-37). Decedent wrote a note to claimant telling her he could not live without her, and he committed suicide on December 30, 1996. (Exs. 88, 88A, 92). At the time of his death, decedent was receiving permanent total disability benefits.

Claimant contends she is entitled to receive widow's benefits. At the time of decedent's death, the record establishes that decedent's physical problems due to the compensable injury were under control. Based on the information decedent gave to medical care providers and his suicide note, decedent's emotional problems were apparently due to the breakup of his marriage.

Claimant relies on ORS 656.208(1) to establish her entitlement to benefits. That statute provides:

> "If the injured worker dies during the period of permanent total disability, *whatever the cause of death*, leaving a spouse or any dependents listed in ORS 656.204, payment shall be made in the same manner and in the same amounts as provided in ORS 656.204." (Emphasis added).

On the other hand, the employer argues that ORS 656.156 controls and claimant is not entitled to an award of benefits. ORS 656.156(1) provides:

> "If injury or death results to a worker from the deliberate intention of the worker to produce such injury or death, neither the worker nor the widow, widower, child or dependent of the worker *shall receive any payment whatsoever* under this chapter." (Emphasis added).

Based on the facts of this case, both statutes could arguably be applicable. Decedent died during a period of permanent total disability and his death resulted from his deliberate intention to produce such death.

We agree with the ALJ that there was no evidence that decedent's suicide was the result of an irresistable impulse or complete lack of understanding of the consequences of his act. *Compare McGill v. SAIF*, 81 Or App 210, *rev den* 302 Or 461 (1986) (the decedent was suffering from a compensable occupational depressive disorder that caused a mental derangement that rendered him incapable of forming a deliberate intent to commit suicide; ORS 656.156(1) did not apply).

The ALJ found *Ahn v. Frito-Lay, Inc.*, 91 Or App 443, *rev den* 306 Or 661(1988), instructive in resolving this case. In *Ahn*, the worker was suffering from an injury-related emotional condition at the time she committed suicide. However, the court found that the medical evidence did not establish any relationship between the worker's emotional disturbance and her inability to resist the compulsion to take her own life. The court concluded that the beneficiaries were not entitled to benefits because the worker's death was a result of a deliberate intention to commit suicide. 91 Or App at 446. The carrier also argued that the beneficiaries were precluded by ORS 656.156(1) from recovering any benefits at all, including those not attributable to the suicide. The court held that ORS 656.156(1) applied only to benefits for injury or death resulting from the deliberate act. *Id.* at 447. Although the beneficiaries were not entitled to benefits for the worker's deliberate suicide, the court cited ORS 656.218(1)[2] and concluded the beneficiaries were still entitled to benefits related to the worker's compensable shoulder and psychiatric conditions. *Id.*

In the present case, the ALJ relied on the *Ahn* case and reasoned that the limitation in ORS 656.156(1) did not apply to all benefits. Rather, it applied only to those benefits that arise because of the act of the injured worker in taking his or her life. The ALJ determined that neither decedent nor his beneficiary (claimant) received any additional benefits, not previously determined, because of decedent's suicide. The ALJ read ORS 656.208(1) and ORS 656.156(1) consistent with the *Ahn* case and determined that claimant was entitled to benefits.

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[2] ORS 656.218(1), which pertains to continuance of permanent partial disability payments to survivors, provides:

> "In case of the death of a worker entitled to compensation, whether eligibility therefor or the amount thereof have been determined, payments shall be made for the period during which the worker, if surviving, would have been entitled thereto."

Although we agree with the ALJ's conclusion, we do so based on the following reasoning.

In construing ORS 656.156(1) and ORS 656.208(1), our task is to discern legislative intent. ORS 174.020. We begin by examining the text and context of the statutes. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610 (1993). The context includes other provisions of the same statute and other related statutes. *Id.* at 611. We utilize rules of construction that bear directly on the interpretation of the statutory provision in context, such as the statutory mandate that "a particular intent shall control a general one that is inconsistent with it." ORS 174.020.

As we discussed earlier, both ORS 656.208(1) and 656.156(1) could arguably apply to this case because decedent died during a period of permanent total disability and his death resulted from his deliberate intention to produce such death. ORS 656.208(1) provides that a spouse is entitled to benefits if the "injured worker dies during the period of permanent total disability, *whatever the cause of death*[.]" Under ORS 656.156(1), a widow shall not receive any benefits if the death to a worker results from the "deliberate intention of the worker" to produce such death. However, ORS 656.156(1) is not an absolute bar to recovery of benefits of death due to suicide. *McGill v. SAIF*, 81 Or App at 213.

One rule of statutory construction is expressed in ORS 174.020, which provides:

> "In the construction of a statute the intention of the legislature is to be pursued if possible; and when a general and particular provision are inconsistent, the latter is paramount to the former. So a particular intent shall control a general one that is inconsistent with it."

The Supreme Court has restated that rule as follows:

> "[W]here there is a conflict between two statutes, both of which would otherwise have equal force and effect, and the provisions of one are particular, special and specific in their directions, and those of the other are general in their terms, the special provisions must prevail over the general provisions[.]" *Smith v. Multnomah County Board of Commissioners*, 318 Or 302, 309 (1994) (quoting *State v. Preston*, 103 Or 631, 637 (1922)).

In such a case, the specific statute is considered an exception to the general statute. 318 Or at 309.

Here, ORS 656.156(1) applies generally to situations in which an injury or death results to a worker from the deliberate intention of the worker to produce such injury or death. On the other hand, ORS 656.208(1) is the more specific statute and applies only to situations involving a death of worker who dies during a period of permanent total disability. Application of each provision would lead to a different result. The inconsistency between the general statute, ORS 656.156(1), and the specific statute, ORS 656.208(1), leads us to conclude that the specific provision of ORS 656.208(1) should control. *See* ORS 174.020; *Smith v. Multnomah County Board of Commissioners*, 318 Or at 309-10. Therefore, we conclude that ORS 656.208(1) provides an exception to the general rule in ORS 656.156(1) that a beneficiary shall not receive any benefits if the death to a worker results from the "deliberate intention of the worker" to produce such death.

This conclusion is consistent with another rule of statutory construction that provides that when two statutes are wholly irreconcilable, the legislature's later enactment usually prevails. *Harris v. Craig*, 299 Or 12, 15 n 1 (1985); *Pioneer Trust Bank v. Mental Health Division*, 87 Or App 132, 136 (1987). Here, ORS 656.156 was last amended in 1965. Or Laws 1965, ch 285, section 20. ORS 656.208, however, has been amended several times since 1965, the most recent of which was in 1985. Or Laws 1985, ch 108, section 2. Because the legislature's later enactment was ORS 656.208, we conclude that that statute should prevail over ORS 656.156.

The employer argues that, as a policy matter, the ALJ came to the wrong conclusion by awarding benefits. That argument is best addressed to the legislature. For the foregoing reasons, we agree with the ALJ that claimant is entitled to receive widow's benefits.

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 $100, 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" urging the adoption of the ALJ's order), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated March 6, 1998 is affirmed. For services on review, claimant's attorney is entitled to $100, payable by the self-insured employer.

Board Member Moller specially concurring.

I am compelled to agree with the conclusion reached in the majority opinion. I write separately because my analysis differs somewhat from that of the majority and in order to address the employer's comment that the drafters most likely did not even consider ORS 656.156 when drafting ORS 656.208, but might well have clarified it to exempt the award of benefits in this fact situation.

Relying on the text and context of the statutory provisions in question, the majority concludes that claimant is entitled to receive widow's benefits under ORS 656.208, in the same manner and in the same amounts as provided in ORS 656.204. The majority relies on rules of statutory construction to arrive at this conclusion. Although I agree that the rules of statutory construction cited and discussed in the majority opinion are properly considered in determining legislative intent and arguably support the majority's conclusion, I believe that, in this instance, the plain meaning of the text of the statutory provisions is dispositive. *See Portland General Elec. Co. v. Bureau of Labor and Industries*, 317 Or 606 (1993).

In this regard, ORS 656.156(1) generally disqualifies a claimant from receipt of benefits for a worker's death if such death results from a specific cause, *i.e.*, the worker's deliberate intention. ORS 656.208, on the other hand, provides for a claimant to receive certain benefits for a permanently totally disabled worker's death "whatever the cause of death" might be. I would conclude that the plain meaning of the all-inclusive language of ORS 656.208 permits no exception to the receipt of benefits "whatever the cause of death." In other words, the prohibition contained in ORS 656.156(1) on receipt of benefits for self-inflicted deaths is, in card game parlance, "trumped" by the unqualified language of ORS 656.208.

To the extent that resort to rules of statutory construction is helpful, reference to the provision immediately following ORS 656.156 further supports this conclusion. ORS 656.160 also contains a prohibition on the receipt of benefits to which a claimant would otherwise be entitled. In the case of ORS 656.160, the prohibition arises when an injured worker is incarcerated for the commission of a crime. However, unlike ORS 656.156, the prohibition in ORS 656.160 is prefaced with the clause "[n]otwithstanding any other provision of this chapter". No such language appears in ORS 656.156(1). If such language were to appear in ORS 656.156(1), then I would conclude that the prohibition in that provision prevails over the contrary language in ORS 656.208. *See Wright v. Professional Services Industries, Inc.*, 153 Or App 102, (1998) (statute prefaced with clause "[n]otwithstanding any other provision of the law" applies regardless of what any other statute may say to the contrary). The absence of such language in ORS 656.156 further compels me to conclude that irrespective of the provisions of that statute, claimant in this case is entitled to recover the contested benefits. *See* ORS 174.010 (In construing a statute, we may not insert what has been omitted by the legislature, nor omit what has been inserted.).

On review, the employer also argues that permitting claimant to recover benefits here contravenes policy considerations apparent in ORS 656.156 and inherent in other provisions of the statutes. The employer may be correct that, under the facts of this case, the legislature might conclude that policy considerations weigh against a recovery of benefits by claimant.[1] However, in construing a statute or statutes, we are not at liberty either to ignore that language or to improve on it to effectuate

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[1] In light of ORS 656.156, I have no doubt that the legislature did not wish to adopt laws that might encourage an otherwise healthy worker to deliberately injure or kill themselves while in the course and scope of employment in order to obtain workers' compensation benefits. I am less confident, however, in concluding that the legislature might not consider it sound public policy to provide continuing benefits to the family of a deceased permanently totally disabled worker even when the worker's death results from his deliberate intention. I note, in this regard, that with the exception of self-inflicted death, the employer does not contest that ORS 656.208 generally allows a widow's recovery of benefits even when the cause of death is unrelated to the compensable injury. Regardless, I believe this is a matter best left to legislative clarification if our conclusion is inconsistent with legislative policy.

what we may speculate the legislature may have intended. *See, e.g., State v. Vasquez-Rubio*, 323 Or 275, 283, (1996) (courts lack authority to "rewrit[e] a clear statute based solely on our conjecture that the legislature could not have intended a particular result.").

For these reasons, I concur with the majority that claimant is entitled to recover benefits for the death of the deceased injured worker.

Board Chair Bock and Board Member Haynes dissenting.

The majority concludes that claimant is entitled to death benefits, despite the language of ORS 656.156(1), which clearly prohibits such an award. For the following reasons, we respectfully dissent.

Based on ORS 656.156, 656.204 and 656.208, we conclude that claimant is *not* entitled to death benefits because decedent's death was the result of a deliberate intention to commit suicide. One maxim of statutory construction is that we attempt to construe the language of the statute in a manner consistent with its purposes. *Welliver Welding Works v. Farmen*, 133 Or App 203, 210 (1995). ORS 656.208(1) provides that if a worker dies during a period of permanent total disability, "whatever the cause of death," the worker's beneficiaries are entitled to benefits "in the same manner and in the same amounts as provided in ORS 656.204." Thus, ORS 656.208 reflects a general legislative policy that beneficiaries under ORS 656.208 should be treated equally as beneficiaries of workers who die from compensable injuries or diseases under ORS 656.204. Under ORS 656.156(1), beneficiaries under ORS 656.204 are not entitled to benefits where the worker's death resulted from his or her "deliberate intent" to cause it.

Nevertheless, based on the majority's interpretation, a beneficiary under ORS 656.208 will receive an entitlement far greater than a beneficiary would under ORS 656.204. That conclusion is inconsistent with the language in ORS 656.208(1) that benefits under ORS 656.208 and ORS 656.204 are to be "in the same manner and in the same amounts[.]" That provision provides a condition that must be fulfilled before a worker's beneficiaries are entitled to benefits. We agree with the employer that ORS 656.156 provides a specific prohibition that applies *equally* to beneficiaries under ORS 656.204 and 656.208.

ORS 656.156(1) states a specific and absolute prohibition on "any payment whatsoever under this chapter[,]" where such payment arises out of an injury or death caused by the worker's deliberate intent. The statute specifically refers to the worker's "widow, widower, child or dependent," indicating that they shall not "receive any payment whatsoever under this chapter." We conclude that ORS 656.156(1) is an exception that must be read into each of the statutes, including ORS 656.204 and ORS 656.208, that otherwise would create an entitlement to payment "under this chapter." In other words, under ORS 656.156(1), the legislature has specifically exempted from the definition of eligible "beneficiaries" those widows, widowers or dependents of injured workers who have committed suicide. Under those circumstances, ORS 656.005(2)(a) provides that those beneficiaries are not among those deemed to be "entitled to receive payments under this chapter."

For the foregoing reasons, we dissent from the majority's opinion. We agree with the employer that, because decedent's death resulted from his deliberate intention to produce such death, claimant is not entitled to an award of benefits pursuant to ORS 656.156(1).

In the Matter of the Compensation of
CAROL OCHS, Claimant
Own Motion No. 98-0224M
OWN MOTION ORDER ON RECONSIDERATION
Schneider, et al, Claimant Attorneys

Claimant requests reconsideration of our July 14, 1998 Own Motion Order in which we declined to reopen her 1983 industrial injury claim for the payment of temporary disability compensation because she failed to establish that she remained in the work force when her compensable condition worsened requiring surgery or hospitalization.

On July 28, 1998, we abated our July 14, 1998 order, and allowed the self-insured employer 14 days in which to file a response to the motion. As no response has been received to date from either party, we will 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.*

On April 18, 1995, claimant underwent an anterior cervical discectomy and interbody fusion at C5-6. Thus, 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).

In support of her contention that she was in the work force at the time of the worsening of her compensable condition, claimant submitted a July 17, 1998 chart note from Dr. Long, her treating physician. Throughout his report, Dr. Long repeatedly opined that not only was claimant not able to do her job as a unit secretary but that she was "not fit to do modified work in a sedentary or light capacity." He went on further to state that "I would consider that [claimant] was unfit for regular or modified work from the time I initially saw her in January 1993 through mid-July 1995, 3 months following the C5-6 discectomy and fusion." This opinion is unrebutted. We interpret Dr. Long's chart note to indicate that it would have been futile for claimant to seek work due to her compensable condition. Thus, we find that claimant has met the second part of the third criterion set forth in *Dawkins, id.*

However, in order to fully satisfy the third *Dawkins* criterion, claimant must also establish, along with the "futility" standard, that he/she was willing to work. Failing to demonstrate his/her willingness to work, then he/she is not considered a member of the work force, and thus, is not entitled to temporary disability compensation. *See Stephen v. Oregon Shipyards*, 115 Or App 521 (1992); *Arthur R. Morris*, 42 Van Natta 2820 (1990); *Judith R. King*, 48 Van Natta, 2303 (1996); *Marlene J. Andre*, 48 Van Natta 404 (1996).

Claimant does not submit an affidavit to attest to her willingness to work and there is no documentation contained in the record that would support that conclusion. In fact, the only document in the record regarding claimant's willingness to work is a partial transcript of a statement she gave the insurer's investigator wherein she stated that she last worked in 1990 and quit to take care of her daughter. She went on to state that, since her last job, she has been at home taking care of her kids and that "my husband makes enough money where I can do that. A lot of women aren't that fortunate." Thus, we find that the record before us does not establish that claimant was willing to work and/or seek work.

Accordingly, our July 14, 1998 order is abated and withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our July 14, 1998 order in its entirety. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
RICHARD L. SUTTON, Claimant
WCB Case No. 97-09186
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Mills' order that redetermined claimant's permanent disability to award an additional 10 percent (32 degrees) unscheduled permanent disability benefits for claimant's low back condition. On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant's compensable low back condition had actually worsened since the time of his initial closure. Accordingly, the ALJ found that claimant was entitled to a redetermination of his disability award. In reaching his conclusion, the ALJ relied on OAR 436-035-0007(8)(b) which provides that:

> "When an actual worsening of the worker's compensable condition occurs, the extent of permanent disability shall be redetermined. When an actual worsening of the worker's compensable condition does not occur, the extent of disability shall not be redetermined, but shall remain unchanged."

Additionally, OAR 436-035-0007(8)(c) provides that: "* * * There shall be no redetermination for those conditions which are either unchanged or improved. * * *"

Subsequent to the ALJ's order, we issued our decision in *Sandra L. Kay*, 50 Van Natta 1415 (1998). In *Kay*, we noted that the Court had previously indicated that the threshold requirement to recover increased permanent disability is a greater permanent disability than formerly existed. *Stepp v. SAIF*, 304 Or 37 (1987); *Kelly R. Holifield-Taylor*, 50 Van Natta 286 (1998). Based on the Court's holding, we concluded that the proper analysis was whether, comparing the claimant's condition at the time of the current claim closure with her condition at the last arrangement of compensation, the claimant had sustained a permanent worsening. Moreover, to the extent the OAR 436-035-0007(8)(b) could be interpreted to permit a redetermination of a worker's permanent disability in the absence of a permanent worsening of the condition, we found the rule to be inconsistent with the *Stepp* Court's interpretation of the statutory scheme and we concluded that the rule should not be given effect.

After reviewing the medical evidence in this case, we find that claimant has failed to establish that he sustained a permanent worsening since the last arrangement of compensation. Specifically, claimant's treating doctor, Dr. Takacs, reported that there was "no worsening in [claimant's] range of motion measurements, so there is no criteria for a worsening of the condition in general, although it is obvious from the intensity of muscle spasms and his complaints of pain that he has endured a decrease in functional capacity." (Ex. 36).

Consequently, although Dr. Takacs found that claimant's functional capacity had decreased due to muscle spasm and pain complaints, there is no indication that claimant permanently worsened. *See Sandra L. Kay*, 50 Van Natta at 1417 (Fluctuation in the claimant's range of motion findings which reflected a waxing and waning as opposed to a specific worsening over time was not sufficient to establish a permanent worsening). Moreover, the remainder of Dr. Takacs' report suggests that claimant's condition has not worsened.

Finally, the medical arbiter, Dr. Yerby, reported that some of claimant's range of motion findings were invalid. More importantly, however, Dr. Yerby concluded that it did "not appear as though there has been any substantial change in the condition of [claimant's] low back for many years...". (Ex. 47).

Under the circumstances, we conclude that claimant has failed to prove that his condition has permanently worsened since the last arrangement of compensation. Accordingly, claimant is not entitled to a redetermination of his permanent disability award. We therefore reverse the ALJ's additional award of 10 percent unscheduled permanent disability.

ORDER

The ALJ's order dated February 18, 1998 is reversed. The ALJ's award of an additional 10 percent (32 degrees) unscheduled permanent disability is reversed. The October 15, 1997 Order on Reconsideration is affirmed.

In the Matter of the Compensation of
CURTIS J. TRON, Claimant
WCB Case No. 97-03802
ORDER ON REVIEW
Rasmussen & Tyler, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Myzak's order that: (1) allowed claimant to raise the issue of medically stationary date; (2) determined that claimant's mid-back condition was medically stationary on November 13, 1996; and (3) awarded temporary disability from October 9, 1995 through November 13, 1996. On review, the issues are hearing procedure, medically stationary date, and temporary disability.

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

SAIF contests the ALJ's award of temporary disability, contending that claimant had no authorization from his attending physician to be off work for most of the period for which the ALJ awarded temporary disability. *See* ORS 656.262(4)(g).[1] SAIF asserts that the ALJ's reliance on *Kenneth P. Bundy*, 48 Van Natta 2501 (1996), in awarding claimant temporary disability without attending physician authorization was misplaced because the legislative amendments to ORS 656.268(3)(d) have eliminated the basis for the court's distinction between procedural and substantive temporary disability articulated in *Sandoval v. Crystal Pine*, 118 Or App 640 (1993). We disagree.

We previously discussed the relevant case law concerning the distinction between substantive and procedural temporary disability benefits in *Daniel W. Garris*, 50 Van Natta 941 (1998). In *Garris*, we noted that the court has consistently recognized the distinction in cases such as *Santos v. Caryall Transport*, 152 Or App 322 (1998); *Atchley v. GTE Metal Erectors*, 149 Or App 581, *rev den* 326 Or 133 (1997); and *Foster Wheeler Constructors, Inc. v. Parker*, 148 Or App 6 (1997). In light of this authority, we continue to conclude that the distinction between procedural and substantive temporary disability exists. Because claimant's entitlement to substantive temporary disability does not depend on attending-physician authorization, we reject SAIF's argument that claimant is not entitled to substantive temporary disability for periods during which he had no time-loss authorization from an attending physician.

Because we have not reduced or disallowed claimant's compensation award 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 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 issues, and the value of the interest involved.

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[1] ORS 656.262(4)(g) 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."

ORDER

The ALJ's order dated March 30, 1998 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
ROY B. WAGGONER, Claimant
WCB Case No. 97-08889
ORDER ON REVIEW
Meyers, Radler, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Michael Johnson's order that awarded a $6,922.50 assessed attorney fee under ORS 656.386(1) for prevailing over SAIF's partial denial of a systemic groin infection arising out of treatment for a compensable elbow and wrist injury. On review, the issue is attorney fees. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In awarding the attorney fee at issue in this case, the ALJ considered the following factors listed in OAR 438-015-0010(4):

"(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."

In particular, the ALJ based the $6,922.50 attorney fee on claimant's counsel's statement of services for 55.3 hours. While SAIF did not challenge the statement of services at hearing, it argues on review that the reported hours are excessive and include time devoted to issues for which claimant is not entitled to a fee. SAIF further contends that the ALJ's attorney fee award is excessive in light of the limited value of the litigation to claimant. We agree that the fee should be reduced, and we offer the following alternative analysis pursuant to our authority under ORS 656.295(6) to supplement or modify the ALJ's findings and conclusions.

When compared with cases generally presented to this forum for resolution, this case involved legal, factual and medical issues of average complexity. Both attorneys are skilled litigators with substantial experience in workers' compensation law, and no frivolous issues or defenses were raised. Claimant's counsel generated three exhibits, including two letters to Dr. Patel which resulted in his persuasive medical opinion that the injections used to treat claimant's compensable injury were the major contributing cause of claimant's groin infection. The hearing transcript consisted of 17 pages, involving the testimony of one witness. There were approximately 35 exhibits. Claimant also submitted a 6-page opening closing argument (2 pages of which were devoted to the compensability issue) and a 2-page reply (1 of which addressed the compensability issue). Considering the conflicting medical opinions, there was a risk that claimant's attorney might go uncompensated.

As noted above, claimant's counsel submitted a Statement of Services for 55.3 hours. However, claimant is not entitled to an attorney fee for the portion of these hours devoted to the issue of attorney fees. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986); *Amador Mendez*, 44 Van Natta 736 (1992). In addition, claimant's counsel has already received a $500 attorney fee for services devoted to the discovery issue. Claimant is also not entitled to an attorney fee for the portion of these hours devoted to matters not relevant to establishing the compensability of claimant's groin infection, including claimant's social security benefits and fusion surgery. Finally, the services expended in unsuccessfully securing a penalty for an unreasonable denial are likewise not reimbursable. In regard to the value of the interest involved and the benefit to claimant, unpaid medical bills for the groin infection were limited to $620.05, and claimant was free of infection for seven months prior to hearing. Such medical services are considered to be of modest value. *See Michael J. Galbraith*, 50 Van Natta 603 (1998), *Melvin L. Martin*, 47 Van Natta 268 (1995).

After considering these factors, we find that $4,500 is a reasonable fee for claimant's attorney's services at hearing. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue, the value of the interest involved, the nature of the processing, and the risk that claimant's counsel might go uncompensated for his services. The ALJ's attorney fee award is reduced accordingly.

ORDER

The ALJ's order dated June 2, 1998 is affirmed in part and modified in part. In lieu of the ALJ's $6,922.50 attorney fee award, claimant is entitled to a $4,500 assessed attorney fee award under ORS 656.386(1), to be paid by the SAIF Corporation. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
BILLY W. WILSON, Claimant
WCB Case No. 97-04924
ORDER ON REVIEW
Gayle A. Shields, Claimant Attorneys
Alice M. Bartelt, Defense Attorney

Reviewed by Board Members Haynes, Bock and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Lipton's order that: (1) upheld the SAIF Corporation's partial denial of claimant's "new medical condition" claim for chronic post-herniorraphy pain; and (2) declined to assess penalties or a penalty-related attorney fee for SAIF's allegedly unreasonable denial. In his brief on review, claimant requests remand for further development of the record. In the alternative, claimant requests a penalty or penalty-related fee for SAIF's allegedly unreasonable "post-hearing" discovery violation. On review, the issues are remand, compensability, penalties and related attorney fees. We deny claimant's motion to remand, affirm the ALJ's compensability and penalty rulings, and decline to assess a penalty or penalty-related fee for SAIF's alleged discovery violation.

FINDINGS OF FACT

We adopt the ALJ's findings.

CONCLUSIONS OF LAW

Remand/Compensability/Penalty for Unreasonable Denial

As a preliminary matter, we address claimant's motion for remand for admission of Dr. Parshley's written report of his initial examination of claimant on January 29, 1998. At hearing, claimant requested that the ALJ keep the record open so that claimant could obtain and submit this report. At that time, claimant's attorney explained that she hoped Dr. Parshley's report "has some of the crucial

information that he did not [have] in his letter, like his letter doesn't say anything definite about causation." On review, claimant seeks remand for the admission of Dr. Parshley's report "should the Board find that more medical evidence regarding treatment or any other medical issue is needed."

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, we are unable to determine from claimant's brief what she is seeking to establish with Dr. Parshley's written report. However, based on the remarks made by claimant's counsel at hearing, we conclude that claimant seeks to rely on Dr. Parshley's report to establish the requisite causal link between claimant's accepted claim and his post-surgery symptoms. We conclude below that the record, as currently developed, establishes this causal link. Consequently, the inclusion of additional medical opinion from Dr. Parshley would not affect the outcome of the case. For this reason, we deny the motion for remand and proceed to our analysis of the compensability issue.

Claimant contends that the ALJ erred in upholding SAIF's denial of his post-surgery complications as a new consequential condition under ORS 656.005(7)(a)(A). We affirm the ALJ's ultimate ruling based on the following alternative analysis.

Claimant has an accepted injury claim with the employer for a left inguinal hernia that was surgically repaired in May 1995. Following that surgery, claimant developed chronic pain in the left groin and along the surgical incision. SAIF denied claimant's new medical condition claim for his post-surgery complaints. The ALJ upheld SAIF's denial, reasoning that "claimant has declined treatment for the [post-surgery] condition and none of the physicians who have examined claimant have identified his pain as disabling." In reaching that decision, the ALJ relied on ORS 656.005(7)(a), which defines a compensable condition as one that *requires medical services* or results in disability or death.

Unlike the ALJ, we find that claimant's post-surgery complaints do require medical services, including numerous medical evaluations, a nerve block injection in February 1997, and the pain center treatment recommended by Dr. Parshley. We further conclude that the opinions of Drs. Hayes and Heinonen persuasively establish that claimant's post-surgery complaints are due in major part to his hernia surgery. In addition, we recognize that the lack of a definitive diagnosis or mechanism of disease does not per se defeat a claim. *See Tripp v. Ridge Runner Timber Services*, 89 Or App 355 (1988).

Nevertheless, an insurer 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. *See* ORS 656.262(7)(a).

Accordingly, claimant must establish that he suffers from a new consequential medical condition that is not encompassed in SAIF's acceptance of the left inguinal hernia diagnosis. The medical experts have not identified any diagnosis other than the accepted hernia and pain associated with treatment for that condition. In particular, there is insufficient evidence to establish the existence of a nerve entrapment or any other additional condition by a preponderance of the evidence. On this record, we conclude that SAIF's acceptance of claimant's left inguinal hernia injury reasonably apprises claimant and the medical providers of the nature of the compensable condition within the meaning of ORS 656.262(7)(a). Consequently, we conclude that SAIF need not accept claimant's post-surgery complaints as a new consequential condition. Consistent with this rationale, we affirm the ALJ's ultimate decision to uphold SAIF's denial, and to deny claimant's request for a penalty and/or penalty-related fee for the allegedly unreasonable denial.

Finally, we deny claimant's request for a penalty and/or penalty-related fee for SAIF's alleged post-hearing discovery violation. Assuming for the sake of argument that we could address a "post-hearing" issue on review, in light of our compensability ruling, there are no "amounts then due" on which to base a penalty under ORS 656.262(11)(a), and there has been no resistance to the payment of compensation giving rise to a penalty-related fee under ORS 656.382(1).

ORDER

The ALJ's order dated March 24, 1998 is affirmed.

Board Member Hall dissenting in part.

I agree with the majority's conclusion that the medical record in this case establishes that surgical treatment of the accepted hernia condition is the major contributing cause of claimant's current complaints. However, I do not agree that SAIF's acceptance of the hernia diagnosis encompasses claimant's chronic post-surgery complications. I am not persuaded that SAIF's acceptance reasonably apprises claimant and his medical providers of the nature of the compensable condition, within the meaning of ORS 656.262(7)(a). Furthermore, given that the majority agrees the post-surgery complications are compensable, it follows that the September 3, 1997 denial (Ex. 25) must be set aside. Indeed, to not order the denial set aside leaves the majority opinion internally inconsistent. The carrier should be ordered to issue an amended acceptance to include the compensable post-surgery complications.

In the Matter of the Compensation of
KERRY L. WRENN, Claimant
WCB Case No. C8-02012
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Malagon, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

On September 3, 1998, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for her compensable injury. We approve the proposed disposition.

The proposed agreement states, on page 1 of the document:

"$7,500.00 Total Due Claimant (Less DHR Support Withholding*)"

ORS 656.234(2)(b) provides: "moneys payable pursuant to ORS * * * 656.236 * * * are subject to an order to enforce child support obligations pursuant to ORS 25.311." Additionally, ORS 656.234(3)(b) provides that the amount of child support obligation subject to enforcement shall not exceed one-fourth of moneys paid under 656.236.

The agreement does not specify the amount to be withheld for child support. However, consistent with the statute, we conclude that it is the parties' intention that no more than one-fourth of the moneys paid under the CDA shall be subject to the order to enforce child support. *See Philip B. Oberman*, 50 Van Natta 1211 (1998).

As interpreted herein, the CDA is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' agreement is approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
CARRIE NEWTON, Claimant
WCB Case No. 97-09192
ORDER ON REVIEW
Westmoreland & Mundorff, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) set aside its denial of claimant's right rotator cuff tear claim; and (2) awarded an assessed attorney fee of $5,500. In its brief, SAIF requests remand to the ALJ for reviewable findings supporting the attorney fee award. On review, the issues are compensability, remand and attorney fees. We deny the motion to remand, affirm in part and modify in part.

FINDINGS OF FACT

Claimant has performed part and full-time work as a filleter and packer in canneries since January 1962. Claimant is right-handed, and this work involves rapid, repetitive use of the right hand. Claimant has worked in the employer's fish cannery since August 1996, and she had previously worked for the employer as a filleter for three years.

On July 15, 1997, claimant experienced the onset of significant right shoulder pain, which radiated into her neck and right upper extremity. The onset of these symptoms occurred when claimant was pushing a fully-loaded pan of fish up a steel rack onto a conveyor belt, and the loaded pan came into contact with a pan being pushed by another worker. Claimant had previously experienced some discomfort in her right elbow, but otherwise had no prior history of neck, right shoulder or right upper extremity problems.

Claimant's symptoms continued and worsened to the point that she sought medical care from Dr. Park, M.D., on August 5, 1997. Diagnostic x-rays on that date were read as demonstrating degenerative changes at the acromioclavicular and glenohumeral joints and probable underlying rotator cuff degeneration and/or tear. Dr. Park diagnosed a cervical strain and a possible acromioclavicular bursitis.

Claimant filed a claim for a neck and shoulder injury occurring on July 15, 1997, and SAIF issued a denial of that claim on September 25, 1997.

Claimant experienced a marked decrease in her neck, acromial and forearm pain with light duty and conservative treatment from Dr. Park. However, claimant continued to experience pain in the medial and lateral aspect of the upper arm and over the deltoid insertion, with a further exacerbation of right upper arm pain when she returned to her regular work. Claimant sought further treatment from Dr. Puziss, orthopedic surgeon, who became the treating physician on November 6, 1997. Dr. Puziss diagnosed a chronic right rotator cuff tear which he surgically repaired on November 20, 1997.

Dr. Woodward, orthopedic surgeon, examined claimant for SAIF on December 30, 1997.

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

The rotator cuff tear surgically repaired by Dr. Puziss is due in major part to claimant's repetitive work activity and her July 15, 1997 work injury with the employer.

CONCLUSIONS OF LAW AND OPINION

Compensability

SAIF conceded at hearing that, as a result of a discrete injury on July 15, 1997, claimant sustained a strain that combined with a preexisting rotator cuff tear. SAIF further conceded that claimant's condition in July and August 1997 was compensable under ORS 656.005(7)(a)(B) because it was due in major part to this work injury. However, SAIF otherwise argued that claimant's condition

on and after September 1, 1997 was not compensable because it was due in major part to her noncompensable rotator cuff tear. The ALJ rejected that argument and, instead, concluded that claimant had established a compensable claim for her current right rotator cuff tear based on the opinion of Dr. Puziss. On review, SAIF challenges the ALJ's ruling and underlying rationale. We affirm the ALJ's ultimate conclusion based on the following alternative rationale.

Claimant's rotator cuff tear is compensable as an occupational disease if it is due in major part to her work activity, including the July 15, 1997 injury. ORS 656.802(2)(a); *Kepford v. Weyerhaeuser Co.*, 77 Or App 363 (1986); *Sandra L. Dehart*, 49 Van Natta 1437 (1997). Resolution of this compensability issue involves complex medical questions that must be resolved with expert medical opinion. *Uris v. Compensation Department*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279, 283 (1993). Special deference is generally given to the opinion of a treating physician, absent persuasive reasons to do otherwise. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here, the record includes causation opinions from two orthopedic surgeons, Dr. Puziss, the treating surgeon, and Dr. Woodward, who examined claimant for SAIF.

Dr. Puziss opined that the rotator cuff tear he surgically repaired was "a very old tear, or at least [a tear] that had gone on for some time [with] early cuff tear arthropathy." Dr. Puziss further opined that this tear was due in major part to claimant's repetitive work activity in the canneries and/or a superimposed acute injury on July 15, 1997. Thus, Dr. Puziss' opinion supports a compensable occupational disease claim based on the combined effect of claimant's repetitive work activity and a discrete injury on July 15, 1997.

Dr. Woodward concluded that claimant's rotator cuff tear was due in major part to aging. Dr. Woodward further opined that, while a strain caused by the July 15, 1997 work injury was the major contributing cause of the initial disability and need for treatment in July and August 1997, the work injury and related strain ceased to be the major contributing cause of claimant's disability and need for treatment sometime in September 1997.

We conclude that the record does not establish persuasive reasons not to defer to the opinion of Dr. Puziss, the treating surgeon. Dr. Puziss' opinion is based on a complete and accurate history, and Dr. Woodward's contrary opinion is not well-reasoned. In particular, claimant credibly testified that Dr. Woodward did not elicit a thorough history of her repetitive work activity, and Dr. Woodward acknowledged that continued repetitive use and trauma can accelerate degenerative changes in the rotator cuff. Moreover, Dr. Woodward reasoned that "[a]s far as I know, fish filleting has not been blamed as a cause of the tear of the rotator cuff [and] I believe that the rotator cuff tear is generally a degenerative condition related more to age than any other single factor." Thus, Dr. Woodward's opinion is less persuasive because it is based on generalities and does not address claimant's specific work history and Dr. Puziss' opinion that claimant's repetitive work activities contributed to her rotator cuff tear.

Accordingly, we defer to Dr. Puziss' opinion and conclude that claimant has established a compensable occupational disease claim for her current rotator cuff tear.

Attorney Fees/Remand

The ALJ awarded claimant an assessed fee for prevailing over SAIF's denial. ORS 656.386(1). In so doing, the ALJ considered the following factors listed in OAR 438-015-0010(4):

"(a) The time devoted to the case;

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

"(c) The value of the interest involved;

"(d) The skill of the attorneys;

"(e) The nature of the proceedings;

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

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

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

The ALJ stated that all of the rule-based factors had been considered, with particular emphasis on four of the factors (time devoted to the case, value of the interest involved, benefit secured for the represented party, and risk that attorney's efforts might go uncompensated).

On review, SAIF requests remand to the ALJ to make reviewable findings supporting the attorney fee award consistent with *Schoch v. Leupold & Stevens*, 325 Or 112, *on remand* 49 Van Natta 788 (1997). In *Schoch*, the Court remanded a case to the Board because "the order [did] not contain a sufficient explanation to permit an appellate court to review the Board's exercise of discretion in setting a reasonable attorney fee." Here, SAIF contends that the ALJ's order is not consistent with *Schoch* because the ALJ failed to demonstrate the reasoning that led from the facts that he found to the conclusions that he drew from those facts. Alternatively, SAIF challenges the "2.5 multiplier" the ALJ used to reflect the risk claimant's attorney might go uncompensated.

We first address SAIF's procedural argument under *Schoch*. We rejected a similar challenge in *Russell L. Martin*, 50 Van Natta 313 (1998). In *Martin*, we found that an ALJ was not obligated to make specific findings regarding the factors enumerated in OAR 438-015-0010(4) where there was no specific attorney fee request or statement of services, and the parties had not submitted any argument to the ALJ as to how the factors should be weighed in determining a reasonable fee. Under such circumstances, we concluded that *Schoch* was distinguishable. *Martin*, 50 Van Natta at 314. *See also McCarthy v. Oregon Freeze Dry, Inc.*, 327 Or 84, *on recon* 327 Or 185 (1998) (standing alone, absence of explanatory findings to support an award or denial of attorney fees is not a ground for reversal; Court of Appeals' obligation to make findings under attorney fee statute may be satisfied by including a brief description or citation to the factor or factors relied on in denying an award of attorney fees). On the other hand, more specific findings may be necessary to address arguments as to how particular factors should be weighed in determining a reasonable fee. *Accord McCarthy*, 327 Or at 189 (findings are necessary to assist the appellate court in carrying out a meaningful review of the competing arguments of the parties).

Here, the ALJ's order satisfies the procedural requirements enunciated in *Schoch, McCarthy* and *Martin*. In response to SAIF's general contention that specific findings on each rule-based factor were required, the ALJ's order stated that the factors recited in OAR 438-015-0010(4) were considered, particularly the time devoted, value of the interest, benefit secured, and risk factor. In addition, the ALJ separately addressed the parties' specific arguments regarding the risk that claimant's attorney might go uncompensated. *See* OAR 438-015-0010(4)(g).

We turn to SAIF's argument on review as to how particular factors should be weighed in determining a reasonable attorney fee. We offer the following alternative analysis pursuant to our authority under ORS 656.295(6) to supplement or modify the ALJ's findings and conclusions. In light of this authority, we reject SAIF's contention that this case must be remanded to the ALJ for the supplementation of findings regarding claimant's attorney fee award. *See Sherlie A. Dial*, 50 Van Natta 1405 (1998).

We begin our alternative analysis with the time devoted to this case. Claimant's attorney did not submit a statement of his services. Nevertheless, the record consists of 14 exhibits, and no depositions were taken. Claimant's attorney referred claimant to Dr. Puziss, which resulted in his dispositive January 30, 1998 opinion. The hearing before the ALJ lasted two hours and involved testimony from claimant. In determining an appropriate fee, we do not consider time that was devoted to the issue of attorney fees. *See Amador Mendez*, 44 Van Natta 736 (1992).

We turn to the other relevant criteria. When compared with cases generally presented to this forum for resolution, this case involved legal and factual issues of average complexity, but medical issues of above average complexity. The value of the interest involved and the benefit to claimant are significant, in that claimant has obtained benefits for the rotator cuff tear surgically repaired by Dr. Puziss, as well as the condition that was previously treated by Dr. Park in July and August 1997. Both attorneys are skilled litigators with substantial experience in workers' compensation law, and no

frivolous issues or defenses were raised. Finally, considering the conflicting medical opinions, there was a risk that claimant's attorney might go uncompensated.[1]

After considering these factors, we find that $4,000 is a reasonable fee for claimant's attorney's services at hearing. In particular, in light of the limited number of exhibits and relatively brief testimony at hearing, we find this award to be more appropriate than the award granted by the ALJ's order.

Claimant's attorney is also entitled to an attorney fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $1,200, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee on review for his counsel's services regarding the ALJ's attorney fee award. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated March 5, 1998 is affirmed in part and modified in part. SAIF's motion for remand is denied. In lieu of the ALJ's $5,500 attorney fee award, claimant is entitled to a $4,000 assessed attorney fee award under ORS 656.386(1), and a $1,200 assessed attorney fee award under ORS 656.382(2), to be paid by the SAIF Corporation.

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[1] In reaching this conclusion, we disagree with the ALJ's utilization of a so-called "2.5 multplier." This "factor" was apparently based on "official records of the Director of DCBS." Inasmuch as there is no indication that these "official records" represent agency decisions or orders, such documents are not subject to administrative notice. *See Dewey W. Kennedy*, 47 Van Natta 399 (1995). In any event, it is well-settled that a contingency factor or "multplier" is not applied in a strict mathematical sense, but rather the risk that claimant's counsel may go uncompensated in this proceeding is considered in conjunction with the other relevant factors of OAR 438-015-0010(4) in ultimately determining a reasonable attorney fee award. *See John M. Morley*, 50 Van Natta 1598 (1998); *Lois J. Schoch*, 49 Van Natta 788,790 N.1 (1997).

September 18, 1998 Cite as 50 Van Natta 1753 (1998)

In the Matter of the Compensation of
JODIE M. DUBOSE, Claimant
WCB Case No. 97-01993
ORDER OF ABATEMENT
Welch, Bruun & Green, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

The SAIF Corporation requests abatement and reconsideration of our August 20, 1998 Order on Review that denied claimant's motion to dismiss SAIF's request for review and affirmed the Administrative Law Judge's (ALJ's) order setting aside SAIF's "noncooperation" denial and awarding an assessed attorney fee under ORS 656.382(1). In requesting reconsideration, SAIF contends that the "noncooperation" denial should be upheld because claimant did not prove that her failure to cooperate with its investigation was for reasons beyond her control. Claimant has filed a response rebutting SAIF's argument.

In order to further review this matter, we withdraw our August 20, 1998 order. After completion of that review, we will issue our order on reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
KEN J. SULLIVAN, Claimant
WCB Case No. 98-04134
ORDER OF DISMISSAL
Bischoff, Strooband & Ousey, Claimant Attorneys
Snarskis, Yager, et al, Defense Attorneys

Claimant, *pro se*, has requested review of Administrative Law Judge (ALJ) Stephen Brown's July 31, 1998 order. In response to our August 31, 1998 acknowledgment of the appeal, the insurer states that its first notice of claimant's request for review occurred on September 1, 1998, when it received our acknowledgment letter. In light of the insurer's announcement, we have reviewed this case to determine whether we retain appellate jurisdiction. Because the record does not establish that the other parties received notice of claimant's request within 30 days of the ALJ's order, we dismiss. *See* ORS 656.289(3); 656.295(2).

FINDINGS OF FACT

On July 31, 1998, the ALJ issued an order dismissing claimant's request for hearing. The order contained a statement explaining the parties' rights of appeal, including a notice that a request for review must be mailed to the Board within 30 days of the ALJ's order and that copies of the request for Board review must be mailed to the other parties within the 30-day appeal period.

On August 28, 1998, the Board received an August 10, 1998 letter from claimant requesting review of the ALJ's order. Claimant's request did not indicate that copies had been provided to the other parties to the proceeding.

On August 31, 1998, the Board mailed a computer-generated letter to the parties, acknowledging claimant's request for Board review of the ALJ's July 31, 1998 order. The insurer received this acknowledgment letter on September 1, 1998, which constituted its first notice of claimant's request for Board review.

CONCLUSIONS OF LAW AND OPINION

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

The failure to timely file and serve all parties with a request for Board review requires dismissal, *Mosley v. Sacred Heart Hospital*, 113 Or App 234, 237 (1992); except that a non-served party's actual notice of the appeal within the 30-day period will save the appeal. *See Zurich Ins. Co. v. Diversified Risk Management*, 300 Or 47, 51 (1985); *Argonaut Insurance Co. v. King, supra.* All parties to the ALJ's order must be served or receive notice. *See Kelsey v. Drushella-Klohk NCE*, 128 Or App 53, 57 (1994); *Mosley v. Sacred Heart Hospital, supra.*

Here, the 30th day after the ALJ's July 31, 1998 order was August 30, 1998, a Sunday. Thus, the final day for us to reconsider our decision was Monday, August 31, 1998. *Steve H. Salazar*, 49 Van Natta 5 (1997). Inasmuch as claimant's request for review was received by the Board on August 28, 1998, it was timely filed. *See* ORS 656.289(3); ORS 656.295(2); OAR 438-005-0046(1)(b).

However, the record fails to establish that the other parties to the proceeding before the ALJ were provided with a copy, or received actual knowledge, of claimant's request for review within the statutory 30-day period. Rather, the record indicates that the insurer's first notice occurred when it received, on September 1, 1998, a copy of the Board's August 31, 1998 letter acknowledging claimant's request for review. Because September 1, 1998 is more than 30 days after the ALJ's July 31, 1998 order, such notice is untimely. *Debra A. Hergert*, 48 Van Natta 1052 (1996); *John E. Bafford*, 48 Van Natta 513 (1996).

Under such circumstances, we conclude that notice of claimant's request was not provided to the other parties within 30 days after the ALJ's July 31, 1998 order.[1] Consequently, we lack jurisdiction to review the ALJ's order, which has become final by operation of law. *See* ORS 656.289(3); 656.295(2).

Finally, we are mindful that claimant has apparently requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. However, instructions for requesting review were clearly stated in the ALJ's order. Moreover, we are not free to relax a jurisdictional requirement. *Alfred F. Puglisi*, 39 Van Natta 310 (1987); *Julio P. Lopez*, 38 Van Natta 862 (1986).

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

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[1] In the event that claimant can establish that he provided notice of his request for Board review to the insurer within 30 days of the ALJ's July 31, 1998 order, he may submit written information for our consideration. However, we must receive such written information in sufficient time to permit us to reconsider this matter. Because our authority to consider this order expires within 30 days after the date of this order, claimant must file his written submission as soon as possible. Claimant is further admonished that any document he submits to the Board for its review, must be simultaneously served on all other parties to this proceeding.

In the Matter of the Compensation of
TINA M. VANDERBURG, Claimant
WCB Case No. 98-00196
ORDER ON REVIEW
Robert J. Guarrasi, Claimant Attorney
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Livesley's order that: (1) affirmed an Order on Reconsideration award of 26 percent (83.2 degrees) unscheduled permanent disability for the neck and left shoulder; and (2) awarded an employer-paid attorney fee under ORS 656.382(2). On review, the issue is extent of unscheduled permanent disability and attorney fees. We modify in part and reverse in part.

FINDINGS OF FACT

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

Claimant began working for the employer in January 1991. In July 1991, she became an Electronics Tester. This job required repetitive overhead lifting of 30-pound plates on a production line. While performing her work duties, claimant compensably injured her left shoulder. She was diagnosed with a left shoulder strain, and the employer accepted a claim for this condition. The claim was closed by an October 23, 1993 Notice of Closure that awarded no permanent disability.

In October 1994, claimant again sought treatment for pain and aching in her neck, left shoulder and arm. She was referred to Dr. Kitchel, who released her to modified work and declared her medically stationary on July 27, 1995. Dr. Kitchel opined that claimant was permanently precluded from repetitive use of the left shoulder. The claim was closed by a December 5, 1995 Notice of Closure; the unscheduled permanent disability award (PPD) was increased to a total of 18 percent by a January 25, 1996 Order on Reconsideration. On November 18, 1996, claimant entered an Authorized Training Program (ATP) to prepare her for work as a medical office assistant.

On January 7, 1997, Dr. Kitchel examined claimant for neck and left shoulder complaints. He found no abnormalities and agreed that she had no worsening of her condition and no need for

palliative care. On May 30, 1997, claimant was examined by Dr. Marble, orthopedist, and Dr. Rich, neurologist. Dr. Kitchel concurred with their report. On June 13, 1997, claimant withdrew from the ATP program.

Claimant's claim was reclosed by an August 18, 1997 Notice of Closure, amended September 12, 1997, that decreased claimant's PPD award to 7 percent (22.4 degrees). That award was in part based on values of 4 for impairment and 1 for adaptability. Claimant requested reconsideration and an arbiter was appointed. A December 16, 1997 Order on Reconsideration increased that award to 26 percent (83.2 degrees), based in part on impairment values of (9) for the cervical spine and (5) for the left shoulder, and (4) for adaptability.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that the preponderance of medical opinion failed to establish a level of impairment or adaptability different from that found by the arbiter and, accordingly, affirmed the Order on Reconsideration award of 26 percent unscheduled PPD. On review, the employer contends that claimant's PPD award should be reduced to 7 percent, disputing the values for impairment and adaptability. Specifically, the employer argues that claimant's range of motion findings were subjective and self-limiting, and that we should rely on the opinion of Drs. Marble and Rich, rather than that of the arbiter, regarding claimant's alleged reduced range of motion in the neck. The employer also argues that there is no medical evidence of a chronic condition that limits repetitive use of claimant's left shoulder. Finally, the employer argues that a value of (1) should be given for adaptability, as claimant had been released to regular work.

Impairment

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 Notice of Closure. ORS 656.283(7); 656.295(5); OAR 436-035-0003(2). Here, the claim was closed by an August 18, 1997 Notice of Closure. Therefore, the applicable standards are found at WCD Admin. Order 96-072.

With the exception of the medical arbiter, only the attending physician at the time of claim closure may make findings concerning a worker's impairment. ORS 656.245(2)(b)(B); *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666 (1994), *aff'd Liberty NW Insurance Corp. v. Koitzsch*, 155 Or 494 (1998). However, impairment findings from a physician other than the attending physician may be used if those findings are ratified by the attending physician. *See* OAR 436-035-0007(12); *Roseburg Forest Products v. Owen*, 127 Or App 442 (1994). Moreover, the Board does not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment, but on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment. *Kenneth W. Matlack*, 46 Van Natta 1631 (1994).

Claimant's attending physician at claim closure was Dr. Kitchel, orthopedist. (Ex. 145, 146, 171). On May 30, 1997, Drs. Marble and Rich evaluated claimant's left shoulder and neck and Dr. Kitchel concurred with their report. Marble and Rich reported that, from time to time, claimant experienced symptoms in the trapezius muscle, the scapula and into the arm and forearm. They noted that claimant did not exhibit severe pain behavior or interfere with their evaluation. Moreover, although they stated that claimant's current complaints were subjective and not due to capsulitis, tendinitis, impingement syndrome, cervical radiculopathy or peripheral neuropathy, they did not indicate that their impairment findings were invalid or due to a different, noncompensable condition. (Ex. 166).

Dr. Dupuis, the medical arbiter, reported that claimant had not experienced a reinjury since the May 30, 1997 examination, although claimant stated that at times she is more symptomatic than at other times, with left neck and shoulder blade symptoms that worsen with activities such as prolonged reading, writing or driving, or lifting, pushing or pulling anything heavier than five pounds. Dr. Dupuis found that there was no evidence of symptom magnification or malingering, and opined that claimant's current impairment was totally due to her accepted left shoulder and cervical strain conditions. (Ex. 202-10, -12).

We are not persuaded that the evaluation of claimant's injury-related impairment concurred in by Dr. Kitchel was more complete and well-reasoned than that of Dr. Dupuis. For instance, Dr. Dupuis, unlike Drs. Marble and Rich, was aware that claimant sought additional treatment and evaluation for

her left shoulder and neck from Dr. Kitchel in 1997, and subsequently treated with a chiropractor for her ongoing complaints. Moreover, Dr. Dupuis explained that, although a cervical strain typically resolves within a limited time, and ongoing symptomatology is usually attributed to an underlying condition, symptom magnification or a missed diagnosis, that was not the case with claimant, who, despite extensive evaluation and treatment, had not returned to her pre-injury status. In contrast, Drs. Marble and Rich merely opined that claimant's ongoing complaints were "subjective," without further explanation (even though they measured reduced range of motion in claimant's neck).

Because Dr. Dupuis provided a more complete and well-reasoned evaluation of claimant's permanent impairment than Drs. Marble and Rich, we rely on his opinion. Finally, because there is no medical evidence that the findings of reduced range of motion in claimant's neck were invalid or due to a condition other than the accepted cervical strain, we conclude that the reduced range of motion findings are due to claimant's accepted condition. Accordingly, after our *de novo* review of Dr. Dupuis' findings of reduced range of motion in claimant's cervical spine, we agree with the ALJ's value of 8.69, rounded to 9. *Former* OAR 436-035-0360(13) through (16).

Finally, the employer argues that there is no medical evidence that claimant is entitled to a chronic condition award. We agree that claimant is not entitled to a chronic condition award, but for a different reason.

A worker may be entitled to unscheduled chronic condition impairment where a preponderance of medical opinion establishes that the worker is unable to repetitively use a body area due to a chronic and permanent medical condition. *See former* OAR 436-035-0320(5). Nevertheless, because the total unscheduled impairment within this body area is equal to or in excess of 5 percent, the worker is not entitled to any unscheduled chronic condition impairment. *Former* OAR 436-035-0320(6); *Schultz v. Springfield Forest Products*, 151 Or App 727 (1997). Therefore, the value for claimant's impairment due to her accepted injury remains at 9.

Adaptability

Finally, the employer contends that the ALJ erred in calculating the adaptability factor (4), as claimant's job at injury was light work and claimant had been released to "regular" medium work. We disagree.

After our review of the record, we adopt that portion of the ALJ's opinion that the attending physician had not released claimant to regular work at the job held at the time of at injury. Thus, claimant's adaptability is measured by comparing Base Functional Capacity (BFC) to the worker's maximum Residual Functional Capacity (RFC) at the time of becoming medically stationary. *Former* OAR 436-035-0310(2).[1]

BFC in this case is the highest strength category assigned in the DOT for the most physically demanding job that the worker has successfully performed in the five years prior to determination. *Former* OAR 436-035-0310(4)(a).[2] Here, claimant worked as a Kitchen Helper (DOT 318.617-010) in the five years prior to determination. (Ex. 96). Accordingly, her BFC is medium. Dr. Dupuis found that claimant could lift 20 pounds occasionally, but restricted lifting, carrying, reaching, pushing and pulling with the left arm to below shoulder height. (Ex. 202-12, -13). Thus, claimant's RFC is Sedentary/Light. *Former* OAR 436-035-0310(3)(e) and (f). In comparing claimant's BFC to her RFC, the value for adaptability is 4. We therefore affirm the ALJ's decision on the issue of adaptability.

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[1] *Former* OAR 436-035-0310(2) provides:

"For those workers who have ratable unscheduled impairment found in rules *[former]* OAR 436-035-0320 through 436-035-0375, the adaptability value is determined according to sections (3) through (7) of this rule. Adaptability is measured by comparing Base Functional Capacity to the worker's maximum Residual Functional Capacity at the time of becoming medically stationary."

[2] Although the employer contends that claimant's job at injury was in the "light" category, the employer gives no reason, and we can determine none under the rules, why claimant's BFC should be established by the job at injury rather than under the rules cited above.

The parties do not dispute the age (0) and education (3) values. 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 (4), for a result of 12. *Former* OAR 436-035-0280. This result is added to the impairment value (9), for a total of 21. *Former* OAR 436-035-0280(7). Thus, claimant is entitled to 21 percent unscheduled permanent disability. We modify the Order on Reconsideration and the ALJ's order accordingly.

ORS 656.382(2) Attorney Fee

Inasmuch as we have reduced the PPD award to 21 percent, claimant has not successfully defended the Order on Reconsideration award (26 percent) against the employer's request for hearing. Consequently, we conclude that an ORS 656.382(2) attorney fee is not warranted under the facts of this case.

ORDER

The ALJ's order dated May 13, 1998 is modified in part and reversed in part. In lieu of the Order on Reconsideration award of 26 percent (83.2 degrees), claimant is awarded 21 percent (67.2 degrees) unscheduled permanent partial disability for a neck and left shoulder injury. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
TRACY G. WEISS, Claimant
WCB Case No. 97-08742
ORDER DENYING RECONSIDERATION
Welch, Bruun & Green, Claimant Attorneys
Lundeen, et al, Defense Attorneys

On July 8, 1998, we affirmed an Administrative Law Judge's (ALJ's) order which upheld the insurer's denial of claimant's occupational disease claim for a right hand condition. Submitting a "Stipulation and Order," the parties seek approval of their agreement which proposes to resolve the compensability of claimant's right hand condition. Because the stipulation has been presented for our consideration and pertains to issues addressed in our July 8, 1998 order, we treat the parties' submission as a motion for reconsideration. Inasmuch as our order has become final, we are without authority to consider the proposed agreement.

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).

Here, the 30th day following our July 8, 1998 order was August 7, 1998. Inasmuch as our July 8, 1998 order has neither been stayed, withdrawn, modified, nor appealed by August 7, 1998, we are without authority to alter our prior decision. *See* ORS 656.295(8); *International Paper Co. v. Wright, supra; Fischer v. SAIF, supra; Barbara J. Cuniff*, 48 Van Natta 1032 (1996). Likewise, we lack authority to consider an agreement which addresses issues arising from that decision.

Accordingly, the parties' request for reconsideration for purposes of considering their stipulation is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOE G. CAPRON, Claimant
Own Motion No. 98-0111M
OWN MOTION ORDER
Martin J. McKeown, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable left knee medial meniscal tear. Claimant's aggravation rights expired on August 14, 1984. SAIF opposes authorization of temporary disability compensation, contending that: (1) claimant's current condition is not causally related to the accepted condition; (2) SAIF is not responsible for claimant's current condition; and (3) 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 May 12, 1998, SAIF submitted its recommendation to deny claimant's request for own motion relief. SAIF disputed the compensability of and responsibility for claimant's current condition. SAIF further contended that claimant was not in the work force at the time of the current disability. The Board wrote to both SAIF and claimant requesting further clarification of SAIF's recommendation and requesting a copy of the denial if one had issued.

SAIF has responded, contending that claimant has not formally requested acceptance or denial of any new medical condition. SAIF further contended that claimant's March 5, 1998 letter "only made a formal request for 'Own Motion Relief'" and that his letter is insufficient to constitute a formal written request for claim acceptance or denial.

Claimant's initial reply addressed only the work force issue. Subsequently, claimant has submitted a medical report from his treating physician, Dr. Yates, who also addressed claimant's work force status as it related to his compensable injury. SAIF has not responded to claimant's subsequent submission.

However, the issue of whether claimant's current need for left total knee athroplasty for his left knee osteoarthritis/degenerative joint disease remains a compensability and a responsibility question which are undetermined at this time.[1]

Inasmuch as the dispute between the parties remains unresolved, we are not authorized to reopen claimant's 1978 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 1978 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] Inasmuch as the compensability of and responsibility for claimant's current condition remains undetermined, we need not address whether claimant was in the work force at the time of his current alleged worsening.

In the Matter of the Compensation of
ANTHONY R. HOLDER, Claimant
WCB Case No. 97-10210
ORDER ON REVIEW
Gary L. Tyler, Claimant Attorney
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Hall and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Hoguet's order that: (1) awarded an assessed fee of $250 pursuant to ORS 656.382(2) for claimant's counsel's services in defending against the insurer's request for an offset of temporary disability; (2) directed the insurer to pay temporary disability from December 16, 1996 through March 13, 1997 pursuant to a June 25, 1997 Determination Order; (3) awarded an assessed fee pursuant to ORS 656.382(2) for claimant's counsel's services in prevailing against the insurer's failure to pay temporary disability; and (4) assessed a 25 percent penalty for the insurer's allegedly unreasonable refusal to pay temporary disability. On review, the issues are temporary disability, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ ordered the insurer to pay temporary disability from December 16, 1996 through March 13, 1997 as authorized by a June 25, 1997 Determination Order, which awarded temporary disability from February 14, 1996 through May 22, 1997, "less time worked." (Ex. 6). In doing so, the ALJ rejected the insurer's argument that this period qualified for the "less time worked" deduction in the Determination Order because claimant failed to begin modified work pursuant to ORS 656.268(3)(c).[1] The ALJ reasoned that the insurer did not strictly comply with the requirements of ORS 656.268(3)(c), because it offered claimant a modified job prior to the attending physician advising claimant and documenting in writing that he was released to return to the modified job. Thus, the ALJ concluded that the insurer's modified job offer could not be the basis for the "less time worked" deduction in the Determination Order. Moreover, the ALJ determined that the insurer's failure to strictly follow the requirements of ORS 656.268(3)(c) was unreasonable, thereby warranting assessment of a 25 percent penalty under ORS 656.262(11)(a).

On review, the insurer contends that the order in which the requirements of ORS 656.268(3)(c) are satisfied is not important, only that they are all met. The insurer asserts that all the statutory criteria were eventually satisfied. Therefore, it argues that it properly offered claimant modified work (which he failed to begin), and had no legal obligation to pay claimant temporary disability from December 16, 1996 through March 13, 1997. Further, because it had no legal obligation to pay temporary disability during this period, the insurer argues that this period qualified for the "less time worked" deduction in the Determination Order. Finally, the insurer contends that, even if claimant was entitled to the disputed temporary disability, its claim processing was reasonable. For the following reasons, we disagree with the insurer's contentions.

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

"(a) The worker returns to regular or modified employment;

"(b) the attending physician advises the worker and documents in writing that the worker is released to return to regular employment;

"(c) The attending physician advises the worker and documents in writing that the worker is released to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment; or

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

At the outset, we emphasize that we do not decide whether a failure to begin properly offered modified work (which would excuse payment of temporary total disability under ORS 656.268(3)(c)) qualifies for the "less time worked" deduction in a Determination Order. In other words, even assuming that it does, we agree with the ALJ that the insurer did not strictly satisfy the statutory requirements of ORS 656.268(3)(c). Thus, we find that the insurer was required to pay claimant temporary disability during the disputed period.

ORS 656.268(3)(c) permits termination of TTD if 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. In this case, there is no dispute that the attending physician (Dr. Noall) did not advise the worker or document in writing that claimant was released to the modified job prior to the employer's written offer of modified work. In addition, there is no dispute that claimant failed to begin the modified job.[2] The dispute in this case concerns the sequence of events; *i.e.*, whether the written job offer may precede the attending physician's written approval of modified work. Although the insurer asserts that the statute does not require any particular sequence of events, only that all elements of the statute are satisfied, we agree with the ALJ that the attending physician's approval of the modified job must precede the written job offer.

The language of ORS 656.268(3)(c) sets forth the sequence of events. The attending physician must first document in writing that the worker is released to modified work. After this has occurred, the employer must offer the job in writing and then the worker must fail to begin such employment Therefore, we conclude that the actual language of the statute requires attending physician approval before modified work is offered in writing. Moreover, OAR 436-060-0030(5) provides:

> "An insurer shall cease paying temporary total disability compensation and start paying temporary partial disability compensation under section (8) of this rule as if the worker had begun the employment when an injured worker fails to begin wage earning employment pursuant to ORS 656.268(3)(c), under the following conditions:
>
> "(a) The attending physician has been notified by the employer or insurer of the physical tasks to be performed by the injured worker;
>
> "(b) The attending physician agrees the employment appears to be within the worker's capabilities; and
>
> "(c) The employer has confirmed the offer of employment in writing to the worker stating the beginning time, date and place; the duration of the job, if known; the wages; an accurate description of the physical requirements of the job and that the attending physician has found the job to be within the worker's capabilities."

OAR 436-060-0030(5)(c), which implements ORS 656.268(3)(c), therefore, requires the employer's written offer of modified work to state, among other things, that the attending physician has found the job to be within the worker's capabilities.[3] It follows that, pursuant to the language of the rule, attending physician approval must precede the written job offer of modified employment.

In this case, Dr. Noall did not approve the modified job prior to the employer's written offer of modified work. Moreover, the employer did not re-offer the modified job to claimant after Dr. Noall approved the job. Therefore, we agree with the ALJ that the employer did not strictly comply with the requirements of the statute and administrative rule. Inasmuch as strict compliance with ORS

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[2] Claimant received an offer for modified work (safety monitor) on December 13, 1996. The modified work was to begin on December 16, 1996. Claimant did not formally accept or reject the offer, but he did not begin work on December 16th. Dr. Noall approved the modified work in writing on December 19, 1996. The employer did not re-offer the modified job to claimant subsequent to Dr. Noall's approval. Claimant did not perform the modified job after December 19, 1996.

[3] In the context of ORS 656.325(5)(b), the attending physician must review and consent to the specific modified job, not just modified work in general. *See Deanna L. Rood*, 49 Van Natta 285, 286 (1997). Because the dispute in this case concerns the issue of whether the employer's job offer can precede the attending physician's written approval of modified work, we need not decide whether *Rood* has any applicability to this case.

656.268(3)(c) and OAR 436-060-0030(5)(c) is required, the offer of modified work was invalid. *See Fairlawn Care Center v. Douglas*, 108 Or App 698 (1991); *Safeway Stores, Inc. v. Little*, 107 Or App 316 (1991); *Eastman v. Georgia Pacific Corp.*, 79 Or App 610 (1986); *cf. Liberty Northwest Insurance Corporation v. Jensen*, 150 Or App 548 (1997) (offer of modified work not defective under *former* OAR 436-60-030(12)(c) simply because it stated that job was temporary and subject to re-evaluation; rule required employer to provide statement of duration only if known, and there was no showing that employer knew duration of job but withheld it).

Accordingly, even assuming that a failure to begin properly offered modified work can qualify for the "less time worked" deduction in a Determination Order, the insurer incorrectly refused to pay temporary disability from December 16, 1996 through March 13, 1997. Moreover, because the requirements of ORS 656.268(3)(c) and the OAR 436-060-0030(5)(c) are clear, and considering the well-established precedent that strict compliance with the statute is required before temporary total disability may be terminated, we also find that the insurer did not have a "legitimate doubt" regarding its liability for payment of temporary disability from December 16, 1996 through March 13, 1997. *Dawes v. Summers*, 118 Or App 15, 19 (1993).[4] Thus, we agree with the ALJ that the insurer's refusal to pay temporary disability during the disputed period was unreasonable and warranted assessment of a 25 percent penalty.

For prevailing against the insurer's attempt to reduce claimant's award of temporary disability, the ALJ awarded an assessed fee pursuant to ORS 656.382(2). The insurer contends that the ALJ improperly awarded an assessed fee pursuant to that statute, alleging that any fee must come from claimant's compensation. We agree.

ORS 656.382(2) provides in part that "If a request for hearing * * * is initiated by an employer or insurer, and the Administrative Law Judge * * * finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer or insurer shall be required to pay to the claimant or the attorney of the claimant a reasonable attorney fee in the amount set by the Administrative Law Judge * * *."

As is apparent from the language of the statute, the insurer or employer must "initiat[e]" a request for hearing. Here, the insurer did not request a hearing. Instead, claimant requested the hearing seeking temporary disability for the disputed period. Moreover, the dispute concerned the interpretation of the phrase "less time worked." The insurer did not disagree with the award of temporary disability awarded by the Determination Order. *See Jerald J. Cooper*, 50 Or App 914 (1998) (the claimant's request for an assessed fee under ORS 656.382(2) denied where the carrier's request for offset did not involve a disagreement with the claimant's award of temporary disability). Under these circumstances, we find that claimant's attorney was not entitled to an assessed fee pursuant to ORS 656.382(2). Because the ALJ concluded otherwise, we reverse.[5] In lieu of the ALJ's attorney fee award, claimant's counsel is awarded 25 percent of the increased compensation created by the ALJ's order, as affirmed by this order, not to exceed $2,800, payable directly to claimant's counsel.

Claimant's attorney is, however, entitled to an assessed fee for services on review regarding the temporary disability issue because the insurer initiated a request for review and we have not disallowed or reduced claimant's award of temporary disability. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's

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[4] In *Dawes*, the court held that, in interpreting the phrase "less time worked" in the portion of a Determination Order requiring it to pay temporary disability, the employer had a reasonable doubt regarding its liability to pay temporary disability during the time the claimant would have continued to work but for the termination of her employment. Although stating that the employer should have continued to pay temporary disability and then sought to recover the payments to which the claimant was not entitled as offsets against future benefits, the court found that the language of the Determination Order was ambiguous, thus giving the employer legitimate doubt regarding its liability to pay temporary disability. *Id.* In contrast to the employer in *Dawes*, which did not have prior case authority for guidance in interpreting the phrase "less time worked," the insurer had such authority (the *Dawes* case itself). Moreover, because the sequence of events that must precede termination of temporary total disability is clear from the statute and administrative rule, we conclude that the insurer's claim processing was unreasonable in this case.

[5] The insurer also contests the ALJ's award of a $250 fee pursuant to ORS 656.382(2) for claimant's counsel's services in defending against the insurer's request for an offset of temporary disability. The insurer does not contest the merits of the ALJ's determination that claimant's attorney was entitled to a fee pursuant to that statute, but alleges that there was no "factual basis" for an assessed fee. We adopt the ALJ's reasoning and conclusion on this issue.

attorney's services on review is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We have also considered that claimant is not entitled to a fee for services regarding the penalty and attorney fee issues. *Saxton v. SAIF*, 80 Or App 631 (1986); *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated April 6, 1998 is reversed in part and affirmed in part. That portion of the ALJ's order that awarded an assessed fee pursuant to ORS 656.382(2) is reversed. In lieu of the ALJ's attorney fee award, claimant's counsel is awarded 25 percent of the increased compensation created by the ALJ's order, as affirmed by this order, not to exceed $2,800, payable directly to claimant's counsel. The remainder of the ALJ's order is affirmed. For services on review regarding the temporary disability issue, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
MARTI L. BENNETT, Claimant
WCB Case No. 98-00849
ORDER ON REVIEW
Bottini, Bottini & Oswald, Claimant Attorneys
David J. Jorling, Defense Attorney

Reviewed by Board Members Hall and Bock.

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 right wrist condition. On review, the issue is compensability.

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

The ALJ set aside the employer's denial of claimant's injury claim, relying on the medical opinions of Drs. Johnson and Rusch. Both doctors treated claimant and related her right wrist condition to an alleged incident at work on October 29, 1997 when, after a period of using a stamper, claimant reached for an object and felt sudden pain in the right forearm.

On review, the employer contends that the ALJ should have relied on the medical opinions of several examining physicians (Drs. Button, Hills, Duff and Swarner), who opined that there was no organic basis for claimant's right wrist condition. Based on this evidence, the employer asserts that the ALJ incorrectly set aside its denial. We disagree.

The employer does not contend, and the medical evidence does not establish, that a preexisting right wrist condition "combined" with the alleged injury of October 29, 1997 to cause a need for treatment; consequently, ORS 656.005(7)(a)(B) is not applicable. Therefore, in order to establish a compensable injury, claimant must show an accidental injury arising out of and in the course of employment. ORS 656.005(7)(a). The injury must be established by medical evidence, supported by objective findings. *Id.* Claimant's disability or need for treatment is compensable if the alleged industrial injury is a material contributing cause. *Mark Weidle*, 43 Van Natta 855 (1991). Claimant has the burden of proving a compensable injury. ORS 656.266. For the following reasons, we agree with the ALJ that claimant sustained her burden of proof.

The ALJ found claimant to be a credible witness based on her demeanor and manner of testifying. We generally defer to such demeanor-based credibility findings on review. *See International Paper Co. v. McElroy*, 101 Or App 61, 64 (1990); *but see Gail A. Albro*, 48 Van Natta 41, 42 (1996) (inconsistencies in the record may be a sufficient basis to disagree with the ALJ's credibility finding if they raise such doubt that we are unable to conclude that material testimony is credible); *Angelo L. Radich*, 45 Van Natta 45, 46 (1993) (same). Although the employer contends that we should not do so in this case because of alleged inconsistencies in the record, we note that a defense witness (Holmes) corroborated to some extent claimant's testimony that, after using a heavy stamper, she experienced a sudden onset of pain at work while reaching for an object. (Trs. 17, 18). Holmes testified that she

observed claimant shaking her hand and assumed that it was a result of using the stamping machin (Tr. 76). Holmes further testified that it was stressful to use the stamper and that claimant stated that her wrist was "bothering her." (Trs. 76, 77).

Both Dr. Johnson and Dr. Rusch received a history similar to that to which claimant testified. (Exs. 2, 15). Based on this history (which we find to be credible), both Dr. Johnson and Dr. Rusch related claimant's right wrist condition to the alleged incident of October 29, 1997. (Exs. 24, 31). We ordinarily give greater weight to the conclusions of an attending physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810, 814 (1983). Here, we do not find persuasive reasons to do otherwise. Instead, because they are well-reasoned and based on a complete and accurate history, we find the opinions of Drs. Johnson and Rusch persuasive.[1] *Somers v. SAIF*, 77 Or App 259 (1986);

Moreover, we find that this medical evidence is supported by objective findings, including an absent right biceps reflex on November 3, 1997 (Ex. 4), a November 13, 1997 bone scan which revealed changes in the right wrist suggestive of a fracture or possible ligament injury (Ex. 10), and a November 18, 1997 MRI scan which showed findings consistent with a bone bruise in the right wrist. (Ex. 12).

Accordingly, we conclude that claimant has sustained her burden of proving that the alleged incident at work on October 29, 1997 did, in fact, occur, and that it was a material contributing cause of her medical treatment commencing on October 31, 1997. Therefore, we agree with the ALJ's decision to set aside the employer's denial.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review 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 May 21, 1998 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the employer.

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[1] We find those opinions more persuasive than those of the examining physicians on whom the employer would have us rely. In particular, we do not find Dr. Button's opinion attributing claimant's symptoms to functional overlay/symptom magnification persuasive because Dr. Button did not have access to all medical records when he performed his examination in December 19, 1997. (Ex. 18-1). The Hills/Duff/Swarner panel concluded that there were no "objective findings" to support a physical diagnosis and that a psychosomatic explanation for claimant's right wrist symptoms was likely. (Ex. 29). However, we are not persuaded by their conclusions drawn from a one-time examination of claimant. We agree with claimant that, at most, their examination only establishes that, at the time it was performed, the panel was unable to find objective evidence of injury. On the other hand, as attending physicians, Drs. Johnson and Rusch had the opportunity to evaluate claimant's condition for an extended period. Because of their greater familiarity with the development of claimant's right wrist condition, we believe they were in a better position to comment on whether claimant suffered an injury due the alleged work incident.

In the Matter of the Compensation of
RICHARD A. SCHIEL, Claimant
Own Motion No. 97-0374M
OWN MOTION ORDER OF ABATEMENT
Glen J. Lasken, Claimant Attorney

Claimant requests reconsideration of our August 20, 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.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID M. BIRD, Claimant
WCB Case Nos. 97-08117 & 97-07313
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney
Hoffman, Hart, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation, on behalf of employer Matrix Communication Corporation, requests review of that portion of Administrative Law Judge (ALJ) Hoguet's order that set aside its denial of claimant's "new injury" claim for a combined right shoulder condition. United Grocers, Inc., cross-requests review of that portion of the ALJ's order that assessed an attorney fee for allegedly prevailing over its compensability denial of claimant's current right shoulder condition. On review, the issues are responsibility and attorney fees. We reverse in part, affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the following correction: In the second sentence of the second paragraph on page 2, the date should be "November 1992" (rather than "November 1997").

We briefly summarize the pertinent facts as follows:

Claimant, age 33 at the time of hearing, began working for United Grocers in 1991. In November 1992, he compensably injured his upper back and right shoulder pulling product orders. United Grocers accepted a right shoulder and upper back strain. Claimant returned to work in less than two weeks without restrictions and the claim was later closed without an award of permanent disability.

On March 31, 1994, claimant again injured his right shoulder pulling product orders. Despite conservative treatment, his symptoms persisted. In June 1994, claimant began treating with Dr. Ragsdale, who diagnosed bilateral posteriorly subluxating glenohumeral joints and tendonitis of the right shoulder secondary to subluxation. United Grocers accepted an acute right shoulder strain/contusion and resultant acute tendonitis.

Claimant's claim was closed by Notice of Closure in November 1994 which awarded temporary disability and 17 percent unscheduled permanent disability. Claimant completed an authorized training program (ATP) in November 1995, and was retrained as a telephone technician. A January 1996 Determination Order reduced his unscheduled permanent disability award to 10 percent.

Claimant began working for SAIF's insured, Matrix, in November 1995. Although he experienced intermittent right shoulder pain, stiffness and tightness, claimant was able to perform his regular duties as a telephone technician without medical treatment or time loss. Claimant's intermittent symptoms caused him to avoid using his right arm above shoulder level as much as possible, however. He would also take Advil and/or ice his right shoulder approximately three or four times a month because of pain.

On June 30, 1997, claimant was standing on a ladder, drilling a 1 and 1/2 inch hole through wood and drywall (approximately one inch below the ceiling/wall joint) when he experienced the acute onset of tingling and a popping in his right shoulder. He had been using a five pound electric drill (with both hands on the drill and his right hand on the trigger) for about seven or eight minutes when he felt the stinging pain. He sought immediate treatment and was diagnosed with a chronically lax shoulder.

On August 5, 1997, claimant returned to Dr. Ragsdale for treatment. Dr. Ragsdale recommended stabilizing surgery for the right shoulder. In September 1997, United Grocers denied claimant's aggravation claim as well as compensability and responsibility for his current condition. Thereafter, SAIF denied claimant's current condition, asserting that the June 30, 1997 incident was not the major cause of his combined condition.

CONCLUSIONS OF LAW AND OPINION

Responsibility

At hearing, United Grocers contended that claimant had not shown a worsening of his accepted shoulder condition and that, even if he had, his worsened condition was due to a new injury on June 30, 1997, while employed by SAIF's insured. SAIF, on the other hand, asserted that claimant did not sustain a "new compensable injury" on June 30, 1997, and that responsibility for claimant's condition remained with United Grocers pursuant to ORS 656.308(1).[1]

The ALJ found that although claimant's right shoulder had not pathologically worsened since his last arrangement of compensation, claimant did sustain a new compensable injury arising out of his work activity for SAIF's insured on June 30, 1997. The ALJ therefore concluded that, pursuant to ORS 656.308(1) and ORS 656.007(7)(a)(B), responsibility for claimant's right shoulder condition shifted to SAIF, until such time as the June 30, 1997 incident ceased to be the major cause of claimant's combined condition.

On review, SAIF contends the ALJ erred in assigning responsibility for claimant's right shoulder condition. Specifically, SAIF argues that the record fails to establish that claimant's work activity on June 30, 1997 was the major contributing cause of his disability or need for treatment of the combined condition. We agree.

As noted above, in cases involving combined conditions, ORS 656.308(1) requires that the standards for determining compensability under ORS 656.005(7)(a)(B) be used to determine whether a worker sustained a "new compensable injury or disease" for purposes of assigning responsibility. In other words, if the work incident is found to be the major contributing cause of the ensuing disability or need for treatment, then the claimant is considered to have sustained a "new compensable injury" and responsibility shifts to the subsequent carrier. If, however, the preexisting compensable condition is the major contributing cause of the disability or need for treatment of the combined condition, then responsibility remains with the original carrier. *See SAIF v. Drews*, 318 Or 1, 8-9 (1993).

In *SAIF v. Nehl*, 148 Or App 101, *mod* 149 Or App 309, 311 (1997), the court construed ORS 656.005(7)(a)(B) and held that "regardless of the extent of claimant's underlying condition, if claimant's work injury, when weighed against his preexisting condition, was the major contributing cause of claimant's need for treatment, the combined condition is compensable." The *Nehl* decision turned on the fact that there was a difference between the primary cause of the claimant's combined condition and the primary cause of his need for treatment. *Id.* at 313.

In this case, we find that claimant's treating doctor, Dr. Ragsdale, provided the most complete and well-explained analysis of claimant's combined condition and need for treatment. He explained that claimant developed posterior instability and associated tendonitis of the right shoulder as a result of the March 1994 injury while working for United Grocers. (Ex. 43-22). Dr. Ragsdale also opined that claimant's underlying posterior instability and recurrent tendonitis of the right shoulder was a very significant factor in claimant's current condition, although his work activity on June 30, 1997 precipitated

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[1] This section provides as follows:

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

his need for treatment.[2] (Ex. 43, pp. 11, 20, 25). Dr. Ragsdale explained that the June 30, 1997 incident did not pathologically worsen the underlying instability, but it caused an exacerbation of claimant's resultant tendonitis condition as well as a subluxation of the shoulder.[3] (Ex. 43, pp. 26-29). He also noted that claimant sought treatment following the June 30, 1997 incident to address the exacerbation of his tendonitis, but that the proposed surgery would address the underlying posterior instability. *Id.* In addition, Dr. Ragsdale opined that, whatever influence the June 30, 1997 incident had on claimant's condition, claimant would likely return to his baseline (the preexisting posterior instability condition) within six weeks. *Id.* at 30.

After considering the record as a whole, particularly Dr. Ragsdale's reports and deposition testimony, we are persuaded that although the June 30, 1997 work incident precipitated claimant's need for treatment, it was not the major contributing cause of his disability or need for treatment following the incident. *See Dietz v. Ramuda,* 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995) (the "precipitating" or immediate cause of an injury may or may not be the major contributing cause; in determining major cause, the persuasive medical opinion must evaluate the relative contribution of the different causes and explain why one condition, activity or exposure contributes more to the claimed condition than all other causes or exposures combined). Indeed, both Dr. Ragsdale and Dr. Strum indicated that the primary cause of claimant's current condition was the injury of March 1994, and that the June 1997 incident resulted in a symptomatic exacerbation only.

Because the medical evidence does not establish that the June 30, 1997 incident was the major contributing cause of claimant's disability or need for treatment of the combined condition, we conclude that, for purposes of ORS 656.308(1), claimant did not sustain a "new compensable injury" in 1997. Consequently, responsibility for claimant's right shoulder condition remains with United Grocers.

Attorney Fee

On cross-review, United Grocers contends that the ALJ erred in assessing it one half of the $3,500 attorney fee, because claimant did not prevail over its denial. Insofar as we have reversed the ALJ's decision and determined that responsibility for claimant's current right shoulder condition remains with United Grocers, claimant has, in fact, prevailed over United Grocers' denial. We therefore find that United Grocers is liable for the entire assessed fee for services at hearing regarding the compensability dispute.

We affirm the ALJ's determination, based on the factors set forth in OAR 438-015-0010(4), that $3,500 is a reasonable fee for claimant's attorney's services at hearing for prevailing on the compensability issue.

ORDER

The ALJ's order dated May 20, 1998 is reversed in part, affirmed in part and modified in part. That part of the order that partially set aside SAIF's September 24, 1997 denial is reversed, and the entire denial is reinstated and upheld. That part of the order that upheld United Grocers' September 3, 1997 denial of claimant's aggravation claim is affirmed, but the current condition/compensability and responsibility portions of United Grocers' denial are set aside. In lieu of the ALJ's order directing SAIF and United Grocers to pay one half of the $3,500 assessed fee, United Grocers is liable for the entire $3,500 assessed fee for services at hearing regarding the compensability issue.

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[2] Dr. Ragsdale described the June 1997 work incident as the "blasting cap" for claimant seeking treatment, and explained that this incident probably would not have occurred in the absence of preexisting right shoulder instability. (Ex. 43 at pp. 25-26).

[3] Dr. Strum, who reviewed claimant's medical records at SAIF's request, similarly opined that claimant's work activity on June 30, 1997 combined with his preexisting right shoulder instability to produce a situation where claimant became clinically symptomatic. (Ex. 37-5). Dr. Strum also opined that claimant did not suffer a completely new injury on June 30, 1997, but rather a continuation of the same previously treated right shoulder condition. *Id.*

In the Matter of the Compensation of
AMY CAUDELL, Claimant
WCB Case No. 98-01871
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller, Hall, and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Peterson's order that affirmed an Order on Reconsideration awarding 30 percent (96 degrees) unscheduled permanent disability for a head injury. On review, the issue is extent of unscheduled permanent disability.

We adopt and affirm the ALJ's order.

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

ORDER

The ALJ's order dated May 4, 1998 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $750, to be paid by the insurer.

Board Member Moller dissenting.

Claimant has an accepted claim for numerous conditions, including "syncopal episode," as a result of an accident at work when she fainted and struck the right side of her head on a filing cabinet. A Determination Order awarded only temporary disability. The Order on Reconsideration awarded 30 percent unscheduled permanent disability, which was affirmed by the ALJ. Because I disagree with the majority that claimant is entitled to any permanent disability, I dissent.

The ALJ initially found that, because the insurer requested a hearing challenging the Order on Reconsideration, it had the burden of proving that claimant was not entitled to impairment. The ALJ also agreed with the Department that, based on the medical arbiter's report, claimant was entitled to impairment under Class II of OAR 436-035-0390(10).

I first disagree that the burden of proof is on the insurer. As I stated in my dissent in *Patrick J. Callow*, 50 Van Natta 1665 (1998), I believe that ORS 656.266 puts the burden of proof on the worker throughout the litigation proceedings, whether or not the insurer is the appealing party. Thus, although the insurer requested a hearing from the Order on Reconsideration, it is *claimant's* burden to show that she is entitled to permanent disability.

Class II of OAR 436-035-0390(10) relates to head/brain injury impairment. It provides:

"Cognitive:

The worker functions at a Rancho Los Amigos Scale of 8 (e.g. the worker is alert and oriented; **behavior is appropriate** and the worker is able to recall and integrate past and recent events) and is ADL-independent.

"Language:

Language deficit is **mild** (e.g. language comprehension and production might **occasionally** interfere with daily living).

"Emotional:

Emotional disturbances or personality changes are **mild** (while they may be disproportionate to the stress or situation, they **do not significantly** impair the worker's ability to relate to others or to live with others).

"Sleep Disorder:

Episodic sleep disturbances and/or lethargy are **mild** (e.g. any sleeping irregularity or lethargy only **occasionally** interferes with daily living).

"Episodic Neurological Disorder:

Any episodic neurologic disorder is **not completely controlled**. For example, it may interfere with daily living and cause the worker to have driving restrictions, limit the worker's ability to operate industrial machinery and/or cause the worker to avoid heights." (Emphasis in original.)

The record in this case contains only two medical opinions concerning impairment. Examining neurologist, Dr. Farris, found that claimant had no impairment from the concussion. (Ex. 11-6). In particular, Dr. Farris found that "attention and concentration are normal" and that "language shows normal fluency, effort and articulation of speech." (*Id.* at 4). Claimant also demonstrated "normal comprehension." (*Id.*) Claimant's treating physician, Dr. Tidball, concurred with the report. (Ex. 15).

Psychiatrist Dr. Bellville performed as the medical arbiter. He reported that claimant had a history of syncopal episodes and the most recent fainting episode at work "has not led to any obvious recordable cognitive deficits based on the limited examination today." (Ex. 20-5). He further found that "there does seem to be a mild but significant emotional component" and that "several factors have led to some increase in her preexisting anxiety and suspected depression since the injury of record." (*Id.*) Dr. Bellville then reported:

"Therefore, because she functions at a Rancho Los Amigos scale of 8, because there is not much language deficit, because she has had some mild emotional disturbance, and because she still has some other residual symptoms as noted above, she would be called Class II at this time as far as head/brain injury impairment." (*Id.*)

In examining Dr. Bellville's report, I first find it insufficient in relating any "head/brain injury impairment" to the accepted conditions. Dr. Bellville merely places claimant in Class II without explicitly indicating impairment is due to the accepted injury. I find this especially notable in light of Dr. Bellville's diagnoses of preexisting "social phobia, claustrophobia, and hydrophobia," his suspicion of a preexisting "mild dysthymia" and an adjustment reaction that he noted "may tend to overfocus on her physical symptoms and aggravate them[.]" (Ex. 20-6). In sum, although acknowledging the presence and contribution of noncompensable preexisting psychological conditions to claimant's condition, Dr. Bellville lacks any explanation why any impairment is from the compensable injury, as opposed to the noncompensable preexisting conditions.

I further find Dr. Bellville's report unpersuasive because his examination findings and the accompanying discussion simply does not support his conclusory statement attributing claimant's symptoms to a "head/brain injury impairment." In particular, Dr. Bellville found that the fainting episode did not lead to an "obvious recordable cognitive deficits" and claimant's "speech flows directly with no signs of significant inhibition of blocking[.]" The report does not mention any sleep disturbance and there is no indication that any episodic neurological disorder is not completely controlled. Consequently, I fail to understand how claimant has a mild language deficit, mild episodic sleep disturbances and/or lethargy, and a episodic neurologic disorder that is not completely controlled, all of which is required for claimant to qualify under Class II. Finally, although Dr. Bellville's report is consistent in finding a mild emotional disturbance, as explained above, his report is not at all clear that such disturbance is due to the compensable injury.

In sum, Dr. Bellville's report is insufficient in proving a Class II impairment under OAR 436-035-390(10). Moreover, it is rebutted by evidence from claimant's treating physicians, who saw claimant shortly after the accident and treated her throughout the course of the claim, that claimant has no permanent impairment. In comparing Dr. Farris' examination findings to those of Dr. Bellville, I find them to be very similar. Given the deficiencies of Dr. Bellville's report, even if the burden of proof is on the insurer, I would find that it showed that claimant is not entitled to unscheduled permanent disability. Because the majority comes to the contrary conclusion, I dissent.

In the Matter of the Compensation of
CAROL D. COURTRIGHT, Claimant
WCB Case No. 97-07455
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) declined to admit Exhibits 25A, 25B, 25C, 44A, and 48;[1] and (2) declined to reclassify her hips, legs, and low back strain/sprain injury claim from nondisabling to disabling. Claimant's attorney moves to remand the matter to the ALJ for consideration of Exhibits 25A, 25B, 25C, 44A, and 48. In addition, claimant herself submitted additional argument and copies of various documents directly to the Board. We consider such submittals as an additional request for remand. On review, the issues are remand and claim classification.

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

We make the following corrections to the ALJ's findings of fact. The first sentence of the fourth paragraph of the findings of fact should read as follows. "Claimant first treated with Dr. Lewis for this problem on December 27, 1995. (Ex. 9A-1)." The first sentence of the sixth paragraph of the findings should read as follows. "As of December 27, 1995, Dr. Lewis urged claimant to seek work requiring less repetitive bending, lifting, and twisting. (Ex. 15)." The eighth paragraph of the findings should read as follows. "Dr. Lewis responded to inquiry from claimant's counsel on September 5, 1996, May 1, 1997, and January 14, 1998. (Exs. 24, 32, 49A)."

Remand

At hearing, the self-insured employer's counsel objected to Exhibits 25A, 25B, 25C, 44A, and 48, which were submitted by claimant's counsel, on the grounds that these documents were either generated after the one year period from the date of injury or they were from a physician who did not see claimant within one year following the injury. (Tr. 1-7). The ALJ took the employer's counsel's objection under advisement at hearing. In his order, the ALJ found the employer's counsel's objection persuasive and declined to admit those documents into the hearings record. Nevertheless, the ALJ fully addressed Exhibit 48 in his opinion and explained why the document was unpersuasive. Thus, we find that the ALJ actually admitted Exhibit 48 into the record. In addition, we agree with the ALJ's analysis of that exhibit.

As to Exhibits 25A, 25B, 25C, and 44A, claimant's counsel argues that the ALJ erred in excluding those documents on the grounds that they had been generated more than a year after the date of injury. Furthermore, claimant's counsel requests that this matter be remanded to the ALJ for consideration of this "additional, otherwise admissible, evidence."

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). However, we need not resolve the issue of whether the ALJ abused his discretion in declining to admit the documents in question because, as discussed below, the result would not change even if those documents were considered. We base this conclusion on the reasons expressed in the following "Remand" section.

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[1] Respectively, Exhibits 25A, 25B, 25C, 44A, and 48 consist of copies of: (1) a "Chiropractic, Physical, Orthopedic, Neurological Exam" form completed on November 22, 1996 (Ex. 25A); (2) a "Case History Record" completed by claimant on November 22, 1996 (Ex. 25B); (3) chart notes dated November 22, 1996 and March 3, 1997, from Dr. Gerhart, treating chiropractor (Ex. 25C); (4) an October 9, 1997 chart note from Dr. Lindquist, claimant's current attending physician (Ex. 44A); and (5) a response from Dr. Gerhart to a letter from claimant's counsel dated December 4, 1997 (Ex. 48).

We may "remand" to the ALJ for the taking of additional evidence if we determine that the record has been improperly, incompletely or otherwise insufficiently developed. *Id.* Remand, however, is generally appropriate only upon a showing of good cause or other compelling basis. *Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). A compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable with due diligence at the time of the hearing; and (3) is reasonably likely to affect the outcome. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986).

The issue before us is whether claimant's injury claim was disabling within a year from the August 8, 1995 date of injury. ORS 656.005(7)(c);[2] ORS 656.277(2);[3] *Donald Dodgin*, 45 Van Natta 1642 (1993).

Claimant's counsel submitted Exhibits 25A, 25B, 25C, and 44A at hearing; therefore, there is no doubt that these exhibits were obtained with due diligence at the time of hearing. However, these exhibits do not address the issue at hand, *i.e.*, whether claimant's claim was disabling within a year from the date of injury. Thus, while we may disagree with the grounds cited by the ALJ in refusing to admit these exhibits, we find the exhibits are not relevant. In other words, an examination performed after a year from the date of injury or a report generated after that date might be relevant to the issue of whether a claimant's claim became disabling within a year from the date of injury, if the analysis contained in the examination or report addressed that issue. Of course, the weight given to such analysis would depend on its persuasiveness under the facts of the case. However, here, the exhibits in question do not address the issue at hand. Therefore, Exhibits 25A, 25B, 25C, and 44A are not reasonably likely to affect the outcome. Consequently, we conclude that remand is not warranted for admission of Exhibits 25A, 25B, 25C, and 44A .

In addition to the request for remand from her counsel, claimant herself requested remand to the ALJ for consideration of additional argument and documents that she submitted directly to the Board.[4] The same standards as enumerated above apply to claimant's request for remand.

Much of claimant's argument focuses on her disagreement with the ALJ's summary of a December 21, 1995 chart note from Dr. Baertlein, treating physician. That chart note was admitted into the record as Exhibit 14. We find that the ALJ's summary is accurate, *i.e.*, Dr. Baertlein found no significant objective findings. (Ex. 14). In addition, claimant testified at hearing as to her disagreement with Dr. Baertlein's examination methods and findings. (Tr. 13-16, 24-28). Therefore, we find that the record regarding Dr. Baertlein's report is not insufficiently developed.

Claimant also submitted several documents on review. These included copies of the following: (1) Exhibit 16, a release to modified work from Dr. Lewis, treating physician, dated December 27, 1995; (2) Exhibit 19, a note from Dr. Lewis stating that claimant would benefit from a sedentary job, which might require job retraining; and (3) Exhibit 25D, a copy of a prior ALJ's October 21, 1996 Opinion and Order that found the initial injury claim compensable. Because all of these documents were actually admitted into the hearings record, there is no need for remand relating to these exhibits. (Exs. 16, 19, 25D). To the extent that claimant requests remand to consider the handwritten comments she made in the margins of the October 21, 1996 Opinion and Order, we deny that request. Claimant had the opportunity to make those comments at hearing. More importantly, those comments do not address the issue at hand, *i.e.*, whether claimant's injury claim was disabling within a year of the date of injury. Thus, those comments are not reasonably likely to affect the outcome.

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[2] ORS 656.005(7)(c) provides:

"A 'disabling compensable injury' is an injury which entitles the worker to compensation for disability or death. An injury is not disabling if no temporary benefits are due and payable, unless there is a reasonable expectation that permanent disability will result from the injury."

[3] ORS 656.277(2) provides: "A claim that a nondisabling injury originally was or has become disabling, if made more than a year after the date of injury, shall be made pursuant to ORS 656.273 as a claim for aggravation."

[4] Because it is not clear whether claimant sent copies of these submissions to her counsel or the employer's counsel, copies of claimant's submittal are included with the counsels' copies of this order.

Claimant also submitted copies of several exhibits that were initially submitted and later withdrawn by the employer at hearing. These include the following proposed exhibits: (1) Exhibit 38, a July 8, 1997 letter from Dr. Lindquist to the employer's claims processing agent; (2) Exhibit 46, an October 21, 1997 chart note from Dr. Lindquist; and (3) Exhibit 47, a November 4, 1997 chart note from Dr. Lindquist. Claimant's counsel did not object to the employer's withdrawal of these exhibits, nor were these exhibits submitted on claimant's behalf at hearing. (Tr. 2-7). Those withdrawn exhibits were obviously available at hearing with due diligence. In addition, none of these exhibits is reasonably likely to affect the outcome because they do not address whether claimant's injury claim was disabling within a year of the date of injury.

Finally, claimant submits several documents that were not submitted at hearing. These include: (1) claimant's drawing and narrative describing the mechanism of her work injury; (2) claimant's drawing and narrative describing her pain; (3) copies of claimant's check stubs for work performed for the employer from August 6, 1995 through August 26, 1995; and (4) a work capacity evaluation dated February 24, 1998, including spinal ranges of motion measured on that date. Except for the work capacity evaluation, all of these documents were available with due diligence at the time of the December 29, 1997 hearing. Furthermore, none of these documents, including the work capacity evaluation, address whether claimant's injury claim was disabling within a year of the date of injury. Thus, they are not reasonably likely to affect the outcome.

For all of the above reasons, we conclude that remand is not warranted. The motions to remand are denied.

Claim Classification

In *Karren S. Maldonado*, 47 Van Natta 1535, 1535-36 (1995), we held that to establish a disabling injury under ORS 656.005(7)(c), "it is not enough that a claimant be limited to modified work; there also must be entitlement to temporary disability benefits or a reasonable expectation of permanent disability."

Here, the parties agree that claimant is not entitled to temporary disability and can only prevail if she shows a reasonable expectation of permanent disability. ORS 656.005(7)(c). To support her argument that she has established a reasonable expectation that permanent disability will result from the injury claimant relies, in part, on releases to modified work provided by Dr. Lewis, her former treating physician. However, as we held in *Karren S. Maldonado*, a modified work release, in and of itself, is not sufficient to establish a reasonable expectation of permanent disability. Furthermore, both Dr. Lewis and the examining physicians attributed claimant's need for a modified work release to her age, size, and physical capabilities, not the work injury. (Exs. 20, 32). Thus, we agree with the ALJ that claimant failed to prove that her injury claim became disabling within a year from the date of injury.

ORDER

The ALJ's order dated April 17, 1998 is affirmed.

In the Matter of the Compensation of
CHERYL CHAPIN, Claimant
WCB Case No. 98-00676
ORDER ON REVIEW
Blake & Schilling, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Mills' order that set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. On review, the issue is compensability.

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

On review, the employer argues that the record contains no current claim for a left carpal tunnel syndrome (CTS). However, the employer did not raise this particular issue at hearing. The employer's November 25, 1997 letter said it was unable to accept her "claim for bilateral carpal tunnel." (Ex. 14). At hearing, the parties agreed that the issue was compensability of a claim for bilateral CTS. (Tr. 1). The employer's attorney said the employer did not dispute that claimant had CTS and it was a "medical causation issue[.]" (Tr. 2). Because the employer did not raise the issue regarding claimant's failure to file a claim for a left CTS condition at hearing and it agreed to litigate bilateral CTS, we decline to consider the employer's argument for the first time on review. *See Stevenson v. Blue Cross*, 108 Or App 247, 252 (1991); *Thomas v. SAIF*, 64 Or App 194 (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 self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated April 30, 1998 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
JAMES I. DORMAN, Claimant
WCB Case No. 97-08449
ORDER ON RECONSIDERATION
Starr & Vinson, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Claimant requests abatement and reconsideration of our August 24, 1998 Order on Review that reversed an Administrative Law Judge's (ALJ's) order that increased claimant's unscheduled permanent disability for his low back condition from 16 percent (51.2 degrees), as awarded by an Order on Reconsideration, to 34 percent (108.8 degrees). The ALJ increased the award after deciding that claimant had not returned to "regular work" and, thus, was entitled to more than an impairment value. We found that the record showed that claimant was performing the same truck driver job that he performed at the time of injury, with the same duties, responsibilities, knowledge, skills and abilities. Although there was evidence that claimant was performing the job in a different manner, we concluded that claimant had self-modified his manner of carrying out the same job duties he performed at the time of injury rather than in response to a job change. Consequently, we concluded that claimant returned to regular work held at the time of injury and, thus, the only factor we consider is impairment. *See* ORS 656.726(3)(f)(D)(i).

Claimant contends that, because examining physician, Dr. James,[1] put him in the light category and restricted him to occasional lifting of no more than 20 pounds and frequent lifting of no more than 10 pounds, claimant has shown that he did not return to his regular work. In particular, claimant argues that such evidence should be compared to the DOT description for "log truck driver"; because that description provides a strength category of medium, and he was released for light work, he proved that he did not return to his "regular work." Claimant seems to assert that the DOT description should be used because the standards contemplate comparing the worker's condition with the general labor market and not the particular job with the employer at injury.

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[1] Dr. Goodwin, claimant's treating physician, declined to give a closing examination, so one was provided by examining orthopedic surgeon, Dr. James. Dr. Goodwin concurred with Dr. James' report.

We disagree with claimant's argument concerning the application of the DOT in determining whether a worker "returns to regular work." ORS 656.726(3)(f)(D)(i) states that impairment is the only factor considered in evaluating permanent disability if the worker "returns to regular work *at the job held at the time of injury.*" (Emphasis added.) Because the provision qualifies "regular work" as being "at the job held at the time of injury, "we find a legislative intent to define "regular work" in the context of the worker's particular job duties at the time of injury and not the general labor market. The standards are consistent in that "regular work" is defined as "the job the worker held at the time of injury or employment substantially similar in nature, duties, responsibilities, knowledge, skills and abilities." OAR 436-035-0005(17)(c).

Consequently, based on the statute and standards, we find that, in deciding if a worker "returns to regular work," we compare his particular job duties at the time of injury with the job duties the worker is performing at the time of evaluation. With regard to the DOT description, such a factor may be relevant if it is consistent with the job held at the time of injury; application of the DOT in every case, however, could be contrary to the statute and standards if the DOT description does not reflect the "job held at the time of injury" or "employment substantially similar in nature, duties, responsibilities, knowledge, skills and abilities." Thus, we find that consideration of the DOT description should be on a case-by-case basis.

Here, although the DOT description for "log truck driver" has a strength category of "medium," there is an absence of affirmative evidence showing that the DOT category accurately describes claimant's job at the time of injury. Instead, for the reasons discussed in our order, we continue to find that claimant returned to "regular work."

Thus, we withdraw our August 24, 1998 order. On reconsideration, as supplemented herein, we republish our August 24, 1998 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

Member Hall Dissenting.

For the reasons expressed in my previous dissenting opinion, I continue to disagree with the majority's conclusion that claimant returned to his regular work following his compensable injury. Considering claimant's physical limitations (as confirmed by his attending physician's concurrence with Dr. James' report), I agree with claimant's assertion that his age, education, and adaptability factors should be considered in evaluating his permanent disability award.

In the Matter of the Compensation of
RICHARD R. ELIZONDO, Claimant
Own Motion No. 98-0339M
OWN MOTION ORDER
Andrew H. Josephson, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted claimant's request for temporary disability compensation for his compensable right knee ACL tear, and L4-5 laminectomy and discectomy. Claimant's aggravation rights on that claim expired on February 5, 1987. SAIF 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 is scheduled to undergo a right knee arthroscopy with lateral meniscectomy. 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).

Here, SAIF contended that claimant was not in the work force at the time of his current disability because claimant failed to provide proof of earnings.

Claimant's attorney submitted claimant's 1997 W-2 form, as well as a payroll chart from claimant's current employer demonstrating that he was and is in the work force. Based on claimant's submission, we find that he 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 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.

September 22, 1998 Cite as 50 Van Natta 1775 (1998)

In the Matter of the Compensation of
ELLEN E. HANCOCK, Claimant
WCB Case No. 97-10176
ORDER ON RECONSIDERATION
Vick & Conroyd, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

The self-insured employer requests reconsideration of our August 25, 1998 order that: (1) affirmed an Administrative Law Judge's (ALJ's) order that affirmed claimant's Order on Reconsideration awards of 5 percent (9.6 degrees) scheduled permanent disability for loss of use or function of the left arm and 9 percent (13.5 degrees) scheduled permanent disability for loss of use or function of the right forearm (wrist); and (2) declined to remand the case for consideration of Dr. Winthrop's April 17, 1998 letter. In response, claimant submits that our prior order is "clearly explained and well-supported." In addition, claimant seeks the imposition of sanctions for the employer's allegedly frivolous request for remand.

On reconsideration, the employer requests remand so that Dr. Winthrop's April 17, 1998 letter can be admitted in evidence. The employer also contends that claimant was not medically stationary at the time of the medical arbiter's examination and, therefore, her disability should be rated as of the original Notice of Closure. On reconsideration, after fully considering the employer's contentions, we adhere to our prior decision.[1]

Finally, claimant is entitled to a carrier-paid attorney fee award for her counsel's services on reconsideration. *See* ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable attorney fee for claimant's counsel's services on

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[1] Although we have ultimately rejected the assertions advanced in the employer's motion for reconsideration, we consider its contentions to represent a colorable argument in response to the conclusions reached in our prior order. *Sheri A. Wheeler*, 48 Van Natta 1780 (1996). Because we consider the employer's motion to have been initiated with a reasonable prospect of prevailing, sanctions for a frivolous appeal are not warranted. ORS 656.390(2). In reaching this conclusion, we assume for the sake of argument that the statute is applicable to frivolous motions for reconsideration of Board orders.

reconsideration is $250, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue posed by the employer's reconsideration request (as represented by claimant's response), the complexity of the issue, and the value of the interest involved. Claimant's counsel's services regarding the "sanctions" request have not been considered.

We withdraw our August 25, 1998 order. On reconsideration, as supplemented and modified herein, we republish our August 25, 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
HOLLY J. HENDERSON, Claimant
WCB Case No. 97-07478
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
John M. Pitcher, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Spangler's order that set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome (CTS). Claimant cross-requests review of the ALJ's award of a $3,500 assessed attorney fee. On review, the issues are compensability and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings.

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant's bilateral CTS is a compensable occupational disease if her work activity was the major contributing cause of that condition. ORS 656.802(2)(a). Preexisting conditions are deemed to be causes in determining the major contributing cause. ORS 656.802(2)(e). "Preexisting condition" means any injury, disease, congenital abnormality, personality disorder or similar condition that contributes or predisposes a worker to disability or need for treatment and that precedes the onset of an initial claim for an injury or occupational disease, or that precedes a claim for aggravation. ORS 656.005(24).

The ALJ deferred to Dr. Goodwin's opinion that claimant's work activity was the major contributing cause of her bilateral CTS. In so doing, the ALJ rejected the contrary opinions of the employer's medical examiners, Drs. Jewell, Duff and Button. These contrary opinions are based, in part, on claimant's increased risk of developing CTS because she was middle-aged and obese. As claimant was neither middle-aged nor obese when she began her work activity for the employer, the ALJ reasoned that claimant's age and weight were not "preexisting conditions" within the meaning of ORS 656.802(2)(e). Thus, the ALJ concluded that the employer's medical examiners should not have considered these factors in determining the major contributing cause of claimant's CTS.

On review, the employer contends that its medical examiners properly considered claimant's middle-age and weight as either "preexisting conditions" under ORS 656.802(2)(e), or non-work causes that must be considered in the major contributing cause analysis required under ORS 656.802(2)(a). Thus, the employer contends that the ALJ should not have discounted the opinions of these examiners on this basis.

For the sake of argument, we accept the employer's contention that the consideration of claimant's middle-age and weight is not a persuasive basis for discounting the opinions of Drs. Jewell, Duff, Button. Even so, we find no persuasive basis for not deferring to the contrary opinion of Dr. Goodwin, who is claimant's treating physician. *Weiland v. SAIF*, 64 Or App 810, 814 (1983) (absent

persuasive reasons to do otherwise, great weight is accorded the opinion of a workers' treating physician). As noted by the ALJ, Dr. Goodwin's opinion is based on an accurate understanding of claimant's work activities, he logically explained his conclusion, and he did not alter his opinion under cross-examination. In particular, we note that Dr. Goodwin explained that claimant's daily living activities did not involve the type of repetitive activity that would contribute to CTS. On this basis, we affirm the ALJ's ultimate compensability determination based on Dr. Goodwin's opinion.

Attorney Fees

Claimant challenges the ALJ's award of a $3,500 assessed attorney fee for his counsel's efforts in prevailing over the employer's compensability denial at hearing. Specifically, claimant seeks an attorney fee of $7,500. In response, the employer contends that the ALJ's award is reasonable.

In determining a reasonable attorney fee, we consider the following factors listed in OAR 438-015-0010(4):

"(a) The time devoted to the case;

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

"(c) The value of the interest involved;

"(d) The skill of the attorneys;

"(e) The nature of the proceedings;

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

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

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

The present litigation involved factual, medical and legal issues of average complexity. Claimant's counsel's firm devoted approximately 26.5 hours of services at the hearing level regarding the compensability denial issue. Claimant's attorney generated one exhibit, the September 18, 1997 opinion letter from Dr. Goodwin. The nature of the proceedings was more extensive than those that are normally convened before this forum in that, although the hearing took only two hours, claimant's attorney participated in four lengthy depositions. The value of the interest involved and the benefit to claimant are substantial, in that claimant has undergone surgery to treat her compensable condition, which has resulted in temporary and potentially permanent disability. Considering the countervailing medical opinions, there was a risk that claimant's counsel might go uncompensated.[1] Finally, claimant's counsel and defense counsel are skilled litigators with substantial experience in workers' compensation law, and no frivolous issues or defenses were raised.

After considering these factors, we find that $5,000 is a reasonable fee for claimant's attorney's services at hearing. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the hearings record and claimant's counsel's affidavit), the value of the interest involved, the nature of the proceedings, (including four depositions), and the risk that claimant's counsel might go uncompensated.

Claimant's attorney is also entitled to an attorney fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $1,300, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee on review for his counsel's services regarding the ALJ's attorney fee award. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986); *Amador Mendez*, 44 Van Natta 736 (1992).

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[1] A contingency factor or "multiplier" is not applied in a strict mathematical sense, but rather the risk that claimant's counsel may go uncompensated in this proceeding is considered in conjunction with the other relevant factors of OAR 438-015-0010(4) in ultimately determining a reasonable attorney fee award. *See John M. Morley*, 50 Van Natta 1598 (1998); *Lois J. Schoch*, 49 Van Natta 788, 790 n.1 (1997).

ORDER

The ALJ's order dated March 5, 1998 is affirmed in part and modified in part. In lieu of the ALJ's $3,500 attorney fee award, claimant is awarded a $5,000 attorney fee for his attorney's services at hearing, payable by the self-insured employer. In addition, claimant is awarded a $1,300 attorney fee for his attorney's services on review, to be paid by the employer.

In the Matter of the Compensation of
DEBBIE A. KAHN, Claimant
Own Motion No. 97-0114M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Malagon, Moore, et al, Claimant Attorneys
Industrial Indemnity, Insurance Carrier

Claimant requests review of the insurer's May 14, 1998 Notice of Closure which closed her claim with an award of temporary disability compensation from March 17, 1997 through May 7, 1998. The insurer declared claimant medically stationary as of May 7, 1998. Claimant contends that she is entitled to additional benefits as she was not medically stationary as to all her compensable conditions when her claim was closed.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that she was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12 (1980).

The insurer initially contended that claimant was medically stationary with regard to her compensable low back condition at the time her claim was closed. However, the insurer has now advised that it has accepted claimant's "pain disorder" as compensably related to her accepted 1977 low back injury. It also submitted a medical report authored by Dr. Brown, claimant's attending psychiatrist, wherein he opined that claimant's pain disorder condition was not medically stationary.

In order to close a claim, the following two criteria must be satisfied: (1) claimant must be medically stationary on the date her claim was closed; and (2) claimant must be medically stationary with respect to all compensable conditions on that date. *Gerald D. Duren*, 49 Van Natta 722 (1997). Here, the insurer accepted claimant's pain disorder condition as a compensable component of her accepted injury. As to this pain disorder condition, in Dr. Brown's unrebutted opinion, claimant was not medically stationary at the time of claim closure.

Inasmuch as one of claimant's compensable conditions was not medically stationary at the time of the insurer's May 14, 1998 Notice of Closure, we find that claimant was not medically stationary at the time the claim was closed.

Accordingly, we set aside the May 14, 1998 Notice of Closure as premature. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-012-0055.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
DENNIS R. LOUCKS, Claimant
WCB Case No. 98-00691
ORDER ON REVIEW (REMANDING)
Emmons, Kropp, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Myzak's order that remanded the case to the Department for a reconsideration proceeding. We vacate and remand to the ALJ for further proceedings.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

We begin by briefly summarizing the procedural background of the case. Claimant sustained a compensable injury in April 1997 that was closed by a Notice of Closure mailed on September 18, 1997. Claimant mailed a request for reconsideration on November 14, 1997, which included a request for a medical arbiter examination. The Department received the reconsideration request on November 20, 1997.

On December 5, 1997, the Department issued an Order Denying Request For Reconsideration on the ground that the reconsideration request was untimely. (Ex. 7). Claimant requested a contested case hearing before the Director on December 11, 1997. On January 26, 1998, claimant filed a hearing request with the Board's Hearings Division.

At hearing, the ALJ "bifurcated and reserved" issues arising out of the Notice of Closure or from the reconsideration order pending resolution of the other issues raised by the parties. Those issues were jurisdiction to review the order denying reconsideration, the timeliness of claimant's hearing request and request for reconsideration, and the appropriate disposition of the case if claimant's reconsideration request was timely filed.

In response to SAIF's motion to dismiss claimant's hearing request, the ALJ held that the Hearings Division had jurisdiction to review the Department's order, citing *Jordan v. Brazier Forest Products*, 152 Or App 15 (1998). Proceeding to the other issues, the ALJ determined that claimant's request for hearing before the Hearings Division was timely, as was claimant's request for reconsideration.

Finally, the ALJ addressed the issue of whether the extent of disability should be rated at hearing or whether the case should be remanded, as argued by claimant, to the Department to conduct a reconsideration proceeding. Given her disposition of the other issues, and the fact that the Department had not referred the claim to a medical arbiter as claimant had requested and had not provided the parties with an opportunity to submit evidence at the reconsideration proceeding, the ALJ determined that a remand to the Department was appropriate so that a "full, complete, substantive reconsideration proceeding" could be conducted.

On review, SAIF does not contest the ALJ's rulings on the jurisdictional and timeliness issues. Instead, it only challenges the ALJ's decision to remand to the Department for a new reconsideration proceeding. SAIF contends that the ALJ lacked authority to remand to the Director. SAIF asserts that the case should be remanded to the ALJ for a hearing on issues raised by the Notice of Closure.

For the following reasons, we agree with SAIF that the case should be remanded to the ALJ, rather than to the Department. However, our disposition of the case differs from that which SAIF has requested.

In *Pacheco-Gonzalez v. SAIF*, 123 Or App 312 (1993), the Court of Appeals held that the Board lacked authority to remand to the Department for consideration of a medical arbiter's report. In that case, the Department had ordered a medical arbiter's report because there was a dispute over the impairment findings used to close the claim; however, the report was not considered by the Department because it arrived after the order on reconsideration was issued. The claimant requested a hearing contesting the rating and impairment findings in the reconsideration order. The ALJ dismissed the hearing request and the Board affirmed. Reasoning that the Department's reconsideration order was "invalid" because the Department did not review the medical arbiter's report, we concluded that the ALJ had no jurisdiction to review an "invalid" reconsideration order.

The Court of Appeals reversed, concluding that there was no statutory requirement of a "valid" reconsideration order in order for the ALJ to have jurisdiction. The court also concluded that, even though the medical arbiter's report was not reviewed by the Department, the report could and should have been considered by the ALJ and the Board under *former* ORS 656.268(6)(a), which provided: "Any medical arbiter report may be received as evidence at a hearing even if the report is not prepared in time for use in the reconsideration proceeding." Finally, the court held that the ALJ and the Board did not have authority to remand the case to the Department, reasoning that former ORS 656.268(6)(a) permitted the ALJ to receive and consider the medical arbiter's report and that the statutes did not authorize the remand of cases to the Department.

We applied the court's reasoning in *Pacheco-Gonzalez* to conclude in *Linda M. Cross*, 45 Van Natta 2130 (1993), that the ALJ did not have authority to remand to the Department for the appointment of a medical arbiter to examine the claimant. In *Cross*, the Department issued a reconsideration order rescinding the notice of closure based on the finding that the claimant's condition was not medically stationary. Because the Department found that the claim had been prematurely closed, no medical arbiter was appointed. The employer requested a hearing contesting the premature closure finding in the reconsideration order. The ALJ concluded that the claim had not been prematurely closed and reinstated the closure notice. Finding that the claimant had objected to the impairment findings used to rate her disability, the referee concluded that the claimant was entitled to a medical arbiter's examination and therefore remanded the case to the Department for the appointment of a medical arbiter.

We reversed on the remand issue. Based on the court's reasoning in *Pacheco-Gonzalez*, we held that the ALJ lacked authority to remand the case to the Department. While we agreed with the ALJ's conclusion that the claimant was entitled to a medical arbiter's examination, we fashioned an alternative remedy (other than remand to the Department) for obtaining the examination. We remanded the case to the ALJ to bifurcate the "extent of disability" issue (by assigning a separate WCB Case number for that issue) and issue a final, appealable order resolving the "premature closure" issue. We then ordered the ALJ to defer action on the "extent of disability" issue pending receipt of the medical arbiter's examination report. Finally, we advised the parties to inform the Director of the ALJ's decision that the claim was not prematurely closed and request that the Director schedule a medical arbiter's examination.[1]

In this case, claimant requested a medical arbiter examination when he requested reconsideration of the Notice of Closure. Because the Department concluded that the request for reconsideration was untimely, no medical arbiter examination was scheduled. The ALJ determined, however, that the reconsideration request was timely, a determination that SAIF does not challenge on review. Therefore, while we lack the authority to remand this matter to the Department for appointment of a medical arbiter, claimant is statutorily entitled to a medical arbiter report because he timely disagreed with the impairment findings used to rate his disability. *See* ORS 656.268(7)(a). 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.

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[1] In *Juan Ramirez*, 49 Van Natta 2117 (1997), we fashioned a remedy similar to that we devised in *Cross*. In *Ramirez*, the claimant had been unable to attend a medical arbiter's examination because of his incarceration. However, we held that the claimant had a statutory right to a medical arbiter examination that he had not relinquished or waived. Thus, we were required to devise a remedy that would satisfy both the claimant's right to a medical arbiter examination and *Pacheco-Gonzalez*. As it was in *Cross*, our "best remedy" was a remand to the ALJ for deferral of the "extent of disability" issue pending receipt of the medical arbiter's report pursuant to ORS 656.268(6)(e). *See also Nancy L. Sabin*, 50 Van Natta 508, 509 (1998).

Under the circumstances of this case, we conclude that the "best remedy" is to remand to the ALJ for deferral of issues concerning the closure notice pending receipt of a medical arbiter's report pursuant to ORS 656.268(6)(e). Therefore, 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 challenges to the Notice of Closure, they shall contact the ALJ. Thereafter, the ALJ shall conduct further proceedings in any manner that achieves substantial justice.

ORDER

The ALJ's order dated May 26, 1998 is vacated and remanded in part, and affirmed in part. That portion of the order that remanded to the Department is vacated. Instead, the closure notice/"extent " is remanded to ALJ Myzak for further proceedings consistent with this order. The remainder of the order is affirmed.

September 22, 1998 Cite as 50 Van Natta 1781 (1998)

In the Matter of the Compensation of
GEORGE M. LANDRY, Claimant
WCB Case No. 98-01149
ORDER ON REVIEW
Pozzi Wilson Atchison, Claimant Attorneys
Satherly, Byerly, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Martha Brown's order that upheld the self-insured employer's 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.

On review, claimant continues to assert that the opinion of his treating neurosurgeon, Dr. Soldevilla, proved compensability. We agree with the ALJ that Dr. Soldevilla's opinion was not sufficient to carry claimant's burden of proof. Along with the reasons provided by the ALJ, we further note that Dr. Soldevilla's opinion is conclusory in that he merely indicates that claimant's "employment since 1979, as a whole, has led to this condition" without explaining how claimant's particular work duties caused his disease. Furthermore, Dr. Soldevilla's opinion is rebutted by claimant's initial treating physician, Dr. Breen, who had more extensive contact with claimant than Dr. Soldevilla.[1]

ORDER

The ALJ's order dated May 28, 1998 is affirmed.

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[1] According to the record, Dr. Soldevilla saw claimant one time before performing surgery. (Exs. 11, 13). In contrast, Dr. Breen examined and treated claimant numerous times. (Exs. 3, 4, 7, 9).

In the Matter of the Compensation of
LISA MARTINEZ, Claimant
WCB Case No. 97-07117
ORDER ON REVIEW
Burt, Swanson, et al, Claimant Attorneys
Zimmerman, Nielsen, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Livesley's order that upheld the insurer's denial of her left wrist 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

We adopt the ALJ's opinion regarding objective findings. We substitute the following for that portion of his opinion regarding the compensability of the combined condition.

The medical evidence establishes that claimant has a preexisting chronic tendinitis condition in her left arm and wrist, and that both the preexisting condition and the April 16, 1997 work incident contributed to her need for treatment. Therefore, in order to establish compensability, claimant must prove that the work incident of April 1997 was the major contributing cause of her need for medical treatment or disability for her combined condition. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101, *recon* 149 Or App 309 (1997), *rev den* 326 Or 389 (1998). The fact that a work injury is the immediate or precipitating cause of a claimant's condition does not necessarily mean that that injury was the major contributing cause of the condition. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995). Instead, determination of the major contributing cause involves evaluating the relative contribution of different causes of claimant's need for treatment of the combined condition and deciding which is the primary cause. *Id.*

Dr. Wilson opined that, although the major cause of claimant's symptoms (a pop and sting) in the first dorsal compartment "may have been" the lifting incident at work, the major contributing cause of her left wrist condition (first dorsal compartment tendonitis) was her underlying tendinitis condition. (Ex. 18-13).

Dr. Zirschky opined that the major contributing cause of the initiation of claimant's complaints, the strain and tendonitis *from the strain*, was the work event. (Ex. 17-15, -16, 17). We do not find Dr. Zirschky's opinion to be persuasive. Dr. Zirschky did not weigh the relative contributions from claimant's preexisting chronic tendonitis condition and the work incident, nor did he explain why the work injury contributed more to the claimed condition than the preexisting chronic tendonitis condition. Absent such an evaluation, Dr. Zirschky's opinion is insufficient to carry claimant's burden. *SAIF v. Nehl*, 149 Or App at 312; *Dietz v. Ramuda*, 130 Or App at 401; *see James S. Modesitt*, 48 Van Natta 2542 (1996) (treating surgeon's opinion found unpersuasive where he relied on a temporal relationship without sufficiently weighing the relative contributions from the preexisting degenerative condition and the alleged injury). Therefore, even if we had concluded that there were objective findings to establish claimant's injury claim, there is insufficient medical evidence to support compensability.

ORDER

The ALJ's order dated June 2, 1998 is affirmed.

In the Matter of the Compensation of
ROBERT NICKLE, Claimant
Own Motion No. 97-0380M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Bischoff & Strooband, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's July 15, 1998 Notice of Closure which closed his claim with an award of temporary disability compensation from July 28, 1997 through June 30, 1998. SAIF declared claimant medically stationary as of June 30, 1998. Claimant contends that he is not capable of doing anything physical and "would like to request that the benefits continue until I can see the doctor in October." We interpret claimant's contention to be that he was not medically stationary when his claim was closed.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the July 15, 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 an August 12, 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, however, no further response has been received from claimant. Therefore, we will proceed with our review.

In support of its Notice of closure, SAIF submitted a June 30, 1998 medical report from Dr. Rosenzweig, claimant's treating physician, wherein he addressed claimant's medically stationary status. Dr. Rosenzweig initially stated that "[claimant]'s not maximally medically healed and it may take some time due to his multiple operated hip to get his strength back." However, concluding that "[A]t this point in time [claimant]'s stationary medically," Dr. Rosenzweig did not expect claimant to materially improve with further treatment. Nonetheless, Dr. Rosenzweig reported that "[A]t this point [claimant]'s not maximally medically healed, and therefore, there may be some material improvement which is further healing, convalescence and therapy." (emphasis added).

When read as a whole, Dr. Rosenzweig's report supports the conclusion that claimant was medically stationary at the time of closure. He affirmatively asserts that claimant will not materially improve with further treatment. In regards to his references that claimant would materially improve with the passage of time, he couched his opinion in vague possibilities using terminology such as: "may be," "hopefully," and "pure speculation." Dr. Rosenzweig's medical opinion expressed the possibility, rather than probability, that claimant would materially improve with the passage of time. We do not consider such a reference to be persuasive. *Gormley v. SAIF*, 52 Or App 1055 (1981) (opinions in terms of medical possibility rather than medical probability are not persuasive).

Based on the record, we find that claimant's condition was medically stationary on the date his claim was closed. Therefore, we conclude that SAIF's closure was proper.

Accordingly, we affirm SAIF's July 15, 1998 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
TERRY L. OLYNYK, Claimant
WCB Case No. 97-01470
ORDER ON REVIEW
Shelley K. Edling, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that: (1) awarded 33 percent (105.6 degrees) unscheduled permanent disability for a low back and hip injury whereas an Order on Reconsideration had awarded 30 percent (96 degrees); and (2) awarded no scheduled permanent disability. On review, the issue is extent of scheduled and unscheduled permanent disability.

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

We correct the second to last sentence in the third paragraph of the "Unscheduled Disability" section on page 4 of the ALJ's order to read: "Therefore, Dr. *Neumann's* inability to apportion the causation of claimant's disability is irrelevant."

In his reply brief, claimant, for the first time, offers an alternative Dictionary of Occupational Titles (DOT) code: DOT 929.687-030, "material handler." The DOT code for "material handler" is designated as heavy. Claimant argues that, based on a combination of this DOT code and the code utilized in the Order on Reconsideration, DOT 827.261-010, "electric appliance servicer" (which has a strength of medium), his base functional capacity (BFC) is heavy.

Pursuant to OAR 436-035-0310(4)(a) (WCD Admin. Order 96-072), a worker's BFC is determined by identifying the DOT code which most accurately describes the most physically demanding job that the worker had successfully performed in the five years prior to determination. When a combination of DOT codes most accurately describes a worker's duties, the highest strength category for a combination of codes applies. *Id.*

The evidence in the record regarding claimant's specific job duties is limited. The medical arbiter's report notes that claimant was "an electronics tech and appliance and TV maintenance man." Claimant's affidavit describes the heavy lifting involved in his job, including lifting of televisions and his tool kit, but does not otherwise describe any of claimant's job duties. Other than the fact that the "material handler" job description involves lifting of materials, we are unable to determine from this record whether the job bears any other similarity to claimant's job at injury. Under such circumstances, we find insufficient evidence from which to conclude that a combination of "material handler" and "electrical appliance servicer" most accurately describes claimant's job duties.

ORDER

The ALJ's order dated May 6, 1998, as reconsidered on June 3, 1998, is affirmed.

In the Matter of the Compensation of
GEORGE SENITZ, Claimant
WCB Case No. 97-02650
ORDER ON RECONSIDERATION (REMANDING)
James B. Northrop (Saif), Defense Attorney

The SAIF Corporation requested abatement and reconsideration of our July 16, 1998 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order that set aside its denial of claimant's hepatitis C infection claim. Specifically, SAIF contends that, at the time of hearing, claimant denied that he had ever used intravenous drugs. SAIF argued that it had now obtained evidence that shows that claimant did use such drugs. Citing *Tricia C. Wagner*, 48 Van Natta 2175 (1996), SAIF argued that the case should be remanded to the ALJ to admit records concerning claimant's alleged drug use. In order to consider the matter, we abated our order and permitted claimant an opportunity to respond. However, because the time has passed for claimant's response to be submitted and we have not received such a response, we now proceed with our reconsideration.

SAIF argues that the facts of this matter are similar to those in the *Wagner* case. In *Wagner*, the claimant was seeking to establish compensability of her psychological condition. Prior to hearing, the claimant provided statements to an examining psychiatrist to the effect that: (1) she had not abused alcohol during the period in question; (2) she had not been separated from her husband; and (3) she had not had any affairs during her most recent marriage. The psychiatrist found that, if the claimant had reported an honest and reliable history, the major contributing cause of her depression was stress from work condition. 48 Van Natta at 2175.

However, following the ALJ's order, which set aside the denial, and the order on review, which affirmed the ALJ's order, the carrier provided information obtained from the claimant's testimony in another proceeding. That testimony contradicted the information which the claimant had earlier provided to the examining psychiatrist. Consequently, we concluded that a compelling reason had been shown for remanding as the evidence concerned the disability, the evidence was not previously obtainable, and the evidence was reasonable likely to affect the outcome of the case. *See Compton v. Weyerhauser Co.*, 301 Or 641, 646 (1986).

Here, we similarly find a compelling reason to remand. Claimant testified at hearing that he did not, and had not used drugs of any kind, including intravenous drugs. (Tr. 48). However, the records submitted by SAIF on reconsideration provide evidence of such drug use. Moreover, the doctors who provided opinions in this matter were not aware of claimant's intravenous drug use and specifically stated that claimant had denied such exposure and had no history of drug use. (Exs. 17, 18, 20). Finally, in reaching his conclusion that the claim was compensable, the ALJ found claimant credible and relied on the medical opinions based on the premise that claimant had no prior drug use.

Accordingly, we are persuaded that the proffered evidence concerns the disability, the evidence was not previously obtainable[1], and the evidence is reasonably likely to affect the outcome of the case. Consequently, we grant SAIF's motion to remand for the admission of additional evidence regarding claimant's medical records showing treatment for intravenous heroin use. On remand, the ALJ shall allow claimant an opportunity to cross-examine or rebut the proffered evidence. The submission of this additional evidence shall be made in any manner that the ALJ determines will achieve substantial justice. Following these further proceedings, the ALJ shall issue a final, appealable order concerning the issues raised in this case.

Therefore, the ALJ's order dated December 8, 1997 is vacated. The matter is remanded to ALJ Peterson for further proceedings consistent with this order.

IT IS SO ORDERED.

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[1] The hearing in this matter took place on December 2, 1997. However, claimant did not authorize the release of drug treatment records until July 29, 1998, and SAIF did not receive the records until August 3, 1998.

In the Matter of the Compensation of
PRISCILIANO E. LOPEZ, Claimant
WCB Case No. 97-04898
ORDER ON RECONSIDERATION (REMANDING)
Willner & Associates, Claimant Attorneys
Lundeen, et al, Defense Attorneys

On June 3, 1998, we abated our May 12, 1998 Order on Reconsideration that had adhered to our March 6, 1998 order that reversed the Administrative Law Judge's (ALJ's) order which had set aside the insurer's denial of claimant's injury claim for a "clay shoveler's" fracture. Enclosing a "post-hearing" medical report from a panel of examining physicians (Drs. Reimer and Thomas), which concludes, based on x-ray evidence, that claimant has a "clay shoveler's" fracture at C7-T1, claimant has requested reconsideration for the second time and seeks remand for admission of the Reimer/Thomas report. Having received the insurer's response to claimant's motion and claimant's reply brief, we now proceed with our reconsideration.

In our initial order of March 6, 1998, we concluded that a preponderance of the medical evidence did not establish the presence of a "clay shoveler's fracture" at C7 and T1. Included in that evidence were medical reports from several examining physicians, Drs. Gambee, Marble and Krein, who concluded, based on x-rays taken in conjunction with a March 18, 1997 examination, that claimant did not have a "clay shoveler's" fracture. (Exs. 14, 19, 20). Therefore, we upheld the insurer's denial of that condition.

Claimant's first request for reconsideration concerned a contention that we relied on "secondary medical opinions" rather than the "key piece of evidence"-- actual x-rays interpreted by Dr. Owen, a chiropractor. Claimant's contentions notwithstanding, we continued to find insufficient evidence of a "clay shoveler's fracture." We emphasized that we have no radiological expertise to interpret x-rays. In addition, we noted that the actual x-rays contained markings and drawings, ostensibly supplied by Dr. Owen, which purported to show a "clay shoveler's" fracture. However, we concluded that the drawings added nothing more to the narrative already supplied by Dr. Owen in his written report interpreting the x-rays. Thus, we declined to alter the holding in our initial order.

Claimant has now submitted a medical report from Drs. Reimer and Thomas who performed a "post-hearing" closing examination for the insurer on April 10, 1998. Drs. Reimer and Thomas concluded, based on a review of x-rays taken in Dr. Owens' office, that a "clay shoveler's" fracture is present at C7-D1. Drs. Reimer and Thomas also stated in an addendum to their report that, based on a review of x-ray film taken in conjunction with Dr. Gambee's March 18, 1997 examination, and which formed the basis for Dr. Gambee's, Dr. Marble's and Dr. Krein's opinions, those films did not reveal the area in question and, thus, were of little significance.

The issue now arises as to whether this matter should now be remanded to the ALJ for admission and consideration of the Reimer/Thomas report. For the following reasons, we conclude that remand is warranted.

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

The proffered evidence clearly concerns disability because it directly addresses the question of whether claimant has a "clay shoveler's" fracture. Moreover, the evidence casts doubt on the reliability of the Gambee/Marble/Krein interpretation of the x-ray evidence. Therefore, we find that consideration of this evidence creates a reasonable likelihood that the outcome of this case would be affected. *See Cain v. Wooley Enterprises*, 301 Or 650, 654 (1986). The more difficult question is whether this evidence was obtainable at the time of hearing.

We find that a comparison of this case with *Compton* is helpful in resolving this issue. In *Compton*, the claimant filed a claim for occupational hearing loss in April 1983. Dr. Ediger, the audiologist to whom the employer referred the claimant, found a seven decibel loss of hearing.

Although he characterized the claimant's hearing change as slight, Ediger in his initial report would not rule out the possibility that work for the employer might have caused the change in hearing. The claimant was then referred to an ear, nose and throat specialist, Dr. Hiatt, for evaluation. Hiatt's otological evaluation found no evidence of ear disease and concluded that the cause of additional hearing loss was "undetermined" and not related to noise exposure at the employer, assuming adequate ear protection. After reading the otological report, Dr. Ediger amended his opinion, stating that he did not consider it likely that the claimant's hearing loss was due to employment.

The Referee (now ALJ) found the claim compensable. The employer requested Board review. The employer also requested a "closing report" from Ediger. For that purpose, Ediger conducted another evaluation after the hearing. After this evaluation, Ediger reported evidence of a further reduction in hearing, albeit slight. The report from this evaluation also stated that, after "reviewing and rethinking" the case in light of newly obtained information that the claimant had gone without hearing protection when he needed to communicate with co-workers, Ediger felt that it would be impossible to say that change in hearing from 1966 to 1984, though relatively slight, could absolutely not have resulted from excessive noise exposure as a result of employment.

When the employer requested Board review of the referee's order, claimant moved for remand pursuant to ORS 656.295(5) because the case was improperly, incompletely or otherwise insufficiently developed or heard by the Referee in the absence of this report. We denied remand for consideration of the new report, concluding that a report explaining the [audiologist's] rethinking of his earlier position was not evidence which could not reasonably have been produced and discovered before the hearing. On the merits, we reversed the Referee because the claimant had not established that his work was the major cause of the slight worsening of his hearing loss.

Before the Court of Appeals, the claimant moved pursuant to ORS 656.298(6) to have the court consider the new report as additional evidence concerning disability that was not obtainable at the time of the hearing. The Court of Appeals denied the motion and affirmed our order. The claimant then appealed to the Supreme Court.

The Court agreed with the long line of Court of Appeals decisions that there is a distinction between unavailable and unobtainable evidence and that evidence not submitted at hearing must be "unobtainable," not merely "unavailable" at hearing, before a remand is appropriate. Noting that Dr. Ediger's report was not requested by the claimant, but was requested by the employer for closing the claim, the Court observed that this was not a case of a claimant disappointed with the Referee's decision who engaged in opinion shopping in the medical community to seek additional benefits.

However, the Court held that an erroneous factual foundation or change of opinion did not create "unobtainable" evidence. The Court stated that all the claimant had to do upon receiving Ediger's first report was to produce the doctor to testify at the hearing and merely ask the doctor to assume the disputed fact of unprotected exposure at work and then ask the doctor if this would change his opinion. In the alternative, the Court noted that the claimant could have supplied this information to the doctor and asked for a revised opinion. Observing that all this information existed long before the hearing and, in that sense, was obtainable, the court held that the evidence may not have been made available at the hearing, but it certainly was "obtainable." Accordingly, the Court affirmed the Court of Appeals, emphasizing that the workers' compensation scheme requires not only promptness but also finality in the decisionmaking process, and that to hold otherwise would allow virtually every case to be reopened when a belated discrepancy in the evidence is called to the attention of the claimant. 301 Or at 648-9.

Here, the facts are similar to those in *Compton* in that evidence at issue also resulted from a closing report requested by the carrier. Moreover, the Reimer/Thomas report, like the Ediger report in *Compton*, was also unavailable at hearing. However, unlike the Ediger report in *Compton*, we find that the information in the Reimer/Thomas report was also "unobtainable" at the time of hearing.

In contrast to the disputed evidence in *Compton*, which the court noted could fairly easily have been obtained at or before hearing, the information in this case that the examining physicians may not have viewed the proper area of claimant's spine could not reasonably have been obtained prior to or at the hearing. Granted, in theory, claimant could have cross-examined Drs. Marble, Krein and Gambee and ascertained whether or not the x-rays taken on March 18, 1997 were of the correct area of claimant's

spine. However, Dr. Gambee reported that 5 views of the cervical spine and 3 views of the thoracic spine were taken, including the "Swimmer's" view that a chiropractic radiologist, Dr. Wei, had recommended. (Ex. 14-5). The doctors reported that the many views of the cervical and thoracic spine revealed no bony or soft tissue abnormalities.

Under these particular circumstances, where numerous views of claimant's spine had been taken, and where, until the post-hearing report by Drs. Reimer and Thomas, none of the several physicians reviewing the x-rays in question even suggested that the x-rays did not cover the correct area of claimant's spine, we believe that it was unrealistic to expect claimant to cross-examine Drs. Marble, Gambee and Krein to confirm that x-rays of the proper area of claimant's spine were, indeed, taken. Thus, we conclude that the information contained in the Reimer/Thomas report was both unavailable and unobtainable at the time of hearing. Therefore, we find a "compelling" reason to remand to the ALJ for admission of the Reimer/Thomas report. *See Froilan R. Gonzalez*, 49 Van Natta 1864, 1865 (1997) ("compelling" reason to remand to the ALJ for further proceedings where substantive information contained in "post-hearing" medical reports was not obtainable with the exercise of due diligence prior to the hearing).

Accordingly, on reconsideration, we withdraw our prior orders, vacate the ALJ's order, and remand this matter to ALJ Spangler for further development of the record, including admission of the Reimer/Thomas report regarding the issue of whether claimant has a "clay shoveler's" fracture. Consistent with this order, the ALJ shall have the discretion to proceed in any manner that will achieve substantial justice, and will insure a complete and accurate record of all exhibits, examination, and/or testimony. Thereafter, the ALJ shall issue a final, appealable order.

IT IS SO ORDERED.

Board Member Moller dissenting.

The majority concludes that information contained in the medical report issued by Drs. Reimer and Thomas was both unavailable and unobtainable at he time of hearing. Thus, the majority finds a "compelling" reason to remand to the ALJ for admission of the the report. Because I would reach a different conclusion, I respectfully dissent.

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

I agree with the majority that the proffered evidence clearly concerns disability because it directly addresses the question of whether claimant has a "clay shoveler's" fracture and that consideration of this evidence creates a reasonable likelihood that the outcome of this case would be affected. Where I part company with the majority is in their conclusion that the information contained in the Reimer/Thomas report was unobtainable at the time of hearing.

Similar to the disputed evidence in *Compton*, which the Court noted could have been obtained at or before hearing, the information in this case that the examining physicians may not have viewed the proper area of claimant's spine could reasonably have been obtained prior to or at the hearing. As litigated by the parties, the conflicting interpretive results of various x-ray examinations were critical to the outcome of this case. Dr. Owen obtained x-rays of claimant's spine on January 22, 1997 and submitted those to Dr. Wei for radiological review. Dr. Wei believed those x-rays were suggestive of possible avulsion fractures which would be consistent with a "clay shoveler's" fracture. Subsequently, on March 18, 1997, Dr. Gambee obtained x-rays, which he interpreted as failing to show any fractures. Dr. Owen obtained repeat x-rays on September 8, 1997, which he opined showed "very definite fractures."

In light of this conflicting x-ray evidence as interpreted by the medical experts, claimant could have sought cross-examination of Drs. Marble, Krein and Gambee, which might well have resulted in

an ascertainment whether the x-rays taken on March 18, 1997 were of the correct area of claimant's spine. Similarly, claimant could have obtained and submitted the March 18, 1997 x-rays to either Dr. Owen or Dr. Wei to obtain their interpretation of those examinations in the same manner that Drs. Reimer and Thomas examined the x-rays in reaching their interpretive opinion. Such examination again might well have disclosed whether the March 18, 1997 x-rays were taken of an incorrect area of claimant's spine.

Thus, I would conclude that the information contained in the Reimer/Thomas report, while unavailable at hearing, was "obtainable" with due diligence prior to or at the hearing. Therefore, I would find no "compelling" reason to remand to the ALJ for admission of the Reimer/Thomas report.[1]

[1] In reaching this conclusion, I am mindful of the *Compton* Court's admonition that the workers' compensation scheme requires not only promptness, but also finality in the decisionmaking process. While the Gambee, Marble, and Krein opinions may have been based on an erroneous factual foundation, the fact that such a discrepancy in evidence was called to claimant's attention by the Thomas/Reimer report does not justify remand under *Compton*. Given my conclusion that cross-examination of Drs. Gambee, Marble and Krein was a reasonable course of action for claimant, and considering the need for finality in the decision-making process, as articulated by the *Compton* Court, I am persuaded that remand is not appropriate in this case.

September 23, 1998 Cite as 50 Van Natta 1789 (1998)

In the Matter of the Compensation of
JON O. NORSTADT, Claimant
WCB Case Nos. 94-10782, 94-10774, 94-10781, 94-10773 & 94-05124
ORDER ON REMAND
Cole, Cary, et al, Claimant Attorneys
Brian L. Pocock, Defense Attorney
Mannix, Nielsen, et al, Defense Attorneys
Lundeen, et al, Defense Attorneys
Hornecker, Cowling, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. *Norstadt v. Murphy Plywood*, 148 Or App 484, *on recon* 150 Or App 245 (1997). The court has reversed our prior order, *Jon O. Norstadt*, 48 Van Natta 253, *on recon* 48 Van Natta 1105 (1996), that held that none of the employers/insurers joined in this proceeding were responsible for claimant's occupational disease claim for hearing loss because claimant had not filed a claim against those employers/insurers. Concluding that none of those employers/insurers had properly disclaimed responsibility under *former* ORS 656.308(2) (1990), the court held that these parties were precluded from asserting a responsibility defense to claimant's claim. Consequently, the court has remanded for a determination of how responsibility should be assigned among the improperly disclaimed employers.

The court has held that substantial evidence supported our prior finding that claimant's hearing loss is work related and that, under the last injurious exposure rule, presumptive responsibility initially rested with Douglas County Forest Products/Lumbermen's Underwriting Alliance (DCFP / LUA) because claimant first sought treatment for the condition while employed there in October 1986. The court has further determined that substantial evidence supports our prior finding that claimant's earlier and later periods of employment with DCFP (while it was covered by other workers' compensation carriers) did not independently contribute to his hearing loss condition.

In remanding for reconsideration, the court has instructed us to "determine in the first instance how responsibility should be assigned in this case among Murphy Plywood, DCFP/LN [Liberty Northwest] and Parkway Ford." Claimant's employment for those three employers were as follows: (1) Between October 1991 and March 1992 - DCFP/Liberty Northwest; (2) Between October 1992 and November 1992 - Parkway Ford; and (3) Between September 1992 and July 1993 - Murphy Plywood.

Among those three employers, claimant's most proximate employment exposure to his 1986 "disability date" occurred while he was working for DCFP. Inasmuch as the court has already ruled that all three of these "Liberty" employers are precluded from asserting responsibility as a defense, we hold that DCFP is responsible for the processing of claimant's hearing loss claim.

Accordingly, on reconsideration, we reverse that portion of the Administrative Law Judge's order dated March 17, 1995 that upheld DCFP/ Liberty Northwest's denial of the claim. DCFP/Liberty Northwest's denial is set aside and the claim is remanded to DCFP/Liberty Northwest for processing according to law.

IT IS SO ORDERED.

In the Matter of the Compensation of
YOLANDA V. REYES, Claimant
WCB Case No. 97-09021
ORDER OF DISMISSAL
Meyers, Radler, et al, Defense Attorneys

Claimant has requested review of Administrative Law Judge (ALJ) Thye's August 10, 1998 order. We have reviewed claimant's request on our own motion to determine whether we have jurisdiction to consider the matter. Because the record does not establish that the Board received a timely request for review within 30 days of the ALJ's order, we dismiss.

FINDINGS OF FACT

On August 10, 1998, ALJ Thye issued an Opinion and Order which affirmed an Order on Reconsideration that awarded 12 percent unscheduled permanent disability. That order contained a statement explaining the parties' rights of appeal, including a notice that a request for review must be mailed to the Board within 30 days of the ALJ's order and that copies of the request for Board review must be mailed to the other parties within the 30-day appeal period.

On September 14, 1998, the Board received claimant's request for Board review of the ALJ's order. The request, which was dated September 10, 1998, was not mailed by certified mail. The envelope which contained claimant's request for review was postmarked September 10, 1998.

On September 16, 1998, the Board mailed its computer-generated letter to all parties acknowledging its receipt of claimant's request for Board review.

CONCLUSIONS OF LAW AND OPINION

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

Filing means the physical delivery of a thing to any permanently staffed office of the Board, or the date of mailing. OAR 438-005-0046(1)(a). If filing of a request for Board review of an ALJ's order is accomplished by mailing, it shall be presumed that the request was mailed on the date shown on a receipt for registered or certified mail bearing the stamp of the United States Postal Service showing the date of mailing. OAR 438-005-0046(1)(b). If the request is actually received by the Board after the date of filing, it shall be presumed that the mailing was untimely unless the party filing establishes that the mailing was timely. *Id.*

Here, the 30th day after the ALJ's August 10, 1998 order was Wednesday, September 9, 1998. Thus, September 9, 1998 was the final day to perfect a timely appeal of the ALJ's order. Because claimant's request was not mailed by certified mail and was received by the Board on September 14, 1998, it was "filed" on that date. OAR 438-005-0046(1)(b).[1] Inasmuch as September 14, 1998 is more than 30 days after the ALJ's August 10, 1998 order, the request was untimely filed. *See* ORS 656.289(3); 656.295(2); OAR 438-005-0046(1)(b).

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[1] Even if we were to consider the "postmark" date on the envelope containing claimant's request as the "filing" date, the appeal would still be untimely because September 10, 1998 (the "mailing" date) is also more than 30 days from the ALJ's August 10, 1998 order.

We acknowledge claimant's explanation for the untimeliness of her appeal (that she was out of state due to a death in the family for a month and did not receive the ALJ's order until she returned home). Nevertheless, the determinative issue is not when a claimant *received* her copy of the ALJ's order, but rather the issue is when the order was *mailed*. *Coralee J. Puckett*, 45 Van Natta 1757 (1995). In other words, the statutory scheme unequivocally provides that a party who is dissatisfied with an ALJ's order must mail a request for the Board within 30 days from the date of the ALJ's order. Moreover, that statutory scheme does not authorize the Board to extend or suspend that statutory 30-day appeal period, regardless of a party's explanation for an untimely appeal. *Id.*

Based on the aforementioned reasoning, we lack jurisdiction to review the ALJ's order, which has become final by operation of law. *See* ORS 656.289(3); 656.295(2). Accordingly, claimant's request for Board review is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
PAMELA BILLICK, Claimant
WCB Case No. 98-01381
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Mannix, Nielsen, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Crumme's order that affirmed an Order on Reconsideration that awarded 13 percent (19.5 degrees) scheduled permanent partial disability for loss of use or function of the right forearm (wrist). On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of paragraph 6 on page 2 of the order. We do not adopt the ALJ's "Discussion of Findings."

CONCLUSIONS OF LAW AND OPINION

The ALJ affirmed the Order on Reconsideration award of 13 percent scheduled permanent disability for the right forearm. This award included values for loss of palmar flexion, loss of strength and a chronic condition significantly limiting repetitive use of claimant's right forearm.

When rating permanent impairment, only the opinions of the attending physician and the medical arbiter, if any, may be considered. *See Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666 (1994). Where a medical arbiter is used, as in this case, we do not automatically rely on the medical arbiter's opinion in evaluating impairment, but rather, rely on the most thorough, complete and well-reasoned evaluation of impairment due to the injury. *Kenneth W. Matlack*, 46 Van Natta 1631 (1994). In general, we defer to the opinion of the treating physician absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983).

Claimant's attending physician, Dr. Pribnow, referred claimant to Dr. Wilson, an orthopedic surgeon, who examined claimant and opined that claimant's primary problem was radioscaphoid arthritis. Dr. Wilson did not believe that claimant's condition was related to her surgery for the compensable right carpal tunnel syndrome. After reviewing Dr. Wilson's report, Dr. Pribnow opined that claimant's right carpal tunnel surgery had apparently completely resolved and would be considered medically stationary with no permanent impairment.

Claimant was also examined by a medical arbiter, Dr. Filarski, who is an orthopedic surgeon. Dr. Filarski found loss of strength and reduced palmar flexion. Dr. Filarski also stated that claimant was

"mildly limited" in her ability to repetitively use her hand, wrist and forearm. Dr. Filarski noted that claimant had x-ray evidence of mild radioschaphoid arthritis, but felt that these findings were not associated with symptoms.

After our review, we find no persuasive reason not to defer to claimant's attending physician, Dr. Pribnow, who concluded, based on Dr. Wilson's report, that claimant's right carpal tunnel syndrome condition was medically stationary without permanent impairment. We do not find Dr. Filarski's opinion persuasive because he does not explain the basis for his conclusion that claimant's symptoms and impairment are related to the compensable right carpal tunnel syndrome rather than the radioscaphoid arthritis. Given Dr. Filarski's lack of explanation and Dr. Pribnow's greater familiarity with claimant, we are more persuaded by Dr. Pribnow's opinion. Accordingly, based on this record, we find that claimant has not shown an entitlement to a scheduled permanent disability award.

ORDER

The ALJ's order dated May 22, 1998 is reversed. The Order on Reconsideration is modified to affirm the Notice of Closure. The ALJ's award of an attorney fee is also reversed.

September 24, 1998 Cite as 50 Van Natta 1792 (1998)

In the Matter of the Compensation of
CHERYL MOHRBACHER, Deceased, Claimant
WCB Case No. 96-08566
ORDER DENYING RECONSIDERATION
Peter O. Hansen, Claimant Attorney
Scheminske, et al, Defense Attorneys

The self-insured employer requests abatement and reconsideration of our August 26, 1996 Order on Review that affirmed the Administrative Law Judge's (ALJ's) order which: (1) declined to admit into evidence a hearsay statement regarding the cause of the decedent's death; (2) set aside the employer's denial of claimant's claim for survivor's benefits pursuant to ORS 656.204; and (3) awarded an assessed fee.

The employer's motion states that it does not contest the compensability issue, but rather requests reconsideration of the ALJ's attorney fee award. No explanation is given as to why our order is wrong on the merits of the attorney fee issue. Rather, the employer requests that we abate our order in order to allow it to file additional written argument by October 2, 1998.

However, we have already considered extensive argument regarding the attorney fee issue. Furthermore, because there is no explanation in the employer's motion of why our order is incorrect, the motion for reconsideration is not well-taken. *See* OAR 438-011-0035(2).

Accordingly, the insurer's motion for reconsideration is denied. The parties' rights of appeal shall continue to run from the date of our August 26, 1998 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
TRACEY A. BLAMIRES, Claimant
WCB Case No. 98-02326
ORDER ON REVIEW
Bottini, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by the Board *en banc*.

The insurer requests review of Administrative Law Judge (ALJ) Tenenbaum's order that set aside its partial denial of claimant's claim for his current cervical and lumbar spine condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

Claimant, age 36 at the time of hearing, compensably injured his back on October 16, 1997 when he tripped over a piece of plywood on the floor while carrying a heavy tool box. He caught himself to prevent a fall but, in the process, developed pain between his shoulder blades and in his low back and right hip.

After treating with other providers, claimant came under the care of Dr. Brett on October 7, 1997. A November 11, 1997 cervical spine MRI was within normal limits but the lumbar spine MRI showed preexisting degenerative disc disease at L4-5 and L5-S1. The insurer accepted disabling cervical and lumbar strains on January 5, 1998.

Despite conservative treatment and modified duty at work, claimant's symptoms persisted. By February 1998, Dr. Brett recommended an anterior lumbar interbody fusion at L4-5 and L5-S1 to address claimant's low back pain.

On March 11, 1998, claimant was seen by Dr. Bergquist at the insurer's request. Dr. Bergquist diagnosed chronic mechanical low back pain. He also opined that claimant's compensable injury combined with his preexisting degenerative condition to produce claimant's disability and need for treatment, and that the preexisting condition was the major cause of claimant's current condition.

On March 17, 1998, consistent with the statutory requirement, the insurer issued an "Updated Notice of Acceptance At Closure" indicating that it had accepted cervical and lumbar strains. The same day, the insurer issued a "current condition" denial, stating that claimant's accepted conditions had combined with his noncompensable preexisting degenerative disc disease to cause or prolong his disability and/or need for treatment. The insurer denied claimant's current disability and need for treatment on the basis that his accepted condition was no longer the major contributing cause. The denial further stated that claim closure would be pursued on the accepted portions of the claim. Thereafter, the insurer closed the claim pursuant to a March 17, 1998 Notice of Closure which awarded temporary disability only.

In addition to challenging the insurer's partial denial, claimant requested reconsideration of the Notice of Closure and a medical arbiter examination. He was evaluated by the arbiter, Dr. Hunt, on April 22, 1998. The April 28, 1998 hearing involved only issues arising from the insurer's partial denial.

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant contended that the insurer's partial denial constituted an procedurally impermissible "pre-closure" denial. Relying on *Robin W. Spivey*, 48 Van Natta 2363 (1996) and *Elaine M. Borgelt*, 50 Van Natta 143 (1998), the ALJ agreed. Specifically, the ALJ found that although claimant's lumbar strain involved a combined condition, the insurer did not accept a combined condition involving claimant's cervical and/or lumbar spine and therefore could not avail itself of ORS 656.656.262(7)(b) to deny claimant's current condition prior to closure.[1]

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

On review, the insurer does not challenge the ALJ's application of *Spivey* and its progeny; it instead questions the propriety of the *Spivey* decision itself. We accept the insurer's invitation to revisit the "pre-closure" denial case law established by *Spivey*, *Borgelt* and other cases. Based on the analysis that follows, we now conclude that, regardless of whether the carrier has accepted a combined condition, where the medical evidence establishes that a claimant's accepted injury has combined with a preexisting condition to cause or prolong disability or a need for treatment on an open claim, the insurer may avail itself of the "pre-closure" denial procedure in ORS 656.262(7)(b).

ORS 656.262(7)(b) was enacted in 1995 as part of SB 369. In *Marianne L. Sheridan*, 48 Van Natta 908 (1996), we explained that, pursuant to this provision, 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). In *Elizabeth B. Bernsten*, 48 Van Natta 1219 (1996), we held that, by its terms, ORS 656.262(7)(b) applies only to cases involving a "combined condition."

Thereafter, in *Robin W. Spivey*, 48 Van Natta 2362 (1996), we examined whether the statute requires a carrier, before claim closure, to deny a combined condition that is not first compensable under ORS 656.005(7)(a)(B). After examining the text and context of ORS 656.262(7)(b) and other claim processing provisions, we determined that the statute "cannot apply unless the accepted condition, whether voluntary or by litigation, is a combined condition." 48 Van Natta at 2365. We reasoned that, to hold otherwise would transfer the carrier's claim processing obligation to the Worker's Compensation Division's Appellate Unit or the Board's Hearings Division even though no claim for a combined condition had been made by the claimant and the carrier had not been required to process such a claim. *Id.*

Since that time, we have reiterated and applied the *Spivey* holding in a number of cases and have held that a carrier may not issue a "pre-closure" combined condition denial under ORS 656.262(7)(b) unless it has accepted a combined condition. *See, e.g., Donna Babcock*, 49 Van Natta 208 (1997), *Elaine M. Borgelt*, 50 Van Natta at 143 and *Michael C. Leggett*, 50 Van Natta 151 *on recon* 50 Van Natta 754 (1998) ("Because the employer did not accept the combined condition it is now seeking to deny, ORS 656.262(7)(b) does not apply.").

In reconsidering the soundness of our determination that an acceptance of a combined condition is a prerequisite to a valid pre-closure denial under ORS 656.262(7)(b), we review the holdings and rationale of the pre-SB 369 pre-closure denial cases. In *Guerrero v. Stayton Canning Co.*, 92 Or App 209, 212 (1988), the Court of Appeals expressly held that "[a]n employer may not issue a partial denial of a previously accepted inseparable condition while the claim is still open." In so holding, the *Guerrero* court relied on prior court decisions which viewed the issuance of pre-closure denials as unauthorized attempts to circumvent the ordinary claim closure procedures under ORS 656.268. *See, e.g., Roller v. Weyerhaeuser Co.*, 67 Or App 583, *on recon* 68 Or App 743, *rev den* 279 Or 601 (1984). In *Boise Cascade Corp. v. Katzenbach*, 307 Or 391, 394 n 1 (1989), however, the Supreme Court expressed skepticism about the merits of the *Guerrero* doctrine even though the doctrine was not directly applicable to the case before it.

Subsequent to *Guerrero*, in a 1990 special session, the legislature enacted *former* ORS 656.005(7)(a)(B), which provided that "[i]f a compensable injury combines with a preexisting disease or condition to cause or prolong disability or a need for treatment, the resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment." Thereafter, in *United Airlines, Inc. v. Brown*, 127 Or App 253 (1994), the court interpreted this section as providing a basis for determining a worker's substantive right to disability and medical benefits, but not a procedural mechanism to deny an accepted claim before claim closure. The court reasoned that neither the text nor the context of ORS 656.005(7)(a)(B) indicated that the legislature intended the statute to provide an employer with the procedural authority to deny an accepted claim. The court explained that "[i]f an employer concludes that the compensable injury is no longer the major contributing cause of the disability or need for treatment, the appropriate procedure is claim closure under ORS 656.268." *Id.* at 257.

Since *Brown* was decided, the legislature has substantially amended the relevant statutes. As amended in 1995, ORS 656.005(7)(a)(B) now 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." (Italics added.)

The inclusion of the italicized language underscores the legislature's intent to authorize denials of accepted claims involving combined conditions *at any time* in which the evidence establishes that the compensable injury is no longer the major contributing cause of the combined condition. In fact, the legislative history underlying this revision of ORS 656.005(7)(a)(B) indicates an intent to specifically overrule the *United Airlines v. Brown* holding. *See* Testimony of Jerry Keene, Senate Labor and Government Operations Committee, January 30, 1995, regarding SB 369.[2] This authorization was explicitly extended to "pre-closure" denials as well, as evidenced by the legislature's 1995 enactment of ORS 656.262(7)(b).

Years before the recent statutory amendments, the court in *Roller v. Weyerhauser Co.*, 67 Or App 583 (1984) explained that the rationale underlying the prohibition on "pre-closure" denials was to ensure that a carrier could not "bypass a hearing on the extent of a claimant's disability [by] preempt[ing] the resolution of an issue that is involved in determining the extent of disability." 67 Or App at 586. That decision was appropriate under the statutory scheme then in existence. The statutory changes enacted since *Roller*, however, contemplate precisely the procedure that "pre-closure" partial denials of combined conditions effectuate. In this regard, not only does ORS 656.262(7)(b) mandate such denials before claim closure, but ORS 656.262(7)(c) expressly provides that an appeal of a denied condition shall not delay claim closure, while, at the same time, requiring that a carrier reopen a claim post-closure in the event a denied condition is found to be compensable post-closure. Similarly, ORS 656.268(2)(a) and (4)(b) expressly authorize the closure of a claim when "the accepted injury is no longer the major contributing cause of the worker's combined * * * condition." Consequently, under the current statutory scheme, "pre-closure" partial denials will not have the effect that the court was concerned about in *Roller*, *i.e.*, of circumventing the ordinary claim closure procedures, because the claim processing procedures themselves have been revised.

Considering the text and context of these recent enactments, it is evident that the legislature has expressly endorsed the issuance of "pre-closure" denials, at least in the "combined condition" context. Although in *Spivey* and its progeny, we determined that a carrier must accept a combined condition before availing itself of the pre-closure denial procedure under ORS 656.262(7)(b), we recognize that these cases impose a requirement not expressly mandated by the statute.[3]

The only statutory requirement is that the carrier must have accepted an injury that has combined "at any time" with a preexisting condition to cause or prolong disability or a need for treatment.[4] The determination of whether the carrier has accepted an injury that has -- at any time --

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[2] For example, Mr. Keene testified that the amendments to ORS 656.262 were designed to "overturn[] *Sheridan vs. Johnson Creek* and *United Airlines vs. Brown* and allow[] for an insurer to issue a denial on open claims involving resultant conditions where the work injury component of the claim is no longer the major contributing cause of the resultant condition." He further explained that "the proposed provisions to 656.268(1) also give the insurer another option to close the claim at that point. Either way it gets postured for a decision so the worker can challenge it and that compensability decision can be determined." (Tape 19, side A).

[3] It is a fundamental principle of statutory construction that we are forbidden, both by statutory command and by constitutional principles, to insert language that the legislature, whether by design or by default, has omitted. *See* ORS 174.010; *Deluxe Cabinet Works v. Messmer*, 40 Or App 548, 553 (1996).

[4] Indeed, by its own terms, ORS 656.262(7)(b) refers to the carrier's acceptance of a "claim," not the acceptance of a "combined condition." When the legislature intends that a statute apply only when a carrier has accepted a combined condition, it knows how to so provide. For example, compare the language of ORS 656.262(6)(c), which refers to "[a]n insurer's or self insured employer's *acceptance of a combined or consequential condition* under ORS 656.005(7)(a)(B), whether voluntary or as a result of a judgment or order," to the terms used in ORS 656.262(7)(b) ("Once a worker's *claim* has been accepted * * * "). We believe that the existence of ORS 656.262(6)(c) supports our determination that ORS 656.262(7)(b) was designed to allow a carrier to issue a "preclosure" denial in the combined condition context regardless of whether it has accepted a claim for that combined condition. Furthermore, to construe ORS 656.262(7)(b) as applying only when the carrier has accepted a combined condition would render the provision essentially superfluous in light of ORS 656.262(6)(c), which allows a carrier to deny an accepted combined condition at any time the otherwise compensable injury ceases to be the major cause of the combined condition.

resulted in a combined condition is a question of fact to be resolved on the basis of the record as a whole, not just on the acceptance notice. In other words, if the medical evidence developed subsequent to acceptance discloses that the compensable injury either combined at the outset with a preexisting condition or, as in this case, subsequently combined with a preexisting condition, then ORS 656.262(7)(b) is applicable.[5]

In this case, the insurer closed the claim by Notice of Closure on the same day it issued its partial denial. Thus, the insurer proceeded precisely as contemplated by the current statutory scheme. It issued a partial denial based on the medical evidence indicating that claimant's preexisting condition had combined with the accepted injury and had become the major contributing cause of claimant's prolonged disability. Then it promptly closed the claim. To impose a requirement that the insurer first issue an acceptance of the combined condition and then immediately follow that acceptance with a partial denial of the worker's current disability and/or need for treatment does nothing to advance the policies underlying the statutes.

Accordingly, to the extent that *Spivey, Borgelt, Leggett* and other cases hold that ORS 656.262(7)(b) applies only if the carrier has expressly accepted a combined condition, we disavow those decisions. As noted above, we now hold that, even if the carrier has not accepted a combined condition, so long as the medical evidence on an open claim establishes that the compensable injury combined with a preexisting condition to cause or prolong disability or a need for treatment, the carrier is authorized (and, indeed, is statutorily required) to issue a denial when the accepted injury is no longer the major cause of the worker's combined condition before the claim may be closed. Because that is precisely what the insurer did in this case, we proceed to the merits.

As noted above, under ORS 656.005(7)(a)(B), a "combined condition" is compensable only if, so long as, and to the extent that the compensable injury is the major contributing cause of the disability of the combined condition or the major cause of the need for treatment of the combined condition. Determining the "major contributing cause" of claimant's current condition involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause. *See Dietz v. Ramuda,* 130 Or App 397 (1994). The fact that the work injury may have precipitated the worker's disability or need for treatment does not necessarily mean that the work injury is the major cause. *Id.* Indeed, "major contributing cause" means that the work activity or exposure contributes more to causation than all other causative agents combined. *McGarrah v. SAIF,* 296 Or 145, 166 (1983).

Here, it is undisputed that claimant's compensable injury combined with his preexisting degenerative disc disease to cause or prolong his ongoing disability and need for treatment. The record provides three opinions concerning the cause of claimant's condition in and around the time of the insurer's March 17, 1998 partial denial. Causation opinions have been provided by Dr. Bergquist, who examined claimant at the insurer's request on March 11, 1998; Dr. Hunt, who conducted a medical arbiter examination of April 22, 1998; and the attending physician, Dr. Brett.

Dr. Bergquist opined that claimant has chronic mechanical back pain secondary to degenerative changes of the spine, probably at level L4-5 or L5-S1. Dr. Bergquist reported that claimant's October 1997 work injury resulted in a low back strain that would have resolved within a month or two, and that the cause of his current complaints is his preexisting, idiopathic degenerative disc disease. Dr. Bergquist further concluded that claimant's accepted cervical strain had resolved completely without any residuals. (Ex. 28).

Dr. Brett opined that the work injury was the major contributing factor to claimant's current condition, explaining that "were it not for the work injury combining with the preexisting and asymptomatic minor degenerative disease, claimant would not require treatment nor have any disability." (Ex. 33-2).

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[5] While this case was pending before the Board, the court issued its opinion in *SAIF v. Belden,* 155 Or App 568 (1998), and held that ORS 656.262(7)(b) applies retroactively. The court also affirmed the Board's determination that because the carrier had failed to issue a preclosure current condition denial, all of claimant's impairment had to be attributed to the compensable injury. In so holding, the court characterized ORS 656.262(7)(b) as a "notice statute," and explained that the statute sets forth the procedure that a carrier must follow in order to "take advantage of its newly acquired right to deny an accepted combined condition." *Id.* at 574. Although the court referred to an "accepted combined condition" in the context of ORS 656.262(7)(b), we do not construe the court's holding as limiting the statute's applicability to accepted combined conditions. Indeed, in *Belden,* the carrier had accepted the claimant's combined condition, so the case did not present the issue we address here.

Finally, Dr. Hunt opined that 25 percent of claimant's ongoing low back symptoms were due to his accepted lumbar strain and that the remaining 75 percent are due to the preexisting degenerative disc disease. Dr. Hunt admitted, however, that these numbers were an estimate, as he could not allocate the relative contribution with any certainty. (Ex. 34-9).

After considering the above expert opinions, we are not persuaded that claimant's accepted lumbar strain remains the major contributing cause of his current disability or need for treatment. Although Dr. Brett recited the "magic words", his opinion does not satisfy the *Dietz v. Ramuda* standard. His opinion does not evaluate the relative contribution of claimant's preexisting degenerative changes, nor does it explain why claimant's work injury was the primary cause. Rather, it appears Dr. Brett employed a "but for" analysis in concluding that claimant's work incident was the major cause, which is legally insufficient. *See, e.g., Georgia Barklow,* 49 Van Natta 1261 (1997); *Alec E. Snyder,* 47 Van Natta 838 (1995) (persuasive medical opinion must weigh the relative contribution of different causes; "but for" analysis not well reasoned). Furthermore, both Dr. Bergquist and Dr. Hunt relate claimant's current condition primarily to his preexisting degenerative disease, and not his compensable injury.

Consequently, on this record, we conclude that, as of March 17, 1998, claimant's accepted strain injuries were no longer the major contributing cause of his disability and/or need for treatment. We therefore reinstate the insurer's partial denial.

ORDER

The ALJ's order dated May 1, 1998 is reversed. The insurer's March 17, 1998 denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

Members Hall and Biehl dissenting.

We disagree with the majority's analysis and decision to disavow *Robin Spivey,* 48 Van Natta 2362 (1996) and its progeny. For the reasons articulated by the Board in *Spivey* and such cases as *Elaine M. Borgelt,* 50 Van Natta 143 (1998) and *Michael C. Leggett,* 50 Van Natta 151, *on recon* 50 Van Natta 754 (1998), we would continue to hold that, in order for a carrier to take advantage of its right to deny a combined condition under ORS 656.262(7)(b), the carrier must have *accepted* that combined condition. A reading of the text and context of the subject statutes reveals that they are directed in terms of definition, notice, and procedure to accepted compensable conditions. We believe that, in the absence of an accepted combined condition, the statute is inapplicable.

Consequently, in this case, we would adopt and affirm the ALJ's determination that insofar as the insurer did not accept a combined condition, its "pre-closure" denial of claimant's current combined condition is procedurally invalid under *Spivey* and *Borgelt.*

In the Matter of the Compensation of
JEFFREY N. DAVILA, Claimant
WCB Case No. 97-02700
ORDER ON RECONSIDERATION
Welch, Bruun & Green, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

The SAIF Corporation requested reconsideration of those portions of our September 2, 1998 order that reversed an Administrative Law Judge's (ALJ's) order upholding its denial of claimant's injury claims for lumbar spondylosis, central disc herniation at L5-S1, left disc herniation at L4-5, and a bulging disc at L3-4, on the basis that they were barred by a prior Disputed Claim Settlement (DCS). Specifically, SAIF argues that the parties intended to resolve claimant's initial injury claim for a low back condition, no matter what the diagnosis, because the DCS referred to "the denied injury." SAIF next argues that, if it is necessary to turn to extrinsic evidence to determine the parties' intentions, claimant's "801" indicates that he was filing a claim for a low back injury that was not limited to a lumbar strain, and that SAIF's denial denied claimant's low back injury "claim." Finally, SAIF argues that the parties were aware that it was "possible" that claimant might have a herniated disc prior to entering into the DCS.

For the reasons set forth in our prior order, we remain persuaded that the scope of the DCS concerned only the denied low back strain claim.[1] Therefore, as a matter of law, the DCS did not settle claimant's spondylosis, herniated disc and disc bulge conditions, as they were not denied at the time that the parties entered into the DCS. *Trevisan v. SAIF*, 146 Or App 358 (1997).

As for claimant's "801," claimant specified the nature of the injury as "strained muscle low back," which was the specific condition denied by SAIF. (Exs. 3, 9). Finally, although the record reveals that the parties were aware that "herniated disc" was a possible but unsubstantiated alternative diagnosis at the time they entered into the DCS, the "bona fide" dispute was specifically limited to the "compensability of the conditions and/or services which have been denied." This is evidence that the parties themselves defined the dispute and determined to what the "raised or raisable" language applied. We thus construe the agreement to find that the "raised or raisable" language was limited to that dispute.

Accordingly, we withdraw our September 2, 1998 order. On reconsideration, as supplemented and modified herein, we republish our September 2, 1998 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] As we noted in our order, SAIF stipulated in the DCS that it "denied lumbar strain on October 9, 1996." *See* Order on Review, p. 5. The DCS further provided: "The parties agree that a bona fide dispute exists between them as to the compensability of the *condition(s)* and/or services *which have been denied*. Both parties have substantial evidence to support their contentions and *each desires to settle all issues raised or raisable at this time by entering into a disputed claim settlement under the provisions of ORS 656.289(4)* for the total sum of $7,000.00." (Emphasis supplied.)

We do not find that the "or to the denied injury" language refers to other than SAIF's stipulation that it denied a lumbar strain injury. *See* OAR 438-009-0010(2)(b) (specifying that the DCS shall recite that the claim has been denied and the date of the denial).

In the Matter of the Compensation of
ATSEDE K. GEBRETSADIK, Claimant
WCB Case No. 97-08450
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Lipton's order that set aside its "back-up" denial of claimant's right shoulder impingement syndrome condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The insurer accepted a "contusion/crush injury" of the right upper arm after a door struck claimant in the triceps area of her right arm on April 10, 1997. The insurer subsequently accepted right shoulder impingement and then revoked the acceptance and denied the impingement condition. The parties agree that, for the denial to be upheld, the insurer must prove by a preponderance of evidence that the impingement condition is not compensable. *See* ORS 656.262(6)(a).

The record contains numerous medical opinions concerning causation. Dr. Grewe, orthopedist, saw claimant one time, in July 1997, on referral from claimant's treating chiropractor, Dr. Conklin. Dr. Grewe diagnosed right shoulder impingement and stated that the injury caused decreased use of the right arm, which caused claimant to develop "some posterior capsular tightness," which in turn caused impingement. (Ex. 16-2). In a deposition, Dr. Grewe further explained that immobilization of the right arm from pain caused the impingement condition. (Ex. 34-8).

Dr. Puziss, orthopedic surgeon, performed a record review at claimant's attorney's request. He agreed with Dr. Grewe's opinion, stating that claimant "developed inflammation of the shoulder secondary to the humerus contusion, and subsequently developed, I think, mild adhesive capsulitis resulting, e.g., in loss of adduction and other movements" which "ultimately led to swelling of the rotator cuff and impingement." (Ex. 32-1).

Dr. Conklin indicated that the major contributing cause of the impingement condition was the April 1997 injury. (Ex. 30).

Dr. Schilperoort, examining orthopedic surgeon, also diagnosed subacromial impingement, but found that it was not related to the injury. (Ex. 21-3). According to Dr. Schilperoort, the injury was not consistent with impingement because it did not involve a "direct contusion to the lateral aspect of the shoulder" and such condition normally evolves "over a prolonged period of time in terms of years[.]" (Ex. 22).

Dr. Mandiberg, orthopedic surgeon, treated claimant one time. He concurred with Dr. Schilperoort's opinion. (Ex. 23). He later disagreed, however, with that portion of Dr. Schilperoort's opinion indicating that the condition evolves over a prolonged period of time. (Ex. 28-1). Dr. Mandiberg then stated that, when he saw claimant, "she did not have symptoms of an impingement." (*Id.*)

Finally, Dr. Peters, who initially treated claimant, indicated that the injury was not the major contributing cause of an impingement condition but added that he was "really, unable to comment" because his evaluation took place during the "acute state" while Dr. Grewe's evaluation was three months later and, thus, he could not "comment on [Dr. Grewe's] evaluation, since I was not present." (Ex. 29A).

In evaluating the persuasiveness of medical opinions, we rely on those that are well-reasoned and based on an accurate history. *See Somers v. SAIF*, 77 Or App 259 (1983). According to the insurer, Dr. Grewe's opinion is "speculative" because, having examined claimant three months after the injury, he had no personal knowledge of claimant's condition following the injury and, because he relied on claimant's history that she continued having right arm pain following the injury, he based his opinion on an unreliable history.

Although not every single detail of the accident is consistently reported by claimant, for the most part, claimant's explanation to medical providers and her testimony at hearing is uniform concerning the mechanism of injury.[1] More importantly, we find no reason to discount her testimony that she continued having right arm pain months after the injury. Dr. Peters, the physician who initially treated claimant and was in the best position to evaluate whether or not claimant's initial symptoms would be inconsistent with a subsequent impingement condition, indicated that he could not comment on Dr. Grewe's evaluation. Furthermore, we find no bases for considering claimant not credible; in particular, as explained above, claimant's reports and testimony generally are consistent and the ALJ did not find claimant not credible based on demeanor. The record also contains no evidence that an intervening event caused claimant's arm pain.

In sum, there is insufficient evidence that Dr. Grewe relied on an inaccurate history. Additionally, of those opinions supporting the insurer's position, Dr. Schilperoort's opinion concerning the time period necessary for impingement to evolve is disputed by most of the other physicians (including Dr. Mandiberg) and Dr. Mandiberg simply finds that claimant does not have the condition. At best, we find the medical opinions in equipoise. Consequently, we agree with the ALJ that the insurer did not carry its burden of proving that claimant's impingement condition is not compensable.

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[1] We further note that claimant is not a native English speaker and difficulty with obtaining information was noted by at least one physician.

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 June 8, 1998 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
WILLIE KEMP, JR., Claimant
WCB Case Nos. 98-03414, 98-02645, 98-01700, 98-01699, 98-00700 & 98-00699
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Lipton's order that set aside its denial of claimant's October 16, 1997 low back and left leg injury claim. In his brief, claimant contests that portion of the ALJ's order that upheld the employer's denial of his occupational disease claim for his current condition, including an L4-5 disc herniation. 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

Between 1973 and 1979, claimant was treated for a series of low back incidents, including compensable back strain injuries in December 1974 and October 1978 while working at prior employers. Claimant was awarded 30 percent unscheduled permanent disability (PPD) for his low back as a result of the 1974 injury and 5 percent unscheduled PPD for his low back as a result of the 1978 injury.

In 1980, claimant began working at the present employer as a utility worker and as a semi-truck driver about three or four years later. In November 1990, claimant experienced a compensable disabling low back strain when he lifted a portable sub-station. This claim was initially closed by a June 24, 1992 Notice of Closure that awarded no PPD. In January 1993, claimant experienced a compensable aggravation of the November 1990 injury.

In December 1993, claimant experienced a new low back injury, which was accepted as a nondisabling low back strain. Claimant was found medically stationary on April 21, 1994, and the claim was closed by Determination Order that awarded 9 percent unscheduled PPD.

In August 1994, claimant experienced a new low back injury, which was accepted as a disabling low back strain. This claim was closed by an October 3, 1996 Determination Order that awarded no PPD.

A May 13, 1997 Determination Order closed the January 1993 aggravation claim for the November 30, 1990 injury claim with an award of 16 percent unscheduled PPD for claimant's low back. This award was reduced to zero by a September 5, 1997 Order on Reconsideration.

On August 8, 1997, claimant sought treatment for low back pain from Dr. Berselli, orthopedic surgeon, after falling at work. An MRI revealed a disc protrusion at L4-5. Claimant was not taken off work. On September 16, 1997, Berselli noted that claimant's back pain was unchanged and requested

authorization for an epidural injection. Berselli filed an aggravation claim related to the November 1990 low back injury claim, which was denied. Claimant also filed a new injury claim based on the same incident, which was also denied, on the basis that the August 1997 incident was not the major contributing cause of the need for treatment or disability for his low back condition. These denials were upheld by the ALJ and are not at issue on review.

On October 16, 1997, claimant again sought treatment for low back and left leg pain after a lifting incident at work. Dr. Berselli noted paralumbar spasm, restricted motion and tenderness over the sciatic notch.[1] X-rays revealed widespread degenerative changes. Berselli took claimant off work and the epidural injection was performed on October 17, 1997, with good results. (Exs. 67, 68, 69). Claimant filed a new injury claim in relation to the October 16, 1997 work incident, which was denied on the basis that the October 1997 incident was not the major contributing cause of the need for treatment or disability for the low back condition.

On January 23, 1998, claimant filed an occupational disease claim for his current low back condition, including the L4-5 disc protrusion.

Compensability - October 16, 1997 Injury

The ALJ concluded that the October 16, 1997 injury was compensable, based on a material contributing cause standard. On review, the employer contends that the proper standard is "major contributing cause," and that claimant's new injury claim fails under that standard. We agree.

The ALJ found that there was no medical evidence to establish that the October 1997 injury combined with a preexisting condition. However, Dr. Rosenbaum, neurosurgeon, who evaluated claimant on January 26, 1998, diagnosed claimant's condition as chronic lumbosacral strain by history with episodic exacerbations. He reported that the October 16, 1997 incident was similar to the August 8, 1997 incident, which was contributed to by claimant's preexisting lumbar condition that dated back to 1973 and was caused in major part by the 1990 strain, which had never entirely resolved. Rosenbaum also confirmed that claimant had a significant low back condition that included degenerative changes, chronic pain syndrome, and chronic low back discomfort preexisted the September 16, 1997 incident. (Exs. 88, 89). Dr. Berselli, claimant's attending physician, subsequently concurred in Dr. Rosenbaum's reports. (Ex. 97).

Based on this medical evidence, which is supported by the medical record as a whole, we conclude that claimant's preexisting degenerative condition and chronic pain syndrome combined with the October 16, 1997 work incident to cause claimant's disability and need for treatment. Therefore, in order to establish the compensability of his October 16, 1997 injury claim, claimant must prove that the injury was the major contributing cause of the disability and need for treatment of the combined condition. ORS 656.005(7)(a)(B).

Determining the "major contributing cause" involves evaluating the relative contribution of different causes of claimant's condition or disability and 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* 321 Or 416 (1995); *Gregory C. Noble*, 49 Van Natta 764, 765-66 (1997), *aff'd mem* 153 Or App 125 (1998). Based on the medical record, we find that there are multiple potential causal factors involved in claimant's condition and need for treatment; therefore, the causation issue presents a complex medical question which must be resolved on the basis of expert medical evidence. *See Uris v. Compensation Dept.*, 247 Or 420, 426 (1967); *Barnett v. SAIF*, 122 Or App 279, 283 (1993). Claimant has the burden of proving his claim by a preponderance of the evidence. *See* ORS 656.266.

We generally give great weight to medical opinions that are well-reasoned and based on a complete and accurate history. *Somers v. SAIF*, 77 Or App 259 (1986); *Michelle L. Andreasen*, 48 Van Natta 515 (1996).

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[1] We note the employer's assertion that claimant's injury is not supported by medical evidence of objective findings. *See* ORS 656.005(19). Because the October 16, 1997 claim is not compensable, we need not address that assertion.

Opinions regarding the cause of claimant's low back condition and need for treatment were provided by Dr. Rosenbaum, Dr. Gritzka, orthopedic surgeon, and Dr. Berselli.

As noted above, Dr. Rosenbaum and Dr. Berselli opined that claimant's October 16, 1997 low back condition was contributed to by claimant's preexisting degenerative condition and chronic pain syndrome dating back to 1973 and was caused in major part by the 1990 strain, which had never entirely resolved.

Dr. Gritzka diagnosed claimant with chronic lumbosacral sprain with radicular-like symptoms in both lower extremities, posterior disc protrusion at L4-5, and mild degenerative lumbar spondylosis with bilateral articular facet sclerosis. He opined that claimant's work activity as a truck driver for the employer hastened the degenerative changes in claimant's lumbar spine. However, he also opined that no one specific work injury could be identified as the major contributing cause, even though he stated that the 1990 injury "entrained the subsequent course of events and complaints of chronic low back pain." (Ex. 96).

These undisputed medical opinions of Dr. Rosenbaum, Dr. Gritzka and Dr. Berselli establish that the major contributing cause of claimant's chronic low back condition is his preexisting back problems, which were themselves caused by the 1990 work injury, claimant's occupational activities in general, preexisting injuries from the 1970s, and claimant's degenerative condition. In light of this uncontradicted medical evidence,[2] we find that claimant has failed to establish that the October 1997 work incident was the major contributing cause of his October 1997 low back condition or the major contributing cause of his disability or need for treatment.

Occupational Disease Claim

Claimant also argues that the ALJ should have set aside the employer's denial of claimant's occupational disease claim. Citing *Saedeh K. Bashi*, 48 Van Natta 1004 (1996), claimant further argues that the October 16, 1997 work incident was a direct consequence of the occupational disease and, as such, is compensable under a material contributing cause standard pursuant to ORS 656.005(7)(a)(A). We disagree.

In order to establish an occupational disease, claimant must show that employment conditions were the major contributing cause of the disease or, if the occupational disease claim is based on the worsening of a preexisting disease or condition, claimant must show that the employment conditions were the major cause of the combined condition and pathological worsening of the disease. ORS 656.802(2)(a) and (b). Existence of an occupational disease must be established by medical evidence supported by objective findings. ORS 656.802(2)(d).

Here, claimant has been diagnosed with preexisting degenerative disc disease and a disc protrusion at L4-5. Therefore, claimant must establish that employment conditions were the major cause of the combined condition and pathological worsening of the disease.

As discussed in note 2, Dr. Neuman opined that claimant's low back condition on August 12, 1997 was related primarily to degenerative arthritis of the lumbar spine, with a possible contribution from the 1990 lumbar strain. (Ex. 61).

Dr. Rosenbaum concluded that claimant's intermittent exacerbations since 1990 were attributable in major part to the 1990 strain. He opined that the L4-5 disc abnormality was due to the process of aging, was not contributed to by the 1990 or subsequent injuries and was not causing current symptoms. (Exs. 88, 89). Dr. Berselli, claimant's treating physician in the 1970s and currently, concurred with Dr. Rosenbaum's opinion. (Ex. 97). This concurrence is derived from an accurate foundation and logical reasoning and is entitled to full weight. *Roseburg Forest Products v. Glenn*, 155 Or App 318 (1998).

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[2] We also note that Dr. Neuman, who performed a medical arbiter examination on August 12, 1997, in regard to the November 1990 claim, diagnosed degenerative arthritis of the lumbar spine, unrelated to the 1990 claim, and a 1990 lumbar strain injury with recurrent flare-ups of discomfort. He opined that claimant's current symptoms, which included low back pain with intermittent numbness in the left leg and foot, were due to his arthritis. (Ex. 61).

Dr. Gritzka, orthopedic surgeon, evaluated claimant's condition in March 1998. He agreed with Rosenbaum that claimant was not experiencing radicular involvement, and opined that claimant's bilateral lower extremity pain and numbness were probably not the result of nerve root compromise or compression. Gritzka instead opined that the L4-5 disc itself was symptomatic and contributed to claimant's midline low back pain. Based on claimant's history, he opined that the November 1990 injury was probably the major contributing cause of the L4-5 disc protrusion, as claimant's symptoms significantly worsened at that time. He also stated that claimant's current low back problems began in major part with the 1990 injury. (Ex. 96-8, -9). Nevertheless, Gritzka further opined that claimant's work while operating vibrating equipment accelerated the degenerative disc changes, and that, therefore, claimant's overall work activity since 1980 was the major contributing cause of his current low back condition. (Ex. 96).

Upon review of Dr. Gritzka's report, Dr. Rosenbaum explained that, although there may have been some effect on claimant's degenerative disease or L4-5 protrusion by claimant's work, such was not the major contributing cause of those conditions. (Ex. 98). Rosenbaum reasoned that claimant has had intermittent musculoskeletal injuries to the lumbar spine through his work activities, the most notable of which was the 1990 injury, which caused claimant's ongoing chronic strain. However, in opposition to Gritzka's opinion, Rosenbaum opined that there was no indication that claimant's spinal degeneration or disc protrusion were caused in major part by his work; rather, he attributed their cause to a combination of genetics and aging, with claimant's work having only a minimal effect.

We conclude that Dr. Rosenbaum's and Dr. Berselli's opinion is more persuasive than that of Dr. Gritzka. First, Dr. Gritzka provides no support for an occupational disease connection for the L4-5 disc condition, as he specifically agreed with Dr. Rosenbaum's conclusion that the protrusion was caused in major part by the 1990 injury. (Ex. 96-8). Second, in regard to the remainder of the occupational disease claim, Dr. Gritzka's opinion is, at best, ambiguous. He first states that claimant's current low back problems began in major part with the 1990 injury. (Ex. 96-9). He then states that claimant's overall work activities since 1980 are the major contributing cause of his low back condition. (*Id.*) His attempt to clarify this apparent contradiction by stating that the 1990 incident "entrained the subsequent course of events and complaints of chronic low back pain," but that the overall work activities are the major contributing cause of the current condition is not persuasive. Moreover, Dr. Gritzka failed to weigh the various factors contributing to claimant's low back condition, including his numerous prior injuries and the degenerative condition, as required under *Deitz* and *Noble*.

Accordingly, on this record, we conclude that claimant has failed to establish a compensable occupational disease in his low back.

ORDER

The ALJ's order dated June 2, 1998 is reversed in part and affirmed in part. That portion of the order that set aside the employer's denial of the October 16, 1997 new injury claim is reversed. The employer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
SUSAN LAUGHLIN, Claimant
Own Motion No. 97-0536M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Linerud Law Firm, Claimant Attorney
Sather, Byerly, et al, Defense Attorneys

The self-insured employer requests reconsideration of our June 24, 1998 Own Motion Order Reviewing Carrier Closure, which set aside the employer's April 14, 1998 Notice of Closure as premature. On July 22, 1998, we abated our prior order to allow claimant sufficient time to respond to the employer's motion. On reconsideration, we adhere to the conclusion reached in our June 24, 1998 order. We base this decision on the following reasoning.

In our June 24, 1998 order, we relied on Dr. Puziss' May 5, 1998 medical report in finding that claimant was not medically stationary on March 24, 1998, when the employer declared claimant medically stationary, nor was she medically stationary on April 14, 1998, when the employer closed the claim. *See Christi McCorkle*, 48 Van Natta 840 (1996). Dr. Puziss' May 5, 1998 medical report was, in fact, a rebuttal to the insurer-arranged medical examination (IME) report, which found that claimant was medically stationary on March 24, 1998. We concluded that Dr. Puziss offered the most well-reasoned and fact-based opinion and set aside the Notice of Closure as premature.

On reconsideration, the employer has submitted the following documents: (1) the IME's rebuttal to Dr. Puziss' May 5, 1998 report; (2) Dr. Berselli's concurrence with the IME's report; (3) Dr. Berselli's narrative report regarding claimant's medically stationary status; and (4) a June 24, 1998 report from Dr. Puziss acknowledging that he had not had the opportunity to review claimant's entire medical record. In reply, claimant submitted Dr. Puziss' response to the employer's various submissions in support of her contention that she was not medically stationary at the time of closure.

The employer argued that we should defer to Dr. Berselli, claimant's longtime attending physician, (the doctor who performed claimant's October 1997 surgery that prompted the reopening of the claim) regarding her medically stationary status. It contended that Dr. Berselli's opinion should be entitled to "greater weight and deference" due to the considerable length of time he has followed claimant's case.[1] The employer argues that, since Dr. Berselli concurred with the June 1, 1998 IME report which found claimant medically stationary since March 24, 1998, that opinion should also be given greater weight. The IME physicians reported that, although claimant had significant impairment of her shoulder, there was no evidence of a rotator cuff tear and that "a fifth surgical procedure may well lead to further scarring and greater impairment of [claimant]'s shoulder function." Finally, the employer argued that Dr. Puziss had only seen claimant once, on the date of closure, did not "demonstrate a thorough command of [claimant's] complicated medical record" and was proposing a diagnostic procedure, which would make his opinion carry less weight than the IME physicians and Dr. Berselli.

In response, claimant submitted May 15, June 24 and August 11, 1998 reports from Dr. Puziss which demonstrated that he continued to treat claimant after her claim closure and continues to believe that claimant was not medically stationary at the time of her closure. His August 11, 1998 report is particularly noteworthy in that Dr. Puziss acknowledged that he had the opportunity to review claimant's "extensive" medical history and continued in his belief that claimant needed further surgery which would materially improve her compensable condition. He pointed out that during the June 1, 1998 IME examination, the physicians found the same kinds of discomfort he found during his first examination of claimant on April 14, 1998. He further outlined a series of objective findings that support the conclusion that claimant was not medically stationary and in need of further treatment (*i.e.* loss of motion, positive biceps stress test, positive impingement test and tenderness over the distal clavicle and anterior acromion).

Dr. Puziss further explained how the MRI demonstrated an increased signal of the rotator cuff, which "is consistent either with tendinitis or a partial-thickness tear of the rotator cuff." In order to improve her motion, Dr. Puziss recommended manipulation under anesthesia which "would relieve what is likely a captured shoulder or post surgical adhesions." Going further, Dr. Puziss detailed how claimant's pain originated from the adhesions and she was in need of an arthroscopy to observe the interior portion of the shoulder joint. In conclusion, Dr. Puziss stated that claimant "is not medically stationary, and has never been medically stationary since the last acromioplasty surgery which caused increased scarring."[2]

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[1] Dr. Berselli has treated claimant since the inception of her claim in 1982. He performed the surgeries in 1982, 1984 and the most recent acromioplasty surgery in October of 1997. Dr. Berselli continued to treat claimant until April of 1998, when he concurred with the IME report which declared her medically stationary on March 24, 1998 with no further treatment necessary.

[2] As noted previously, Dr. Berselli performed the acromioplasty surgery which Dr. Puziss references. The IME physicians declared that claimant was medically stationary in March of 1998 and opined that there was no evidence of the need for further treatment. As she continued to experience pain and discomfort, she sought further medical care and began treating with Dr. Puziss in April of 1998.

As noted in our June 24, 1998 order, we generally defer to the opinion of claimant's treating physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983). We further give most weight to opinions that are both well-reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259 (1986). Here we have the opinion of Dr. Berselli, claimant's longtime attending surgeon, versus Dr. Puziss, claimant's current attending physician. We continue to find Dr. Puziss opinion more persuasive. Despite the additional reports from the IME physicians and Dr. Berselli's concurrence with their report, Dr. Puziss continues to offer the same well-reasoned opinion as he did on the date of closure. Additionally, contrary to the employer's assertions, Dr. Puziss has had the opportunity to review claimant's medical record and is well-informed as to her medical history. Dr. Puziss continues to provide objective, well-founded medical reasons as to why he believed claimant was not medically stationary and that further treatment (in the form of arthroscopic surgery and therapeutic manipulation) would materially improve claimant's medical condition.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our June 24, 1998 order in its entirety. The parties' rights of reconsideration and appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
VASILY LEVKIV, Claimant
WCB Case Nos. 97-07674 & 97-06368
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Sather, Byerly, 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 the employer's denial of claimant's claim for his right knee condition[1]; and (2) assessed a penalty and attorney fee for the employer's allegedly unreasonable denial. Claimant cross-requests review of that portion of the ALJ's order that upheld the employer's denial of his aggravation claim for his current right shoulder condition. On review, the issues are compensability, penalties and attorney fees and aggravation. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Compensability/right knee

To prove the compensability of his condition as a new occupational disease, claimant must prove that his employment conditions were the major contributing cause of his right knee condition. ORS 656.802(2). To the extent that the occupational disease claim is based on the worsening of a preexisting disease or condition, 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).

On review, the employer argues that Dr. Gritzka's opinion regarding causation is not sufficient. The employer argues that, while Dr. Gritzka may have opined that claimant's right chondromalacia and plica conditions are symptomatic, such an opinion is not sufficient to establish a pathological worsening.

After reviewing Dr. Gritzka's opinion, we agree with the ALJ that his opinion is sufficient to establish compensability. Although Dr. Gritzka did use the word "symptomatic," he also explained that the mechanism of injury (claimant's repetitive kneeling on the edge of a truck cab) would be expected to cause deterioration of the patella cartilage or would worsen a preexisting condition. Dr. Gritzka noted

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[1] We note that, although the employer initially requested review on the issue of timeliness of the occupational disease claim, the issue was subsequently withdrawn by the employer in its reply brief.

that claimant's condition was worse on the right (which was the knee used most often for kneeling at work) and "the chondromalacic tears seemed to be coarser." (Ex. 36-13). Finally, Dr. Gritzka explained that claimant had a symptomatic hypertrophic suprapatellar plica on the right, related to prolonged kneeling on the right knee. Although Dr. Gritzka used the term "symptomatic," he also described the condition as resulting from trauma, which was followed by scarring and fibrosis. (Ex. 36-13).

Under the circumstances, we conclude that Dr. Gritzka's opinion, as a whole, establishes that work activities were the major contributing cause of claimant's condition, or of a pathological worsening of his preexisting condition. We therefore conclude that the ALJ properly set aside the employer's denial of claimant's right knee condition.

Penalty

We adopt the ALJ's "Opinion and Conclusion" on the penalty issue.

Aggravation

The ALJ found that, because the employer had accepted a nondisabling right shoulder strain and claimant now had a rotator cuff tear, an aggravation claim was not appropriate because claimant had not first requested acceptance of that condition. *See* ORS 656.262(6); ORS 656.262(7). On review, claimant argues that the ALJ should not have decided the issue on such a basis because, at hearing, claimant framed the issue as an aggravation, and the hearing proceeded without objection. Consequently, claimant argues that the employer waived any procedural irregularities.

We need not decide whether the employer waived the procedural defects discussed by claimant as we agree with the ALJ's conclusion on the merits of the issue. The ALJ found that there was no evidence that claimant's shoulder strain had worsened, and the medical evidence was insufficient to establish a compensable aggravation. We agree, and we add the following supplementation.

To establish a compensable aggravation claim, claimant must show a worsened condition resulting from the original injury. ORS 656.273(1). In order to show a worsened condition, claimant must prove an actual, pathological worsening of the compensable condition as established by objective findings. ORS 656.273(1). A symptomatic worsening alone is not enough. *SAIF v. Walker*, 145 Or App 294, 305 (1996), *rev allowed*, 325 Or 367 (1997).

Here, several doctors have discussed claimant's current condition. Dr. Coletti reported that the 1997 arthrogram did not show a rotator cuff tear. (Ex. 38). Dr. Yarusso reported that, although claimant had an increase in symptomatology, a clinical examination by Dr. Yarusso and Dr. McNeill "again, failed to identify any pathological worsening of his condition and/or a firm diagnosis." (Ex. 36). Although Drs. Yarusso and McNeill did feel that claimant had a small tear, both doctors indicated that the tear could have been there all along. (Exs. 30, 36-2, 42-2).

Finally, Dr. Gritzka reported that claimant had a pathological worsening since May 8, 1996. However, as the employer notes, claimant was not medically stationary with respect to his accepted shoulder strain until November 4, 1996. Moreover, Dr. Gritzka has not explained how the shoulder strain condition caused a rotator cuff tear. We conclude that, in light of the other medical evidence suggesting that claimant's tear may have existed from the time of the injury, Dr. Gritzka's failure to provide further explanation renders his opinion unpersuasive.

Consequently, after considering the expert medical opinions in the record, we agree with the ALJ that claimant has failed to establish a compensable aggravation.[2]

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[2] Claimant also apparently argues that his rotator cuff tear is compensable as a new occupational disease. However, we do not find that the issue was framed, at the time of hearing, as anything but an "aggravation" of the compensable condition. Moreover, even if the issue had been properly raised, we conclude that the medical evidence does not support compensability. Although Dr. Gritzka believed that claimant's condition was due to a "pinching mechanism" caused by using his shoulder at work, he has not explained why claimant's symptoms have worsened since leaving work in 1997. Additionally, Dr. Gritzka has suggested that certain individuals have acromions which project downward and cause an attrition injury following prolonged overhead work. (Ex. 36-13). However, Dr. Gritzka has not discussed the contribution of such a preexisting condition, as compared to the contribution of work acitivities. *See Dietz v. Ramuda*, 130 Or App 397, 401-02 (1994), *rev dismissed* 321 Or 416 (1995). Finally, none of the remaining medical opinions provide persuasive evidence of a compensable occupational disease.

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

ORDER

The ALJ's order dated December 3, 1997 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by the self-insured employer.

In the Matter of the Compensation of
RHODA M. MAYFIELD, Claimant
WCB Case No. 97-06491
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

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 bilateral carpal tunnel syndrome. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following changes and supplementation. In the fifth full paragraph on page 2, we change the second sentence to read: "Dr. Thayer disagreed with Dr. Jewell that claimant's weight was a major cause of her condition, noting his belief that there was no scientific evidence that weight was causative of carpal tunnel syndrome. (Ex. 43)." In the first full paragraph on page 3, we replace the seventh sentence with the following:

> "Ms. Belcher testified that claimant said her wrists 'hurt prior[,]' but claimant did not say if she had numbness or tingling before starting work for the employer. (Tr. 65). Ms. Gifford testified on rebuttal that claimant did not specify what kind of symptoms she was having when she described them. (Tr. 67)."

On page 3, we change the last paragraph to read: "Dr. Jewell opined that claimant's carpal tunnel condition preexisted her employment and was related to her gender and body habitus. (Ex. 20-3)."

On page 4, we change the first paragraph to read:

> "We find Dr. Thayer's opinion more persuasive than that of Dr. Jewell. First, Dr. Thayer is claimant's treating physician and his longitudinal relationship with claimant gave him a superior perspective on her condition. *See Weiland v. SAIF*, 64 Or App 810 (1983). Second, Dr. Thayer's opinion is persuasive because it is well-reasoned, complete and thorough in its analysis. *Somers v. SAIF*, 77 Or App 259 (1986). Finally, Dr. Thayer correctly assumed that claimant's condition did not preexist 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 $1,000, 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 28, 1998 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
LLANCE A. PETERSON, Claimant
Own Motion No. 98-0242M
OWN MOTION ORDER
Carney, 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 asthma, steroid induced diabetes, depression, myoclonus, osteopenia, hyokalemia and hypertension. Claimant's aggravation rights expired on May 9, 1994. SAIF opposes reopening of claimant's claim, contending that he was not in the work force at the time of the current worsening.

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

On May 18, 1998, claimant was hospitalized due to a worsening of his compensable asthmatic condition. Thus, we conclude that claimant's compensable injury worsened requiring hospitalization.

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

Claimant submits Dr. Keppel's September 11, 1998 report in support of his contention that he could not work due to the compensable condition and that it would have been futile for him to look for work because of his compensable condition. Dr. Keppel opined: "[Claimant] has been continually unable to be regularly and gainfully employed due to his workers' compensation related conditions and the effects thereof since I took [claimant] off work completely on October 28, 1994. In my opinion, it would have been futile for [claimant] to seek work since that time." Thus, we conclude that claimant has provided a persuasive medical opinion demonstrating that he was unable to work at the time of his current worsening and that it would have been futile for him to seek work due to the compensable condition.

Further, in order to satisfy the third *Dawkins* criterion, claimant must also establish, along with the "futility" standard, that he/she was willing to work. Failing to demonstrate his/her willingness to work, then he/she is not considered a member of the work force, and thus, is not entitled to temporary disability compensation. *See Stephen v. Oregon Shipyards*, 115 Or App 521 (1992); *Arthur R. Morris*, 42 Van Natta 2820 (1990); *Judith R. King*, 48 Van Natta 2303 (1996); *Marlene J. Andre*, 48 Van Natta 404 (1996).

Claimant submitted a September 9, 1998 affidavit wherein he asserts: "It is my intention and belief that my condition will improve enough in the near future to allow me to return to work. In that regard, I have already begun to explore various possibilities regarding a potential return to work with friends *** But for my compensable conditions, I would still be an active member of the work force.

However, as a direct result of my compensable conditions, I have been unable to work since 1994."[1] We are persuaded that claimant is willing to seek employment, but unable to do so because of his compensable condition.

Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning May 18, 1998, the date claimant was hospitalized. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

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

IT IS SO ORDERED.

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[1] In support of his position, claimant references our August 23, 1995 Own Motion Order wherein we found that he was in the work force at the time of his current disability. A prior finding does not irrevocably commit a claimant to a certain work-force status for the purposes of workers' compensation benefits. Rather, he must show that he was in the work force at the time of the current disability. *See Dean L. Watkins*, 45 Van Natta 1599 (1993). *See also Wausau Ins. Companies v. Morris*, 103 Or App 270, 273 (1990).

In the Matter of the Compensation of
JAMES L. SAFRANSKY, Claimant
WCB Case No. 97-06702
ORDER ON REVIEW
Michael A. Bliven, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes, Bock and Hall.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Herman's order that vacated a Director's order authorizing SAIF to require claimant to attend a medical examination. In his brief on review, claimant challenges that portion of the ALJ's order that declined to award an assessed fee for claimant's attorney's services at hearing. On review, the issues are review of a Director's order authorizing an additional medical examination and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

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

Due to inconsistent and invalid testing results, Dr. Jensen was unable to determine whether claimant could do more than sedentary, part-time work.

CONCLUSIONS OF LAW AND OPINION

This case concerns a Director's order authorizing SAIF to require claimant to attend a medical examination as part of a biennial reexamination of claimant's permanent total disability (PTD) status under ORS 656.206(5). As part of that reexamination, Dr. Smith, clinical psychologist, and Dr. Jensen, physiatrist, performed a medical examination of claimant in early 1997. SAIF then sought Director approval for an additional examination by an orthopedist/neurologist. The Director granted SAIF's request in an August 8, 1997 Proposed and Final Order, and claimant requested a hearing from that order. The matter proceeded to hearing, and ALJ Herman vacated the Director's order on the ground that it was not supported factually or legally.

On review, SAIF challenges the ALJ's conclusion that "the Hearings Division has *de novo* review of the Director's order" under ORS 656.283. SAIF further contends that the Director's order was a reasonable exercise of the Director's broad discretionary authority in this matter. We conclude that the

record in this case supports reinstatement of the Director's order under a *de novo* review standard. Thus, we do not address SAIF's contention that our review of the Director's order is limited to an "abuse of discretion" standard.

Pursuant to ORS 656.206(5):

> "[e]ach insurer shall reexamine periodically each permanent total disability claim for which the insurer has current payment responsibility to determine whether the worker is currently permanently incapacitated from regularly performing work at a gainful and suitable occupation[.] Reexamination shall include such medical examinations, reports and other records as the insurer considers necessary *or the director may require.*" (Emphasis supplied).

Pursuant to ORS 656.325(1)(a):

> "[a]ny worker entitled to receive compensation under this chapter is required, *if requested by the Director* of the Department of Consumer and Business Services, the insurer or self-insured employer, to submit to a medical examination at a time reasonably convenient for the worker *as may be provided by the rules of the director.* However, no more than three examinations may be requested except after notification to and *authorization by the director*[.]" (Emphasis supplied).

The express terms of these statutory provisions delegate to the Director the authority to authorize medical examinations "as may be provided by the rules of the director." Because the statute delegates broad rule-making authority in this matter to the Director, the review function of the Board is to determine whether the applicable agency rules are within the range of discretion allowed by the general policy of the statute and, if so, whether the Director's order is consistent with the guidelines prescribed in those rules. *Hadley v. Cody Hindman Logging,* 144 Or App 157 (1996); *Patti E. Bolles,* 49 Van Natta 1943 (1997).

The agency's rules for the authorization of medical examinations during a PTD reevaluation are found at OAR 436-030-0065(1), which provides in pertinent part:

> "The insurer shall reexamine each permanent total disability claim every two years or when requested to do so by the director to see if the worker is capable of regularly performing a suitable and gainful occupation[.] Workers who fail to cooperate with the reexamination may have benefits suspended, pursuant to OAR 436-060-0095, until such time as the worker cooperates with the reexamination."

OAR 436-060-0095 provides in pertinent part:

> "(3) A worker shall submit to medical examinations *reasonably* requested by the insurer or the Director[.]" (Emphasis supplied.)

Pursuant to these rules, the Director may only require medical examinations that are "reasonable" under the circumstances of a given case. This guideline is consistent with the stated legislative goal of providing a fair and just administrative system for delivery of financial benefits to injured workers. *See* ORS 656.012(2); *Ronald C. Fuller,* 49 Van Natta 2067 (1997), *on recon* 50 Van Natta 100 (1998); *Myron E. Blake,* 39 Van Natta 144 (1987) (ORS 656.325(1) must be read in light of the Workers' Compensation Act's explicit and implicit statutory policy of providing a forum for the just and fair administration of claims). Accordingly, we find that the agency's rules are within the range of discretion allowed by the general policy of the statute.

We further conclude that the Director's order is consistent with the guidelines prescribed in those rules. In so doing, we read the operative language of the Director's order in the context of the particular factual circumstances of this case. The Director's order provides in pertinent part:

> "The Director has determined that the worker has cooperated with the first two year permanent total disability status evaluation since the worker became PTD in 1994. Dr. Jensen was unable to comment on the worker's permanent total disability status, due to inconsistent and invalid testing results and recommended an additional examination by an orthopedist/neurologist to assist in determining the worker's current permanent total disability status.

"* * * * *

> "ORS 656.206(5) instructs that reexaminations of claimant's PTD status shall include such medical examinations, reports and other records as the insurer considers necessary. Dr. Jensen is unable to comment on the worker's permanent total disability status and is recommending an additional examination to assist in determining the disability status. The director has determined that an additional examination is being recommended as part of the first two year permanent total disability status evaluation to assist in determining the worker's current permanent total disability status[.] Therefore, SAIF Corporation is entitled to an additional examination as part of the two year permanent total disability evaluation."

The ALJ concluded that the Director's decision was based on an incorrect finding that Dr. Jensen "was unable to comment on the worker's permanent total disability status." The ALJ reasoned that this finding was incorrect because Drs. Jensen and Smith were able to determine that claimant could perform at least sedentary work on a part-time basis.

We agree with the ALJ's finding that Drs. Jensen and Smith did, in fact, comment on claimant's PTD status. However, Dr. Jensen also opined that she was not able to determine whether claimant could perform more than part-time sedentary work because of interference on examination, which prevented her from conducting a thorough orthopedic and neurologic assessment. Dr. Jensen also recommended a follow-up examination by a neurologist or orthopedist, who might be able to elicit more complete examination findings.

Based on Dr. Jensen's unrebutted opinion, we find that: (1) the examinations performed by Drs. Jensen and Smith were not sufficient bases for determining whether claimant could perform more than part-time sedentary work; and (2) an orthopedist or neurologist could reasonably be expected to elicit more accurate information regarding claimant's physical disability. Based on these findings, we conclude that the record as a whole establishes that the additional medical examination authorized by the Director was reasonable under the particular circumstances of this case.

In summary, we conclude that the agency rule requiring claimants to submit to medical examinations reasonably required by the Director is consistent with the legislative goal of providing a forum for the just and fair administration of claims. We further conclude that the record in this case establishes that the medical examination authorized by the Director was "reasonably required" under the particular circumstances of this case. Consequently, we reverse the ALJ's order and affirm the Director's order.

Attorney Fees

In light of our decision to affirm the Director's order, we need not address claimant's contention that the ALJ erred in not awarding claimant an assessed fee.

ORDER

The ALJ's order dated March 17, 1998 is reversed in part and affirmed in part. That portion of the order that vacated the Director's August 8, 1997 order is reversed. The Director's order is affirmed. The ALJ's order is otherwise affirmed.

Board Member Hall dissenting.

I agree with the majority's determination that the review function of the Board in this case is to determine whether the applicable agency rules are within the range of discretion allowed by the general policy of the statute and, if so, whether the Director's order is consistent with the guidelines prescribed in those rules. I also agree with the majority's conclusion that, pursuant to OAR 436-030-0065(1) and 436-060-0095, the Director may only require medical examinations that are "reasonable" under the circumstances of a given case, and that this standard is within the range of discretion allowed by the general policy of the statute.

However, for the reasons stated by the ALJ, I disagree with the majority's ultimate conclusion that the additional IME at issue in this case was reasonably requested by the Director. In particular, I agree with the ALJ's criticism that the Director's order is based on an incorrect finding that Dr. Jensen was not able to determine whether claimant was permanently and totally disabled. To the contrary, Drs. Jensen and Smith opined that claimant was capable of performing at least sedentary work on a part-time basis. Furthermore, in the absence of evidence that claimant did not fully cooperate in the initial examination, Dr. Jensen's position that an additional examination would result in more complete findings is speculative. Moreover, given claimant's well-documented history of functional overlay, SAIF should have scheduled the initial examination with a physician skilled in evaluating patients with nonorganic clinical findings and pain behavior.

In short, I agree with the ALJ's conclusion that the Director's authorization of an additional medical examination was not reasonable under the particular circumstances of this case. For that reason, I dissent from the majority opinion.

In the Matter of the Compensation of
STEVEN D. SAMBUCETO, Claimant
WCB Case Nos. 97-07142 & 97-06227
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Scheminske, et al, Defense Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Hall and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) set aside its denial of claimant's "new injury" claim for his current low back condition; (2) upheld Farmers' denial of claimant's aggravation claim for the same condition; (3) assessed a penalty for SAIF's allegedly unreasonable denial; and (4) awarded claimant's counsel an assessed fee of $5,000 for services at hearing. On review, the issues are compensability, responsibility, penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt the ALJ's "Conclusions" on the issue of compensability, with the following supplementation.

On review, SAIF argues that the report of Drs. Smith and Tsang, who examined claimant on SAIF's behalf, is not persuasive. Specifically, SAIF contends that the report does not show that the doctors reviewed claimant's recent MRI before reaching their conclusion. However, Dr. Smith reported that claimant was currently followed by his family physician, Dr. Foggia, and an "MRI has been done which shows only postoperative scarring." (Ex. 106-4). Consequently, we conclude that the Consultants were aware of claimant's recent MRI. Therefore, we do not agree with SAIF that their opinion should be discounted on that basis.

Additionally, SAIF contends that, at most, the report of Drs. Tsang and Smith could only be construed to say that the precipitating cause of claimant's need for treatment was the January 1997 incident. However, Dr. Smith's final opinion was that the January 22, 1997 work incident was the major cause of the need for treatment and/or disability of the combined condition. (Ex. 116-2). Pursuant to *SAIF v. Nehl*, 148 Or App 101, *on recon* 149 Or App 309 (1997) (A claimant need not establish that the compensable injury is the major contributing cause of the entire condition; instead, the claimant need only establish that the compensable injury is the major contributing cause of the need for treatment of the combined condition to establish compensability of the combined condition), we conclude that claimant has established compensability.

Responsibility

On review, SAIF contends that responsibility must be determined under ORS 656.308(1). On the other hand, Farmers argues that the correct standard is the last injurious exposure rule. However, we find that, under either analysis, SAIF is responsible for claimant's low back condition.

As a rule of proof, the last injurious exposure rule operates to relieve the claimant of the burden of proving actual medical causation against any particular employer or insurer, and instead assigns liability for the claim to the carrier on the risk during the last period of potentially causal employment before the date of disability. *Bracke v. Baza'r*, 293 Or 239, 246 (1982). If a claimant receives treatment for a compensable condition before experiencing time loss due to the condition, the date that the claimant first began to receive treatment related to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim. *Timm v. Maley*, 125 Or App 396, 401 (1993) *rev den* 319 Or 81 (1994).

Here, Drs. Smith and Tsang found that claimant's combined condition consisted of his January 1997 injury and the 1993 injury which had resulted in surgery. Based on such evidence, we conclude that initial responsibility for the condition is assigned to Farmers, since it was the insurer at the time of the 1993 injury. Farmers can shift responsibility to SAIF, however, if subsequent employment conditions during SAIF's period of coverage independently contributed to the cause or worsening of the condition. *Bracke*, 293 Or at 250; *Timm*, 125 Or App at 401.

We conclude that the report of Drs. Tsang and Smith establishes that the 1997 injury independently contributed to the cause or worsening of claimant's condition. The doctors reported that the 1997 flared up claimant's condition and irritated the nerve root. Moreover, as explained above, the doctors opined that the January 22, 1997 incident was the major cause of claimant's need for treatment and/or disability of the combined condition. Accordingly, under the last injurious exposure rule, SAIF is responsible for claimant's current low back condition.

Alternatively, the standards for determining the compensability of a combined condition under ORS 656.005(7) are used to determine the occurrence of a new compensable injury. *Id. See Mark A. Middleton*, 50 Van Natta 838 (1998).

Here, the persuasive medical evidence establishes that claimant's first injury combined with his second injury. Hence, to constitute a "new compensable injury," the second injury must be the major contributing cause of the need for treatment and disability of claimant's combined condition. ORS 656.005(7)(a)(B); 656.308(1). We have above agreed with the ALJ that the Consultants, Drs. Smith and Tsang, have provided the most persuasive medical opinion in this case. Consequently, because their opinion establishes that claimant's January 22, 1997 injury is the major cause of his need for treatment and disability of the combined condition, we conclude that claimant sustained a "new compensable injury." Therefore, whether the matter is analyzed pursuant to the last injurious exposure rule or ORS 656.308(1), SAIF is responsible for claimant's current low back condition.

Penalties

We adopt the ALJ's Conclusions on the penalty issue.

Attorney Fees/Hearings Level

On review, SAIF argues that the ALJ's attorney fee of $5,000 was excessive. SAIF also contends that the ALJ erred by not specifically considering each factor, as required by *Schoch v. Leupold & Stevens*, 325 Or 112 (1997).

We have previously rejected SAIF's argument regarding the applicability of the *Schoch* case. *See Russell L. Martin*, 50 Van Natta 313 (1998) (ALJ was not obligated to make specific findings regarding the rule-based factors in a case where there was no specific attorney fee request (or statement of services), and the parties had not submitted to the ALJ any argument as to how the rule-based factors should be weighed in determining a reasonable fee).[1] *See also McCarthy v. Oregon Freeze Dry, Inc.*, 327 Or 84, *on*

[1] We note that our *en banc* decision in *Martin* issued February 27, 1998. SAIF's appellant's brief was submitted to the Board on April 27, 1998. Inasmuch as *Martin* provides the Board's interpretation of the *Schoch* decision, an appellate forum would expect to receive for review a discussion of the reasoning expressed in *Martin*. Nonetheless, SAIF has neither discussed nor distinguished the *Martin* holding.

recon 327 Or 185 (1998) (Court of Appeals would satisfy its obligation to make findings under attorney fee statute by including a brief description or citation to the factor or factors relied on in denying an award of attorney fee; standing alone, absence of explanatory findings to support an award or denial of attorney fees is not a ground for reversal).

Here, there was no specific attorney fee request and no evidence that the parties argued the factors before the ALJ. Accordingly, it was sufficient for the ALJ to state that the rule-based factors had been considered.

On review, SAIF contends that the record does not justify a $5,000 fee for claimant's counsel's services at hearing, especially in light of the limited time spent in hearing. Turning to the factors under OAR 438-015-0010(4), our review of the record reveals the following. Both compensability and responsibility were in issue at hearing. The file contained 121 exhibits. The hearing lasted approximately 1.5 hours with claimant and his wife as the only witnesses. Following the hearing, two depositions were taken with each deposition lasting approximately half an hour.

After reviewing the record, we find that the issues in this case were of more than average complexity. Additionally, given the fact that the insurers had denied compensability as well as responsibility, claimant's attorney assumed a risk that he might go uncompensated for his services. Finally, with respect to the value of the case, we note that claimant established a "new injury" against SAIF, as opposed to merely establishing medical services against Farmers.

Based on our consideration of the factors in OAR 438-015-0010(4), particularly the aforementioned factors of value, benefit and risk, we conclude that $5,000 is a reasonable attorney fee for claimant's counsel's services at hearing. Because we do not consider this case to have presented extraordinary circumstances, $1,000 of this $5,000 attorney fee award has been apportioned to claimant's counsel for active and meaningful participation at the hearings level in finally prevailing over SAIF's responsibility denial. ORS 656.308(2)(d); *Foster-Wheeler Constructors, Inc. v. Smith*, 151 Or App 155 (1997); *Darold E. Perry*, 50 Van Natta 788 (1998). Therefore, we affirm the ALJ's attorney fee award.

Attorney Fee/Board Review

Claimant's attorney is also entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors 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 regarding the compensability issue is $1,200, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant's counsel is not entitled to a fee for services related to the responsibility, penalty, and attorney fee issues. *Foster-Wheeler Constructors v. Smith*, 151 Or App at 155; *Saxton v. SAIF*, 80 Or App 631 (1986); *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated February 6, 1998 is affirmed. Claimant's counsel is awarded an assessed fee of $1,200 for services on review, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
ROBERT SCHRICKER, Claimant
WCB Case No. C8-02043
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Heiling, Dodge & Associates, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Bock and Haynes.

On September 9, 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.

In WCB Case # C802043, the CDA provides on page 2, number 7;

"The claim was accepted as non-disabling. As such, the April 9, 1996 Notice of Claim Acceptance constitutes claim closure."

We have previously held that, whether the claim has been accepted as disabling or nondisabling, a notice of acceptance does not constitute closure of a claim. *See Janna Bailey*, 50 Van Natta 1474 (1998). Thus, we interpret the CDA as providing that the claim has never been closed. Accordingly, we find that the agreement satisfies OAR 438-009-0022(4)(b) (CDA must give a date of the first claim closure, if any).

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

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

IT IS SO ORDERED.

September 24, 1998 Cite as 50 Van Natta 1815 (1998)

In the Matter of the Compensation of
MELVIN R. TEFFT, Claimant
Own Motion No. 98-0368M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable fracture left tibial plateau, cervical interbody fusion at C6-7, displaced fracture, left lateral tibial plateau and L5-S1 disc herniation. Claimant's aggravation rights expired on March 3, 1988. 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. In response to SAIF's contention, claimant submitted a copy of his 1997 W-2 form.

We have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction,[1] is the date he enters the hospital for the proposed surgery. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). Claimant's submission of his 1997 W-2 form demonstrates that he worked in 1997.

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

However, claimant underwent surgery in August of 1998. In order to be considered in the work force at the time of his current disability, claimant must show he was in the work prior to his August 1998 surgery.[2] *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).

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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[2] Here, claimant's time of disability would include the time he worsened requiring surgery in June of 1998 until the surgery actually occurred. Thus, claimant must establish that he was in the work force in June of 1998 when his condition worsened precipitating the surgery recommendation and eventual August 1998 surgery.

September 24, 1998 Cite as 50 Van Natta 1816 (1998)

In the Matter of the Compensation of
TAMARA ZALESKI, Claimant
WCB Case No. 97-09155
ORDER OF ABATEMENT
Cathcart & Borden, Claimant Attorneys
Stoel, Rives, et al, Defense Attorneys

Pursuant to our August 25, 1998 Order on Review, we affirmed an Administrative Law Judge's (ALJ's) order that set aside its denial of claimant's claim for a slip and fall injury. The employer seeks reconsideration, contending that claimant's injury is not compensable because the employer did not exercise sufficient control over the walkway on which claimant fell.

In order to further consider this matter, we withdraw our August 25, 1998 order. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 14 days from the date of this order. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOAN D. ANDERSON, Claimant
WCB Case No. 97-06243
ORDER ON REVIEW
Juli Point, Claimant Attorney
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that: (1) upheld the self-insured employer's denial of her low back and cervical "combined" conditions; and (2) declined to award penalties and attorney fees for the employer's allegedly unreasonable claim processing. On review, the issues are compensability, penalties and attorney fees.

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

Claimant contends that the employer's acceptance of a "temporary exacerbation" of her preexisting low back and cervical degenerative conditions constituted an improper "prospective" denial. We disagree.

In *Gary L. Best*, 46 Van Natta 1694 (1994), the carrier accepted the claimant's osteomylitis condition as "resolved." We held that the term "resolved" implied that the carrier was no longer responsible for future benefits for the claimant's condition, and therefore the carrier's notice constituted an improper denial of future responsibility relating to an accepted claim. *See also Joni M. Varah*, 50 Van Natta 1124 (1998) (removal of the word "resolved" from a carrier's acceptance warranted attorney fee under amended ORS 656.386(1)). Subsequent to *Gary L. Best*, however, we held that an employer's acceptance of a "temporary" condition, when based on the medical treatment evidence, was permissible because the term "temporary" did not represent a conclusion that the employer was not responsible for future benefits related to the accepted condition. *Nancie A. Stimler*, 47 Van Natta 1114 (1995).

We find this case analogous to *Stimler*. Claimant sustained compensable back injury on July 10, 1996. Dr. Bert, claimant's attending physician, later identified preexisting degenerative conditions in the lumbar and cervical spine. (Ex. 12). On September 25, 1996, Dr. Bert opined that claimant's current need for treatment was the result of an aggravation of claimant's preexisting problems, *i.e.*, the preexisting degenerative conditions. (Ex. 14). Dr. Bert further stated that he was optimistic that the "situation would resolve in time with a little physical therapy and anti-inflammatory medication." *Id.* Based on this medical evidence, which indicated that the aggravation of the preexisting degenerative conditions was likely to be temporary, the employer accepted a "temporary exacerbation" of the preexisting low back and cervical degenerative conditions. (Exs. 14, 19A).

Under these circumstances, we conclude that the employer's use of the phrase "temporary exacerbation" did not preclude claimant from subsequently proving future disability or need for treatment arising out of the accepted condition. Therefore, we conclude that the employer's acceptance letters did not constitute a prohibited "prospective" denial.

ORDER

The ALJ's order dated June 5, 1998 is affirmed.

In the Matter of the Compensation of
BARBARA J. BURNS, Claimant
WCB Case No. 98-00574
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Hall and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that affirmed an Order on Reconsideration award of 6 percent (19.2 degrees) unscheduled permanent disability for a right shoulder injury. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

On October 2, 1996, claimant, who worked for a non-profit organization as a sorter/hanger, compensably injured her right shoulder. The insurer accepted right shoulder pain, a rotator cuff tear, and an anterior labrum tear. Surgery to correct those conditions took place on March 4, 1997. On August 7, 1997, Dr. Lantz, claimant's attending surgeon, found claimant medically stationary and released her to work with restrictions of 5 pounds on lifting, pushing or pulling, and no work with the right arm above shoulder level.

The claim was closed by an August 28, 1997 Determination Order that awarded 21 percent unscheduled permanent disability, which was based on both impairment and non-impairment factors. (Ex. 50).

The parties requested reconsideration. The insurer submitted an affidavit by claimant's supervisor averring that claimant had returned to her at-injury job notwithstanding Dr. Lantz's restrictions. (Ex. 51). Claimant objected to the impairment findings and an arbiter examination was conducted by Dr. Coletti. (Ex. 52). Dr. Coletti found that claimant was limited to lifting 10 pounds frequently, pushing and pulling 20 pounds occasionally, and was restricted from repetitive use of the right shoulder overhead. (Ex. 52).

The January 8, 1998 Order on Reconsideration found impairment of 6 percent and no other values, based on a finding that claimant had returned to her regular work and was, therefore, not entitled to any award for factors other than impairment under ORS 656.726(3)(f)(D). (Ex. 53).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant was not entitled to non-impairment factors, based on a conclusion that claimant returned to her regular work at the job she held at the time of injury. *See* ORS 656.726(3)(f)(D)(i). Thus, the ALJ reasoned that the sole basis for claimant's permanent disability award was impairment.

Claimant argues that, although she returned to work with the same employer, she did not return to regular work and that her doctor's release to return to work was a release to modified work only. Consequently, she contends that she is entitled to non-impairment factors, as awarded by the Determination Order. We agree.

"'Regular work' means the job the worker held at the time of injury, or employment substantially similar in nature, duties, responsibilities, knowledge, skills and abilities." OAR 436-035-0005(17)(c) (WCD Admin. Order 96-072).

On August 7, 1997, Dr. Lantz, treating physician, performed a closing examination. He noted that claimant had persistent pain in the shoulder with any lifting or any overhead work, a positive impingement sign, and tenderness over the anterior subacromial space, and he therapeutically injected claimant's anterior subacromial space. Dr. Lantz opined that claimant had permanent work restrictions of no lifting over 5 pounds and no overhead work, and released her to sedentary work which included limitations on pushing, pulling or lifting in excess of 5 pounds and no work with the right arm above shoulder level. (Exs. 48, 49). We accordingly conclude that Dr. Lantz's opinion is less than a release to regular work.

Claimant subsequently returned to her pre-injury position as a sorter/hanger. Although the employer filed an affidavit indicating that claimant was presently performing her sorting and hanging duties, the employer averred that she did so by using both extremities to lift the weight of garbage bags containing clothes, by hanging lighter loads and packing smaller boxes than she had prior to her injury. (Ex. 51). Moreover, when examined by the arbiter, Dr. Coletti, on December 20, 1997, he found that claimant was limited to lifting 10 pounds frequently, pushing and pulling 20 pounds occasionally, and was restricted from repetitive use of the right shoulder overhead. (Ex. 52). This evidence, taken together, indicates that claimant can no longer lift as much as she could prior to her injury, and, although claimant manages to perform her pre-injury job duties, these duties have been modified in accordance with the medical restrictions provided by both the treating physician and the medical arbiter. Consequently, we conclude that claimant did not return to "regular" work held at the time of injury.

We distinguish this case from *James I. Dorman*, 50 Van Natta 1649, *on recon* 50 Van Natta 1773 (1998). In *Dorman*, we examined the text of ORS 656.726(3)(f)(D)(i) and concluded that there is a statutory intent that a physician's release is only a factor to be considered in our examination of the record in determining whether the worker returned to regular work.

After examining the record in *Dorman*, we found that the claimant's treating surgeon released him to full duty without restrictions. The claimant's treating surgeon also concurred with the report of an examining orthopedic surgeon, who performed the closing examination. The examining physician reported that the claimant was working full time, but was cautious in how he used his back, was careful to limit his lifting, and to protect his back in other ways. The examining physician released the claimant to his work as a truck driver, but placed him in the light work category. We found on that record that the claimant had *self-modified* his manner of carrying out the same job duties that he performed at the time of injury. Therefore, we concluded that the claimant had returned to regular work held at the time of injury, and, thus, the only factor we considered in establishing the extent of his unscheduled permanent disability was impairment.

In the case before us, however, after considering all relevant evidence regarding claimant's "post-injury" job duties and responsibilities, including claimant's closing examination, medical release, arbiter examination, and the employer's description of claimant's modified work, we do not find persuasive evidence that claimant had solely "self-modified" her "post-injury" job duties. Thus, under these circumstances, we find that claimant did not actually return to her regular work held at the time of injury. *See Vincent D. Drennan*, 48 Van Natta 819 (1996); *Kathy R. Monfort*, 47 Van Natta 906, 907 (1995) (where the claimant no longer performed her full range of job duties, she had not returned to regular work); *Jim M. Greene*, 46 Van Natta 1527, 1529 (1994) (same); *George O. Hamlin*, 46 Van Natta 491, 493 (1994) (the claimant did not return to "regular" job when he returned to former bus driving job, but could no longer operate manual steering buses).

Having found that claimant did not return to her regular work at the time of injury, we turn now to a determination of the values for age, education and adaptability.[1]

Age

Claimant was over 40 years old at the time of claim closure. She is entitled to a value of 1 for age. *Former* OAR 436-035-0290(2).

Formal Education

Because claimant had not received a high school diploma or GED certificate prior to closure, she is assigned a value of 1 for formal education.

Skills

The skills value is determined by the highest Specific Vocational Preparation (SVP) achieved by a worker in the 5 years prior to closure. The SVP value is obtained from the Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles (SCODDOT). To determine the skills

[1] The extent of unscheduled permanent disability is evaluated as of the date of the Order on Reconsideration, applying the standards effective as of the date of the Determination Order or Notice of Closure. ORS 656.283(7); 656.295(5); OAR 436-035-0003(2). Here, the claim was closed by an August 28, 1997 Determination Order. Therefore, the applicable standards are found at WCD Admin. Order 96-072.

value for a worker, the DOT job title for each job the worker performed during the 5 years prior to determination is identified. With respect to each job title, a determination is made whether the worker has met the SVP number assigned to such job by the SCODDOT. In order to meet the SVP number for a particular job, the worker must have "remained in the field" for the training time which corresponds to the SVP number assigned to that job title. *See former* OAR 436-35-300(4).

Here, claimant has held her present job since 1993. The most appropriate job title for claimant's job is Sorter/Pricer (DOT Code 222.387-054), which has an SVP value of 5. Therefore, claimant is entitled to a skills value of 2. *Former* OAR 436-035-0300(4).

Adaptability

Claimant's adaptability is measured by comparing Base Functional Capacity (BFC) to the worker's maximum Residual Functional Capacity (RFC) at the time of becoming medically stationary. *Former* OAR 436-035-0310(2).

Here, claimant's BFC was "light." We now determine her RFC. Dr. Lantz found that claimant could push, pull or lift no more than 5 pounds and restricted reaching with the right arm to below shoulder level. (Exs. 48, 49). Thus, claimant's RFC is sedentary restricted. *Former* OAR 436-035-0310(3)(c). In comparing claimant's BFC to her RFC, the value for adaptability is 4.

We assemble the various factors to determine claimant's unscheduled permanent disability. The age (1) and education (3) factors are added for a value of 4, which is multiplied by the adaptability factor (4), for a result of 16. *Former* OAR 436- 035-0280. This result is added to the impairment value (6), for a total of 22. *Former* OAR 436-035-0280(7). Thus, claimant is entitled to 22 percent unscheduled permanent disability. We modify the Order on Reconsideration and the ALJ's order accordingly.[2]

ORDER

The ALJ's order dated June 5, 1998 is modified. In addition to the Order on Reconsideration and ALJ's awards of 6 percent (19.2 degrees) unscheduled permanent disability, claimant is awarded 16 percent (51.2 degrees) unscheduled permanent disability, for a total award of 22 percent (70.4 degrees) unscheduled permanent disability for her right shoulder condition. Claimant's attorney is awarded an attorney fee equal to 25 percent of the increased compensation made payable by this order, not to exceed $3,800, payable by the insurer.

[2] Because we have increased claimant's unscheduled permanent disability, it is unnecessary to address claimant's alternative argument seeking an increased award based on a "chronic condition." *See Schultz v. Springfield Forest Products*, 151 Or App 727 (1997).

September 25, 1998 Cite as 50 Van Natta 1820 (1998)

In the Matter of the Compensation of
DANTE J. CARBONELL, Claimant
WCB Case No. 98-01058
ORDER ON REVIEW
Malagon, et al, Claimant Attorneys

Reviewed by Board Members Bock and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that reduced claimant's scheduled permanent disability for loss of use or function of the right foot (lower leg) from 15 percent (20.25 degrees), as awarded by an Order on Reconsideration, to 3 percent (4.5 degrees) for loss of use or function of the right leg. The SAIF Corporation requests review of that portion of the ALJ's order that awarded scheduled permanent disability for the right leg rather than the right foot. On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for right shin laceration/contusion. A Notice of Closure awarded no permanent disability. The Order on Reconsideration awarded 15 percent scheduled permanent disability for a right foot condition after finding that claimant fell in Class II of OAR 436-035-0230(6). The ALJ found that claimant's condition was more consistent with Class I of the standard and reduced the permanent disability to 3 percent for the right leg. Claimant challenges this conclusion, asserting that, because the medical arbiter found that claimant had 10 percent impairment, the Order on Reconsideration correctly awarded disability based on Class II of the standard.

OAR 436-035-0230(6) provides that impairment due to dermatological conditions is based, in part, on the following criteria:

> "Class I: 3 percent for the leg or foot if there are signs of a skin disorder and treatment results in no more than minimal limitations in the performance of the activities of daily living, although exposure to physical or chemical agents may temporarily increase limitations.
>
> "Class II: 15 percent for the leg or foot if there are signs or symptoms of a skin disorder and treatments and prescribed examinations are required intermittently, and the worker has some limitations in the performance of the activities of daily living."

Here, claimant's treating physician, Dr. Otten, indicated in a closing examination that claimant was "released to work without restrictions and released from care." (Ex. 10). He also indicated that he did not recommend curative treatment. (Ex. 11).

The medical arbiter, Dr. Balkovich, reported that claimant "has a thinned scar on the right lower extremity with some symptomatology." (Ex. 19-2). He "suggested" that claimant "try some formal support hose" and stated that "persistent loss of sensibility is probably permanent[.]" (*Id.*) Dr. Balkovich, after "[t]aking into consideration all [claimant's] symptoms, many of which are, however, subjective," rated claimant "between a Class I and II for skin disorder and just place him at 10 percent for the leg." (*Id.*)

We first note that the attending physician and medical arbiter provide impairment findings. ORS 656.245(2)(b)(B), 656.268(7). Following issuance of the Order on Reconsideration, evaluation of the worker's disability is by the ALJ and the Board. ORS 656.283(7), 656.295(5). Consequently, we conduct our own evaluation of claimant's disability based on the impairment findings provided in the record without necessarily deferring to Dr. Balkovich's rating of claimant's impairment. That is, in evaluating claimant's permanent disability, we do not automatically rely on a medical arbiter's opinion in evaluating permanent impairment. *See Raymond L. Owen*, 45 Van Natta 1528 (1993), *aff'd Roseburg Forest Products v. Owen*, 129 Or App 442 (1995) (impairment is established by a preponderance of medical evidence, considering the medical arbiter's findings and any prior impairment findings). Instead, we rely on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment. *See Carlos S. Cobian*, 45 Van Natta 1582 (1993). In addition, we generally rely on the medical opinion of the attending physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983).

After reviewing the record, we agree with the ALJ that claimant falls under Class I. First, Class II requires intermittent "prescribed examinations." Here, Dr. Otten indicated that claimant was "released from care" and did not require further curative treatment; Dr. Balkovich only "suggested" that claimant "try" some support hose. We find such evidence shows that claimant was not under "prescribed examinations."

Furthermore, we find a lack of proof of "some limitations in the performance of the activities of daily living." Dr. Balkovich's report shows only that the scar area dries and requires lotion and that, when claimant stands, he experiences a "burning feeling in his foot." (Ex. 19-1). Nothing else in Dr. Balkovich's report, or Dr. Otten's closing examination, shows limitations in the performance of the activities of daily living.

Consequently, having found insufficient evidence of the requirement of "prescribed examinations" and "some limitations in the performance of the activities of daily living," we find that claimant did not prove entitlement to Class II impairment. Instead, claimant falls under Class I of OAR 436-035-0230(6).

SAIF also points out that the ALJ awarded scheduled permanent disability for the right *leg* when the award should be for the right *foot*. We agree. *See* ORS 656.214(2)(c) (providing that loss of leg is at or above the knee joint); OAR 436-035-0130(2) (providing that the foot is distal to the knee joint and extends to the toe joints). Consequently, we modify the ALJ's order to award 3 percent scheduled permanent disability for the right foot.

ORDER

The ALJ's order dated May 13, 1998 is modified. In lieu of the Order on Reconsideration and the ALJ's awards, claimant is awarded 3 percent (4.05 degrees) scheduled permanent disability for the loss of use or function of the right foot.

In the Matter of the Compensation of
JODIE M. DUBOSE, Claimant
WCB Case No. 97-01993
ORDER ON RECONSIDERATION
Welch, Bruun & Green, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

On September 18, 1998, we abated our August 20, 1998 Order on Review that denied claimant's motion to dismiss the SAIF Corporation's request for review and affirmed the Administrative Law Judge's (ALJ's) order setting aside SAIF's "noncooperation" denial and awarding an assessed attorney fee under ORS 656.382(1). We took this action to consider SAIF's contention that the "noncooperation" denial should be upheld because claimant did not prove that her failure to cooperate with its investigation was for reasons beyond her control. In particular, SAIF contends that, along with showing that she did not attend an insurer-arranged medical examination (IME) for reasons beyond her control, claimant also must provide evidence for the 30-day period following the issuance of the "Order Suspending Compensation Pursuant to ORS 656.262(15)." Because SAIF alleges that claimant "did nothing" during this 30-day period, SAIF argues that the "noncooperation" denial should be upheld. Having considered SAIF's argument and claimant's response, we issue the following order on reconsideration.

ORS 656.262(15) provides that, if "a worker fails to reasonably cooperate with an investigation, the Director shall suspend payment of compensation after notice to the worker." The statute further 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." After the denial, the worker may request and establish that he or she "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."

Here, claimant failed to attend an IME. Following the IME, the Department sent notice to claimant and SAIF that it had received SAIF's request for suspension of benefits and there was sufficient evidence documenting claimant's failure to cooperate with the investigation of the claim. The notice further stated that compensation would be suspended within five working days unless claimant informed the Department that the failure to cooperate was reasonable or SAIF notified the Department that claimant was now cooperating. After finding that it had not received such information, the Department issued an order suspending payment of compensation. SAIF then issued a denial of the claim.

In our order, we adopted and affirmed the ALJ's finding that claimant failed to attend the IME for reasons beyond her control. Furthermore, we are not convinced by SAIF's argument on reconsideration that claimant failed to cooperate with an *investigation* for the 30-day period following issuance of the Order Suspending Compensation. That is, even accepting SAIF's argument that the statute requires claimant to provide evidence concerning her conduct during this period, we find an absence of proof that claimant failed to submit to an information gathering technique. For instance,

claimant was not scheduled for another IME, nor did SAIF ask claimant to participate in a personal or telephonic interview.[1]

SAIF's argument suggests that claimant did not cooperate because she did not provide it or the Department with any documentation or explanation concerning her failure to attend the scheduled IME after the Department issued its notice and order. The statutes, however, require only that a worker cooperate in an "investigation of claims for compensation." We find that "investigation" of the claim is a separate matter than whether a worker provides documentation or explanation concerning her alleged failure to cooperate. The latter issue relates to the consequence of failing to cooperate (*e.g.*, the suspension of compensation by the Department) and does not concern a carrier's effort to obtain information about the claim itself. Consequently, we find no basis in ORS 656.262(15) for finding that claimant failed to cooperate because she did not respond to the Department's notice and order.

Finally, claimant is entitled to a carrier-paid attorney fee award for her counsel's services on reconsideration. *See* ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable attorney fee for claimant's counsel's services on reconsideration is $250, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue posed by SAIF's reconsideration request (as represented by claimant's response), the complexity of the issue, and the value of the interest involved.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our August 20, 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] Prior to claimant's failure to attend the January 6, 1997 IME, SAIF's claim examiner had talked to claimant's counsel's legal assistant on December 18, 1996 and informed the assistant of SAIF's intention to seek a suspension order from the Director in the event that claimant did not appear at the re-scheduled examination. Following claimant's non-appearance at the examination, the Director's January 24, 1997 "notice to cooperate," and the Director's February 6, 1997 suspension order, SAIF's next contact with claimant was its February 25, 1997 "failure to cooperate" denial. (The denial neither requested claimant's cooperation in the investigation nor asked her to contact SAIF to arrange for another examination.) Further contact was not made until SAIF's claim examiner's March 21, 1997 phone call with claimant's counsel's legal assistant, which acknowledged claimant's hearing request regarding SAIF's denial and sought claimant's agreement to attend another examination.

In light of such circumstances, we are not persuaded that SAIF's "post-suspension notice" efforts were sufficient to provide notification to claimant that SAIF continued to request her cooperation in the investigative process. Lacking adequate documentation of such efforts by SAIF, we are not prepared to find that claimant failed to cooperate after issuance of the Director's suspension order.

Board Member Haynes concurring.

I concur with the majority's conclusion that the record does not support SAIF's assertion that claimant failed to cooperate during the 30-day period following the notice of suspension of compensation. I disagree, however, with the majority's construction of *investigation* as meaning only an information gathering technique by the carrier. The statute expressly provides, in pertinent part:

> "If the director finds that a worker fails to reasonably cooperate with an investigation *involving an initial claim to establish a compensable injury* * * *, the director shall suspend all or part of the payment of compensation after notice to the worker. If the worker does not cooperate for an additional 30 days after the notice, the insurer or self-insured employer may deny the claim *because of the worker's failure to cooperate.*" (Emphasis supplied.)

Under these terms, the Director suspends payment of compensation if the worker fails to reasonably cooperate with the investigation of the initial claim. The carrier, however, may issue a denial if the worker continues not to cooperate for the 30 days following the notice of suspension of compensation. Thus, the duty to cooperate includes the period of investigation of the initial claim as well as the 30 days after the notice.

Because the statute distinguishes between "cooperation with an investigation involving an initial claim" and "cooperat[ion] for an additional 30 days after the notice," I find an intent to give the worker an opportunity to "cooperate" by participating in any information gathering procedures *or* showing that the failure to cooperate was for reasons beyond the worker's control or that investigative demands were unreasonable. In other words, I read the statute as allowing the carrier to issue a denial "because of the worker's failure to cooperate" with the carrier's actual investigation of the initial claim or, following the notice, requests by the carrier and the Department concerning the investigation or the failure to cooperate. For instance, if, during the 30 days after the notice, SAIF had notified claimant of another IME or the Department had ordered claimant to submit an explanation for failing to attend the previously-scheduled IME, and claimant had not cooperated with such demands, then I could agree with SAIF that the denial should not be set aside.

Here, however, the notice only informed claimant that compensation would be suspended unless claimant submitted to the Department documentation that the failure to cooperate was reasonable or SAIF notified the Department that claimant was cooperating. SAIF did not contact claimant asking her to attend a scheduled IME or even notify it of her availability for a future IME. Based on such evidence, I agree with the majority that claimant's failure to respond does not constitute a "failure to cooperate."

In the Matter of the Compensation of
JAMES J. FLETCHER, Claimant
WCB Case No. 97-10069
ORDER ON REVIEW
Malagon, et al, Claimant Attorneys
Craig A. Staples, Defense Attorney

Reviewed by Board Members Haynes, Bock, and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that affirmed an Order on Reconsideration which reduced claimant's award of unscheduled permanent disability for a right shoulder injury from 24 percent (76.8 degrees), as awarded by a Notice of Closure, to 21 percent (67.2 degrees). On review, the issue is unscheduled permanent disability.

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

The sole issue at hearing was whether the Order on Reconsideration's award of unscheduled permanent disability should be modified to include 5 percent unscheduled "chronic condition" impairment. Applying OAR 436-035-0320(5)(a) (WCD Admin Order 96-072),[1] the ALJ declined to so modify the Order on Reconsideration because claimant's unscheduled impairment in the relevant body area (right shoulder) exceeded 5 percent based on impairment values for weakness, surgical procedures and diminished range of motion.[2] Citing *Schultz v. Springfield Forest Products*, 151 Or App 727 (1997), the ALJ rejected claimant's contention that the administrative rule was inconsistent with ORS 656.214(5) and 656.726(3)(f)(A) because, according to claimant, there is no reasonable basis to distinguish between unscheduled body parts and scheduled body parts (the latter of which do not have a rule that limits chronic condition awards to only those cases where the scheduled award is below 5 percent). *See* OAR 436-035-0010(6)(a). Finally, the ALJ rejected claimant's attempt to distinguish *Schultz* on its facts.

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[1] OAR 436-035-0320(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."

[2] There is no dispute that, but for the administrative rule, claimant would otherwise be entitled to a "chronic condition" award.

On review, claimant again contends that *Schultz* is distinguishable and does not preclude a "chronic condition" award in this case. For the following reasons, we do not find claimant's arguments persuasive.

In *Schultz*, the court affirmed our order in *Gregory D. Schultz*, 47 Van Natta 2265 (1995), which held that the Director's unscheduled "chronic condition" rule (*former* OAR 436-35-320(5) since renumbered to OAR 436-035-0320(5)) did not exceed the Director's statutory authority to promulgate disability standards. 151 Or App at 733. Identifying the issue as whether *former* OAR 436-35-320(5)(a) was consistent with the applicable statutes, the court agreed with our conclusion that *former* OAR 436-35-320(5) did not violate the statutes. In doing so, the court disagreed with the claimant's contention that the rule was inconsistent with the statutes when it allowed the Director to treat unscheduled chronic conditions differently from scheduled chronic conditions.

Noting that scheduled awards are based on "loss of use or function" of the body part, the court determined that, when such scheduled awards are made (unlike unscheduled awards, which are based on "the permanent loss of earning capacity due to a compensable condition" that encompasses such factors as age, education and adaptability, in addition to permanent loss of use or function of a body part), there is no chance that other factors that have already been considered will be taken into account in evaluating "loss of physical function." The court further reasoned that, in unscheduled disability cases, a claimant's "restrictions" (permanent physical limitations that restrict repetititive motions) are rated either under "adaptability," when total impairment exceeds 4 percent or as a chronic condition award when "adaptability" is not "considered" (when total impairment is between one and four percent) In light of such circumstances, the court concluded that a claimant's chronic condition is ultimately compensated without receiving a double recovery. 151 Or App at 732-33.

Finally, the court rejected the claimant's assertion that all injury-related impairments, including chronic conditions, must be rated before the rating of unscheduled permanent disability may be "modified" under ORS 656.726(3)(f)(A). The court agreed with us 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. The court further reasoned that, to do otherwise, would mean that the legislature intended double recovery in some instances, which would be inconsistent with legislative policy. 151 Or App at 733.

Claimant argues that *Schultz* is distinguishable because, unlike the claimant in *Schultz*, claimant here did not receive a value for "adaptability" because he had returned to regular work. Thus, claimant asserts that the *Schultz* court's concern about double recovery is not applicable because adaptability did not become a part of the unscheduled permanent disability award. Claimant argues that, to deny him a "chronic condition" award would result in him receiving no compensation for a significant component of his disability. We disagree.

First, the *Schultz* court specifically upheld the validity of OAR 436-035-0320(5)(a) in affirming our previous determination that the rule was not inconsistent with the applicable statutes. Thus, we must apply the rule in rating claimant's unscheduled permanent disability. Moreover, we concur with the ALJ that claimant's "chronic condition" is reflected in the impairment values already awarded for weakness, diminished range of motion and surgical procedures.

Finally, while claimant has "restrictions," *i.e.*, has limitations on repetitive use of the right shoulder, no value was given for "adaptability" because claimant had returned to regular work. Despite the fact that no value was given for adaptability, that factor was considered as it was in *Schultz* (in this case, through values for surgery, weakness, diminished range of motion). Thus, we are precluded from awarding "chronic condition" impairment when adaptability has been "considered" in making an unscheduled permanent disability award. 151 Or App at 733.

Therefore, while the facts of this case may differ somewhat from those in *Schultz*, the double recovery concerns are still present in this case. Accordingly, we are not persuaded by claimant's argument that we should not give effect to OAR 436-035-0320(5)(a) in cases where no value for "adaptability" has been awarded, particularly when the court has expressly upheld the validity of the rule as consistent with the statutory scheme. We, therefore, affirm.

ORDER

The ALJ's order dated May 1, 1998 is affirmed.

Board Member Hall dissenting.

I recognize that the court in *Schultz v. Springfield Forest Products*, 151 Or App 727 (1997) upheld the validity of OAR 436-035-0320(5)(a), but it did so within the factual context of that case. I agree with claimant that the facts of this case significantly differ from those in *Schultz* in that claimant, here, did not receive a value for "adaptability." This significant factual difference leads me to conclude that the court may well decide this case differently. Therefore, I cannot join the majority in giving effect to OAR 436-035-0320(5)(a) under the facts of this case. Accordingly, I must respectfully dissent.

In the Matter of the Compensation of
CHERYL MOHRBACHER, Deceased, Claimant
WCB Case No. 96-08566
ORDER ON RECONSIDERATION
Peter O. Hansen, Claimant Attorney
Scheminske, et al, Defense Attorneys

The self-insured employer requests reconsideration of those portions of our August 26, 1998 Order on Review that: (1) affirmed the Administrative Law Judge's (ALJ's) order which awarded an assessed fee of $75,000; and (2) awarded a $15,000 attorney fee for claimant's counsel's services on review.[1]

Citing *Larry G. Newth*, 48 Van Natta 2331 (1996) and *Loren Eells*, 43 Van Natta 316 (1991), cases involving similarly complex litigation, the employer contends that the ALJ's $75,000 attorney fee is excessive. As the employer notes, the attorney in *Eells* devoted 87 hours to services at hearing, resulting in an attorney fee of $14,500, while the attorney in *Newth* devoted 153 hours, resulting in a fee of $22,500. In comparison, the attorneys in this case devoted 491 hours. Therefore, this case differs significantly from both *Eells* and *Newth* in terms of time devoted to the case.

The employer asserts, however, that the amount of time devoted to the compensability issue in this case is unreasonable. It argues that the record shows a duplication of efforts in requesting medical opinions and in preparing closing and reply arguments. The employer also avers that the record does not justify the time devoted to attorney conferences and to preparation for depositions. The employer further contends that the ALJ and the Board should have deducted time spent obtaining an inadmissible exhibit and preparing the statement of services.

We have previously considered these and similar arguments in the employer's briefs on review. As the employer concedes, a reasonable attorney fee is not based solely on a mathematical calculation. *See Danny G. Luehrs*, 45 Van Natta 889 (1993). OAR 438-015-0010(4) instead requires consideration of numerous other factors besides time devoted to the case, such as the complexity of the issues, the value of the interest involved, skill of the attorneys, the nature of the proceedings, the benefits secured, and risk that an attorney's efforts may go uncompensated.

While we agree with the employer that the time devoted to preparation of the statement of services should not be compensated, the 2 hours of time devoted to those efforts (out of a total of 491 hours) do not materially detract from the many factors that support the ALJ's attorney fee award in this case. Moreover, we cannot say that the attorney conference time and the time devoted to depositions are unreasonable given the unusual and complex nature of the case.

Therefore, upon further consideration of the factors in OAR 438-015-0010(4), and giving due consideration to the employer's objections, we continue to conclude that the ALJ's attorney fee award is reasonable and appropriate for claimant's counsel's services at hearing.

Finally, the employer requests that we reduce the $15,000 attorney fee we awarded for services on review. After further consideration of the factors in OAR 438-015-0010(4), and considering the employer's objections, we continue to find that $15,000 fee is a reasonable attorney fee.

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[1] On September 21, 1998, the employer requested abatement and reconsideration of our order, but, because the reconsideration request did not contain a contention that our August 26, 1998 order was in error, the employer's request was denied in an Order Denying Reconsideration issued on September 24, 1998. *See* OAR 438-011-0035(1).

Accordingly, we withdraw our August 26, 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.

In the Matter of the Compensation of
RAYMOND A. GRAVES, Claimant
WCB Case No. 97-06634
ORDER ON RECONSIDERATION
Starr & Vinson, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

The SAIF Corporation requested reconsideration of that portion of our August 3, 1998 Order on Review that, among other decisions, directed SAIF to amend its Notice of Acceptance to include acceptance of claimant's urinary dysfunction condition. Contending that claimant has not established the compensability of the alleged urinary dysfunction, SAIF sought reconsideration of our decision. Accordingly, we abated our order and permitted claimant an opportunity to respond.

In his response, claimant has essentially cross-requested reconsideration of those portions of our order which: (1) excluded claimant's testimony concerning the issue of rate of temporary disability benefits; and (2) reversed that portion of the ALJ's order which disallowed an asserted overpayment of temporary disability benefits. Having received the parties' responses, we proceed with our reconsideration.

We first address SAIF's request for reconsideration. On review, SAIF took the position that the ALJ erred when he held that SAIF was required to accept claimant's low back injury with multiple surgeries and chronic back pain. Specifically, SAIF argued on review that the issue was controlled by ORS 656.262(7)(a), which required that claimant clearly request formal acceptance of the condition. Appellant's Brief, Pg. 3. On reconsideration, however, SAIF contends that claimant "failed to carry his burden of proof as to the alleged urinary dysfunction problem." SAIF's Motion to Reconsider, Pg. 3.

We conclude that, because SAIF has raised compensability for the first time on reconsideration, we will not consider the issue. *See Annette E. Farnsworth*, 48 Van Natta 508 (1996)(The issues on review were limited to "back-up" denial, compensability and penalties. Consequently, the issues of estoppel and penalties, which were raised by the claimant for the first time on reconsideration, were not considered). *See Vogel v. Liberty Northwest Ins. Corp.*, 132 Or App 7, 13 (1994) (Board has discretion not to address issues raised for first time on reconsideration); *Terry Hickman*, 48 Van Natta 1073 (1996); *Stella D. Bales*, 45 Van Natta 1224 (1993). Accordingly, we continue to adhere to our decision regarding acceptance of the urinary dysfunction condition.

We next turn to claimant's request for reconsideration. Claimant argues that his testimony concerning the issue of rate of temporary disability benefits was improperly excluded on review.[1]

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[1] We note that our decision that the "rate of temporary disability" issue is subject to the evidentiary limitations of ORS 656.283(7) is consistent with the court's recent opinion in *Venetucci v. Metro*, 155 Or App 559 (1998). In *Venetucci*, the court held that, because a claimant's objection to a carrier's intention to offset alleged overpaid temporary disability against her permanent disability benefits arose from her receipt of the carrier's "post-notice of closure" letter announcing that intention (and because that intention was not "manifest in the notice of closure"), the claimant was not precluded from raising her objection to the alleged offset at hearing even though she had not first sought reconsideration of the notice of closure under ORS 656.268(4)(e). In reaching this conclusion, the court reasoned that, for mandatory reconsideration pursuant to ORS 656.268(4)(e) to preclude further review, a claimant must have an objection that is manifest in the notice of closure.

Here, we have previously found that the issue regarding claimant's temporary disability rate was manifest in the notice of closure. Consequently, in accordance with ORS 656.268(4)(e) and *Venetucci*, the issue must first be raised during the reconsideration proceeding before it can be addressed at hearing. Likewise, consistent with ORS 656.283(7), the admissible evidence at the hearing is limited to the evidence submitted at the reconsideration proceeding. Thus, although claimant properly raised the issue during the reconsideration proceeding, the evidence he presented at the hearing was not admissible because it was not previously submitted at the reconsideration proceeding.

Claimant contends that his counsel could not have foreseen that the Board would disagree with the Appellate Review Unit's conclusion that it did not have jurisdiction over the matter. Consequently, claimant argues that, although evidence was not submitted on the issue at the time of reconsideration, it would be a violation of his constitutional rights if we do not remand to the Department to now consider such evidence.

We continue to disagree with claimant's argument on this point. We note that claimant was the party who requested reconsideration and raised the rate as an issue during the proceeding. Moreover, pursuant to the existing case law at that time, claimant should have known that the issue would have been limited to the record on reconsideration. *See Joe R. Ray*, 48 Van Natta 325 (1996), *on recon* 48 Van Natta 458 (1996). Nevertheless, claimant has not shown that there was any attempt to present evidence on the issue at the time of reconsideration. *Joe R. Ray*, 48 Van Natta at 333 (Because the claimant's testimony was not submitted at the reconsideration proceeding, it could not be considered on review. However, nothing precluded the parties from presenting such evidence during the reconsideration process). Accordingly, we continue to adhere to our conclusion that such evidence may not be considered for the first time at hearing. ORS 656.283(7).

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

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our August 3, 1998 Order on Review. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

Members Hall and Biehl concurring in part and dissenting in part.

We concur in that portion of the majority's decision that adheres to our prior conclusion that SAIF must amend its Notice of Acceptance to include claimant's urinary dysfunction condition. We disagree with that portion of the majority's opinion that denies claimant's request to remand this claim to the Director for further development of the temporary disability rate issue. As discussed in our previous dissenting opinion, because the Director's Appellate Review Unit declined to conduct a review of the issue during the reconsideration proceeding, claimant must be allowed a meaningful opportunity to develop the reconsideration record. To do otherwise, we respectfully submit, does not achieve substantial justice.

In the Matter of the Compensation of
JOSEPH L. CILIONE, Claimant
WCB Case No. 97-08921
CORRECTED ORDER ON REVIEW

Reviewed by Board Members Hall and Bock.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the SAIF Corporation's denial of his claim for deep vein thrombosis of the left calf. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

In March 1989, claimant was treated for right calf pain, which was diagnosed as thrombophlebitis of the right lower extremity. (Ex. B-1, -2). An ultrasound demonstrated deep vein thrombosis. (Ex. B-2).

Claimant testified that he has been a truck driver for approximately eight years. (Tr. 21). He said that he developed deep vein thrombosis in his left leg after driving a truck from Pasco, Washington to Los Angeles. (Tr. 17-18). He said he had been in a seated position for approximately 18 to 20 hours. (Tr. 18).

Claimant sought medical treatment in the emergency room on May 24, 1997 and was diagnosed with left calf deep vein thrombosis. (Ex. A3-2). The chart note from Dr. Rebagliati indicated that claimant had been on a long truck driving trip over the last three days. (*Id.*)

Claimant was admitted to the hospital and was treated by Drs. Kreinbrink and Calvert. (Exs. A4, A6). Tests showed that claimant had acute thrombophlebitis of the left calf. (Ex. A5).

On September 4, 1997, SAIF denied claimant's claim for an "injury" to his left leg, stating:

> "You have preexisting medical condition(s) which are diagnosed as genetic predisposition to deep vein thrombosis (DVT), smoking and obesity. Your work activity combined with the preexisting condition(s), but your work activity is not the major cause of the combined condition." (Ex. A13).

Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ analyzed the claim as an occupational disease and concluded that Dr. Kreinbrink's opinion was insufficient to establish compensability.

On review, claimant contends that the ALJ did not consider Dr. Calvert's opinion on causation, which stated that the deep vein thrombosis (DVT) was related, in major part, to claimant's truck driving activities. (Ex. B-3). He relies on the opinions of Drs. Calvert and Kreinbrink to establish compensability.

In determining the appropriate standard for analyzing compensability, we focus on whether claimant's DVT 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). The phrase "sudden in onset" refers to an injury occurring during a short, discrete period, rather than over a long period of time. *Donald Drake Co. v. Lundmark*, 63 Or App 261, 266 (1983), *rev den* 296 Or 350 (1984).

Claimant testified that the blood clot in his leg occurred when he had a load that had to be delivered from Pasco, Washington to Los Angeles in a short amount of time. (Tr. 18). Claimant said that he normally stops frequently during trips to check his truck, walk around and eat. (*Id.*) On that trip, however, he was not able to do so and he was in a seated position for probably 18 to 20 hours. (*Id.*) Claimant's symptoms occurred after the May 1997 trip from Pasco to Los Angeles and he continued to have symptoms thereafter. He sought medical treatment in the emergency room on May 24, 1997 and was diagnosed with left calf DVT. (Ex. A3-2). The chart note from Dr. Rebagliati indicated that claimant had been on a long truck driving trip over the last three days and he had experienced increasing left lower calf pain. (*Id.*) Because claimant's symptoms were sudden in onset and occurred over a discrete, identifiable period of time, we conclude that the claim should be analyzed as one for an accidental injury.

We are not persuaded that claimant's May 1997 injury "combined" with a preexisting condition to cause disability or a need for medical treatment. *See* ORS 656.005(7)(a)(B). Dr. Kreinbrink reported on January 19, 1998 that she did not agree that claimant was genetically predisposed to DVT. (Ex. B5-1). She acknowledged that claimant's "right leg and left leg deep vein thromboses incidences *could be* related." (Ex. B5-2; emphasis added). However, because Dr. Kreinbrink's opinion suggests only the possibility that claimant had a "combined" condition, we are not persuaded that ORS 656.005(7)(a)(B) applies to this case. Consequently, claimant need only prove that his May 1997 work injury was a material cause of the left DVT condition. ORS 656.005(7)(a).

In evaluating the medical evidence concerning causation, we rely on opinions that are well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986). We generally rely on the opinion of a claimant's treating physician, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810, 814 (1983). Here, we are persuaded by the opinions of claimant's treating physicians, Drs. Kreinbrink and Calvert, that the claim is compensable.

On January 19, 1998, Dr. Kreinbrink reported that claimant's "prolonged sitting as a long haul truck driver is the largest single contributor to the development" of the DVT. (Ex. B5-1). She agreed that direct pressure restricts blood flow and direct pressure to the back of the leg for an extended period of time could cause DVT. (*Id.*) She explained that it has been clinically shown that pressure to a vein causes decreased blood flow return, which markedly increases the formation of DVT. (Ex. B5-2).

Dr. Kreinbrink's opinion is supported by Dr. Calvert. He signed claimant's "827" form, reporting that claimant had "[d]eveloped [a] blood clot while driving truck for [the employer]." (Ex. A7). In a letter to SAIF, Dr. Calvert reported that claimant's "DVT was related to driving the truck, certainly > 50%." (Ex. B-3).

Based on the opinions of Drs. Kreinbrink and Calvert, we conclude that claimant's May 1997 injury was a material contributing cause of the DVT condition. We note that those opinions would also be sufficient to establish compensability under a "major contributing cause" standard.

ORDER

The ALJ's order dated April 22, 1998 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law.

In the Matter of the Compensation of
DONALD CONVERSE, Claimant
WCB Case No. 96-07686
ORDER ON REMAND
Neil W. Jackson & Associates, Claimant Attorneys
Lundeen, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. *Converse v. Tube Specialists Co.*, 153 Or App 700 (1998). The court reversed our prior order that adopted and affirmed an Administrative Law Judge's (ALJ's) order that upheld the insurer's denial of claimant's injury claim. In our prior order, we agreed with the ALJ that claimant was an active participant in an assault or combat which was not connected to his job assignment and which amounted to a deviation from his customary duties. We agreed that the claim was not compensable pursuant to ORS 656.005(7)(b)(A). Citing *Redman Industries, Inc. v. Lang*, 326 Or 32 (1997), the court has reversed and remanded our prior order for reconsideration.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with some additional supplementation.

At the time of the July 11, 1996 injury, claimant was a 37-year old trim department supervisor for the employer, which fabricates metal parts and equipment. Claimant was hired in February 1992 and became a supervisor approximately two years after that date. (Tr. 8). His duties included supervising three employees and a floating employee and maintaining quality control.

On September 14, 1994, claimant was reprimanded for swearing at one of his employees. (Ex. A). The discipline report indicated that claimant had been warned about his use of abusive language and had been informed that further occurrences could result in removal from his supervisory position. (*Id.*) On May 3, 1995, claimant was reprimanded for disruptive and abusive behavior. (Ex. B). Claimant was suspended for three days without pay. (*Id.*) At hearing, claimant testified that he had been instructed that he should "clean up his mouth" and "keep the profanity out" when talking to his employees. (Tr. 13). The employer sent claimant and three other people to a leadership seminar. (Tr. 13, 50). Mark Weyhrich, vice president in charge of production, testified that part of that seminar included a "combat management section" pertaining to how to deal with people who were not performing adequately. (Tr. 50).

Claimant's supervisors were Mr. Lomas and Mark Weyhrich. (Tr. 10). Mark Weyhrich and Mr. Lomas both testified that the employer's policy was that fighting on the job would lead to termination. (Tr. 56, 68-69).

On July 11, 1996, claimant, at his employer's instruction, gathered the members of his crew together for a brief meeting during which claimant told them that the quality of their work needed to improve. Claimant told one of his crew, Mr. Cornell, that he was a "worthless piece of shit," whereupon Cornell and claimant yelled at each other briefly. Thereafter, each went to his own work station. About ten minutes later, Cornell took his finished project over to claimant and showed him that it had been done correctly. Claimant told Cornell: "You sound so pathetic, you worthless piece of shit, you are such a stupid idiot." Cornell took off his safety glasses and pointed them at claimant and said: "Shut up and leave me alone, just let me work." As Cornell started to turn away, claimant reached out and hit Cornell's hand, knocking the safety glasses out of his hand. Cornell then turned back to claimant and grabbed him by the throat and pushed him backward into a post, which resulted in claimant being injured before other crew members could pull Cornell of him.

Claimant sought medical treatment for head, neck and wrist lacerations and contusions. The employer fired Cornell. After the July 1996 incident, claimant was relieved from his supervisory position and his wages were reduced. (Tr. 9; Ex. 26). On August 30, 1996, the employer wrote to claimant, stating that, based on an investigation, it appeared the claimant's "verbal abuse" of Mr. Cornell "in part provoked the incident." (Ex. 26).

On July 25, 1996, the insurer denied claimant's claim for head, neck and wrist lacerations and contusions. (Ex. 10).

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant testified that he never swore at Mr. Cornell on July 11, 1996. (Tr. 29, 31). However, two other crew members, Mr. Gleeson and Mr. Dodd, testified that claimant had called Mr. Cornell a "worthless piece of shit," among other things. (Tr. 44, Ex. 27-8). Claimant also testified that on July 11, 1996, before the fight occurred, he had told Mr. Lomas, the employer's shop superintendent, that Cornell had a bad attitude. (Tr. 18, 32). Mr. Lomas testified that claimant did not make any such complaint to him about Cornell's attitude on July 11, 1996. (Tr. 60-61, 71). The ALJ found that claimant was not a credible witness and concluded that his testimony must be viewed with suspicion. The ALJ also found that claimant yelled and swore at Cornell and then hit Cornell's safety glasses out of his hand, which provoked Cornell to assault claimant and caused claimant to be injured. Citing *Kessen v. Boise Cascade Corp.*, 71 Or App 545 (1984), the ALJ concluded that claimant actually initiated the fight and was an "active participant" under ORS 656.005(7)(b)(A). The ALJ also determined that claimant was injured in an assault and combat with a coworker, which was not connected with the job assignment and which amounted to a deviation from customary duties.

On July 25, 1997, the Board adopted and affirmed the ALJ's order. Claimant filed a Notice of Appeal on August 25, 1997. On the same date, claimant requested reconsideration from the Board's order, citing *Redman Industries, Inc. v. Lang*, 326 Or 32 (1997), which was decided August 21, 1997. The Board denied reconsideration. The Court of Appeals subsequently reversed and remanded our prior order, citing the Supreme Court's decision in *Lang*.

In claimant's brief to the Court of Appeals, he argued that the injuries he received in an assault at work were connected to the job assignment and did not amount to a deviation from customary duties. Claimant contended that, despite his status as an "active participant," his injuries were compensable because the assault arose out of a risk created by employment. He explained that his job assignment included monitoring the quality of work and criticizing "sub par" work. According to claimant, the risk of assault in this situation is inherently connected with the job assignment. He argued that Mr. Cornell became upset with claimant's efforts to supervise him the morning of the assault and took it out on claimant by assaulting him. For the reasons set forth below, we agree that claimant's injuries are compensable.

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.*

On appeal to the Court of Appeals, the insurer did not dispute that claimant's injury occurred "in the course of" employment. Claimant's injury took place during his regular work hours, on the employer's premises and after a meeting regarding work quality.

The "arising out of" employment element concerns the causal connection between the injury and the employment. *Fred Meyer, Inc. v. Hayes*, 325 Or 592, 596 (1997). In *Redman Industries, Inc. v. Lang*, 326 Or at 39, the Supreme Court explained that, in evaluating whether there is a sufficient link between the injury and the employment, we must look to whether the risk of injury resulted from the nature of the work or from the work environment. The motivation for the assault need not be an argument over job performance or some other work-related factor. *Id.* The court held that, in general, the risk of an assault by a coemployee in the workplace is a risk to which the work environment exposes an employee. *Id.* at 40. Nevertheless, the workplace assault by a coemployee must be caused by circumstances associated with the work environment. *Id.* In other words, if the motivation for an assault by a coemployee is an event or circumstance pertaining to the assailant and the claimant that originated entirely separate from the workplace, and the only contribution made by the workplace is to provide a venue for the assault, the assault does not "arise" out of employment. *Id.*

Here, it is undisputed that claimant was injured in a physical fight with Mr. Cornell, one of his employees. The evidence indicates that the altercation arose after a work meeting in which claimant told his employees that the quality of their work need to improve. Claimant and Mr. Cornell were involved in a verbal dispute about Cornell's work product and the altercation arose as part of that dispute. There is no evidence that claimant and Mr. Cornell had any relationship outside of work that may have caused the fight. Under these circumstances, we conclude that claimant's injuries "arose out of" his employment.

Having determined that claimant's injuries arose out of his employment, we turn to the question of whether these injuries are excluded by the provisions of ORS 656.005(7)(b)(A). ORS 656.005(7)(b)(A) provides:

> " 'Compensable injury' does not include * * * [i]njury to any active participant in assaults or combats which are not connected to the job assignment and which amount to a deviation from customary duties[.]"

As the *Lang* court noted, this provision "excludes from compensability injuries from assaults (1) to an active participant in the assault *and* (2) when the assault is not connected to the job assignment and amounts to a deviation from customary duties." 326 Or at 38 (emphasis in original). Unless both of those elements are met, the exclusion does not apply. *Id.*

Because ORS 656.005(7)(b)(A) operates to exclude certain injuries from the definition of "compensable injury," we conclude that, where, as here, a claimant has shown that his assault-related injuries arose out of and in the course of employment, the burden shifts to the employer to prove that the exception applies. In other words, the employer must establish by a preponderance of the evidence that claimant was an active participant in the assault and that the assault was not connected to the job assignment and amounted to a deviation from customary duties to defeat a finding of compensability. *See, e.g., Grace L. Walker*, 45 Van Natta 1273 (1993), *aff'd mem Walker v. Danner Shoe Manufacturing*, 126 Or App 313 (1994) (if the claimant establishes a prima facie case of compensability, the carrier has the burden under ORS 656.005(7)(b)(C) of proving that the claimant's consumption of alcoholic beverages or the unlawful consumption of any controlled substance was the major contributing cause of the injury); *see also Fernandez v. M & M Reforestation*, 124 Or App 38 (1993) (once the claimant establishes that his compensable injury is a material contributing cause of his worsened condition, the burden shifts to the carrier under ORS 656.273(1) to prove that the major contributing cause of the claimant's worsening was an off work injury); *Roger D. Hart*, 44 Van Natta 2189 (1992), *aff'd Asplundh Tree Expert Company v. Hart*, 132 Or App 494 (1995) (same); *see generally, Harris v. SAIF*, 292 Or 683, 690, (1982) ("The general rule is that the burden of proof is upon the proponent of a fact or position, the party who would be unsuccessful if no evidence was introduced on either side.")

A claimant may be an "active participant" if he voluntarily assumes an active or aggressive role in a fight, or if he has an opportunity to withdraw from the encounter and does not do so. *See Irvington Transfer v. Jasenosky*, 116 Or App 635, 640 (1992).

As noted above, the ALJ found that claimant was not a credible witness and concluded that his testimony must be viewed with suspicion. 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). On *de novo* review, we agree with the ALJ that claimant was not a credible witness. Moreover, we agree with the ALJ's conclusion that claimant yelled and swore at Cornell and then hit Cornell's safety glasses out of his hands, which provoked Cornell to assault claimant and caused claimant to be injured. Consequently, we agree with the ALJ's determination that claimant actually initiated the fight and was an "active participant" pursuant to ORS 656.005(7)(b)(A). *See Kessen v. Boise Cascade Corp.*, 71 Or App at 548 (although the claimant was the recipient of the only blow struck, he was the one who, because of his anger, vocal tirade and threatening gestures, actually initiated the fight).

Next, we address whether the assault was "connected to the job assignment" and whether it amounted to a "deviation from customary duties." In *Lang*, the court concluded that, based on the Board's finding that claimant was not an "active participant" in the assault that injured him, the claim was compensable. *Id.* at 41-42. In other words, because one of the elements prescribed in ORS 656.005(7)(b)(A) had not been satisfied, the exclusion was not applicable. In keeping with its rationale that both elements of the statute must be met for the exclusion to apply, it was not necessary for the court to address the question of whether the claimant's assault was "not connected to the job assignment and amount[ed] to a deviation from customary duties." In this case, however, we must specifically address the issue.

In construing this part of the statute, we look first to its text and context. *PGE v. Bureau of Labor and Indus.*, 317 Or 606, 610-12 (1993). We find no ambiguity in the phrase "not connected to the job assignment."[1] The exception requires that the assault be separate from, and not linked or joined with, the claimant's assigned duties.[2] Thus, to the extent an assault or combat arises out of a quarrel whose subject matter is connected or related to the claimant's job assignment, a claimant's assault-related injuries would fall outside the statutory exclusion.[3]

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[1] *See Kessen v. Boise Cascade*, 71 Or App at 547, where, in construing *former* ORS 656.005(8)(a) (the predecessor to ORS 656.005(7)(b)(A)), the court remarked that it "did not see any ambiguities or uncertainties in the statute" and therefore construed the statute "according to its plain meaning."

[2] Webster's Third New International Dictionary (1993) defines "connected" as "joined or linked together" and as "having parts or elements logically related." The definition of "assignment" includes a "position, post or office to which one is assigned" and "a specified amount of work or a definite task or mission assigned by authority or undertaken as though so assigned."

[3] In this regard, we find guidance in the Court's comments in *Redman Industries v. Lang*. The Court explained:

> "Because the statute excludes only a subset of the types of injuries from assault that will not be deemed compensable, the logical inference is that the legislature intended other types of injuries from assault to be deemed compensable, so long as they arose out of and in the course of employment.
>
> "The parties agree that an injury caused by an assault in the workplace by a coemployee is compensable if the assault grew out of a quarrel whose subject matter is related *directly* to work. *We also agree that the legislature intended such injuries to be compensable.*" 326 Or at 38 (emphasis added).

Furthermore, contrary to the dissent's contention, we do not construe the "connected to the job assignment" language as the equivalent of the threshold "arising out of employment" element. While we believe that the term "connected to" is comparable in meaning to the phrase "arises out of," the term "job assignment" is narrower that the general concept of "employment" for purposes of ORS 656.005(7)(a). In other words, although a workplace assault will have arisen out of employment where it is caused by circumstances associated with the work environment (*i.e.*, general friction in the workplace), it would not be "connected to the job assignment" unless the subject matter of the dispute was related to the claimant's job duties. Finally, unlike the dissent, we see no distinction between the motive/subject matter of the assault and the assault itself. In this regard, every assault has a genesis. We find, however, that by virtue of this passage, the legislature intended to distinguish between those assaults that are connected to the job assignment and those that are not.

In this case, the evidence fails to show that the assault was not connected to claimant's job assignment. To the contrary, as claimant argues, the assault arose out of claimant's position and responsibilities as Mr. Cornell's supervisor. Claimant's job duties included supervising employees and maintaining quality control. Although claimant may have used abusive language in criticizing Mr. Cornell's work quality and smacked the safety glasses out of his hands, the subsequent altercation was nevertheless directly related to (and thereby "connected to") claimant's job assignment as a department supervisor.[4]

We acknowledge that, in *Kessen v. Boise Cascade Corp.*, 71 Or App at 547,[5] the court held that the claimant's assault-related injuries were not compensable where the claimant, a truck driver, was injured in an assault by a coworker that was precipitated by his vocal tirade, threatening gestures and accusations that the coworker was one of the supervisor's favored few. We find *Kessen* distinguishable on its facts, however.[6] The court determined that the claimant's confrontation with his coworker was not connected to claimant's job assignment as a truck driver, with its incidental duties of loading and unloading and checking in and out of the office.

Having determined in this case that claimant's assault was, in fact, connected to his job assignment, we need not decide whether it amounted to a deviation from his customary duties because even if it did, the statutory exclusion will not apply because not all of the elements have been met. *See Redman Industries v. Lang*, 326 Or at 38. Consequently, on reconsideration, we find that claimant's assault-related injuries are not excluded by ORS 656.005(7)(b)(A) and remain compensable under ORS 656.005(7)(a).

Accordingly, on reconsideration, the ALJ's order dated January 21, 1997 is reversed. The insurer's July 25, 1996 denial is set aside, and the claim is remanded to the insurer for processing according to law.

IT IS SO ORDERED.

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[4] Unlike the dissent, we find the fact that claimant was previously reprimanded for swearing at one of his employees and sent to a seminar involving a "combat management section" pertaining to managing people who were not performing their jobs adequately supports our conclusion that the July 11, 1996 assault was *connected to* his *job assignment* as a department supervisor.

[5] In *Kessen*, the claimant was angered when his supervisor refused to give him a night off of work to attend a friend's funeral. He left the supervisor's office and slammed the door. The supervisor called the claimant back and told him to close the door properly. The claimant came back and began complaining to his supervisor, claiming that the supervisor favored the day shift drivers. The claimant then turned his anger toward a coworker seated nearby, pointing and shaking his finger at the coworker and accusing the coworker of being one of the "favored few." The claimant then grabbed the coworker's wrapped and bandaged left arm, which had recently been removed from a cast. The coworker "nailed the claimant with a right to the jaw," causing claimant injury. 71 Or App at 546.

[6] Even if we were not persuaded that *Kessen* is distinguishable, we would question whether the court's rationale (*i.e.*, that an assault would not be connected to the job assignment unless the job description specifically entailed assaultive conduct) remains good law in light of subsequent cases, including *Redman Industries*, which take a broader, more encompassing view of the concept of "connection."

Board Member Moller dissenting.

Because I conclude that the facts of this case bring claimant's injuries squarely within the exclusion from benefits embodied in ORS 656.005(7)(b)(A), I respectfully dissent.

The majority has determined that: (1) claimant has shown that his injuries occurred in the course of and arose out of his employment; (2) under such circumstances, the burden shifts to the carrier to show that claimant's injuries are excluded from compensability under ORS 656.005(7)(b)(A), the "active participant in assaults or combats" exception; and (3) in this case, the carrier has not sustained its burden because claimant's injuries are "connected to his job assignment." While I agree that, under *Redman Industries, Inc. v. Lang*, 326 Or 32 (1997), claimant has established that his injuries occurred in the

course and scope of his employment and that the burden of proof then shifts to the employer to establish application of the assault or combat exclusion, I would conclude that claimant's injuries are excluded from compensability by ORS 656.005(7)(b)(A). Specifically, I disagree with the majority's construction of that portion of the exclusion which requires for its application that the assault is not connected to the job assignment and which amounts to a deviation from customary duties.

The majority examines the text of the statutory exclusion -- utilizing dictionary definitions of "connected" and "assignment" -- to conclude that an assault that grows out of a quarrel whose subject matter is "connected or related" to the claimant's job assignment falls outside the statutory exclusion. In performing its statutory construction analysis, I believe that the majority errs.

My first objection to the majority's analysis is that the majority impermissibly reads more into the statute than is there. The statute does not refer to quarrels the subject matter of which is connected or related to the job assignment. Rather, the statute excludes "assaults or combats which are not connected to the job assignment." By its express terms, it is the assault or combat that must be connected to the job assignment, not the underlying motive or subject matter. In order to reach its construction of the statute, the majority is required to insert language into the statute in violation of ORS 174.020. It is well-settled that, we are forbidden, both by statutory command and by constitutional principles, to insert language that the legislature, whether by design or by default, has omitted. *Deluxe Cabinet Works v. Messmer*, 140 Or App 548, 553 (1996).

Second, I fail to appreciate any real distinction between the majority's broad interpretation of the "connected to the job assignment" language and the threshold requirement that the injury be one that "arises out of" employment. An assault that arises out of employment -- because it is "caused by circumstances associated with the work environment" (*Lang*, 326 Or at 40) -- will almost invariably be an assault or combat that grows out of a quarrel whose subject matter is "connected or related to the job assignment." Presumably, however, the legislature intended some other -- and more narrow -- meaning than "arises out of employment" when it chose the "connected to the job assignment" language found in the exclusion.

Third, the majority's analysis fails to consider the context in which the "connected to the job assignment" language appears. In this regard, the majority overlooks the significance of the ensuing text which requires that the assault "amount to a deviation from customary duties." Again, if the inquiry is focused on the subject matter out of which the quarrel grows, then the "connected to the job assignment" language essentially renders the "deviation from customary duties" language unnecessary. This is true because an assault that grows out of a quarrel whose subject matter is not related to the claimant's job assignment will *always* amount to a deviation from customary duties. In order to give meaning to the final clause of the exclusion, we must construe the "connected to the job assignment" language precisely as it appears in the statute, *i.e.*, with the focus on the assault itself rather than the motive or subject matter that leads to a quarrel that leads to the assault.

My final reason for disagreeing with the majority's construction of the exclusionary statute is that it conflicts with the only direct precedent on this issue. In *Kessen v. Boise Cascade Corp.*, 71 Or App 545 (1984), the court found the claimant was an active participant in the assault. The court then turned to the question whether the assault was connected to the job assignment and whether it amounted to a deviation from customary duties. On this issue, the court found:

> "The assault was not *connected* to claimant's job assignment; it was clearly a deviation from his *customary* duties. Unlike a boxing instructor or a bouncer, whose job may entail assaultive conduct, claimant's job was to drive a truck, along with the incidental duties of loading and unloading and checking in and out of the office. His confrontation with Huff was a deviation from those duties. We conclude that claimant did not sustain a compensable injury." *Id.* (emphasis in original).

Although *Kessen* construed an earlier version of the statute, *former* ORS 656.005(8)(a), the court directly addressed the second element of the exclusion. In doing so, the court focused on the connection between the assault itself and the work duties rather than the subject matter out of which the assault arose. The exclusion was found to apply because claimant's employment duties did not involve assaultive conduct and such conduct was a deviation from his customary duties of driving a truck. Although the court noted only bouncers and boxers as workers whose jobs potentially entail assaults or combats, other occupations such as peace officer or security guard would also qualify.

Moreover, the following scenario provides an example of the potential policy ramifications from today's majority decision which finds that claimant's injuries from this workplace assault or combat were connected to his job assignment. Assume that a worker who is digging holes for fence posts is instructed by his supervisor to dig the holes deeper. When the worker refuses, a quarrel ensues. After the supervisor turns to report the worker's conduct to the manager, the worker strikes the supervisor on the head with his shovel. Although the supervisor is severely injured, the worker also strains his shoulder. Thereafter, the worker files an injury claim for his condition. A determination that the quarrel that resulted in the assault was connected to the worker's job assignment would preclude a carrier from establishing the requisite elements of the statutory exception to compensability under ORS 656.005(7)(b)(A) even though the worker was an active participant in the assaultive conduct which led to his injury and his assault was clearly a deviation from his customary duties. The end result of such an interpretation of the statute would be that the exception to compensability would be unavailable to any Oregon employer attempting to defend against an injury claim arising from a claimant's assaultive conduct regarding a job assignment.

In sum, considering both the text and context of the exclusionary statute, the intent of the legislature when it enacted the language found in the statute was to exclude from compensability injuries to active participants in workplace assaults or combats unless the injured worker's job assignment entailed assaultive or combative conduct and, under the facts of any given case, the assault or combat was not a deviation from customary duties. Here, because claimant's job assignment did not entail assaults or combats and the assault in this case amounted to a deviation from his customary duties, his injuries are excluded from compensability by operation of ORS 656.005(7)(b)(A). Accordingly, even after reconsidering the case under *Redman Industries, Inc. v. Lang*, I would affirm the ALJ's order.

Board Member Haynes dissenting.

The majority concludes that, although claimant verbally abused one of his employees, which was not condoned by the employer, and claimant struck the first blow of that employee, which violated the employer's policy that prohibited fighting, claimant's assault was "connected to the job assignment." Although I agree with the majority that claimant was an "active participant" in the assault, I respectfully dissent from the remainder of the majority's opinion.

To begin, I do not agree with the majority's conclusion that, after a claimant has established that the assault-related injuries arose out of and in the course of employment, the burden shifts to the employer to prove that the exception in ORS 656.005(7)(b)(A) applies. The majority reasons that, because ORS 656.005(7)(b)(A) operates to exclude certain injuries from the definition of "compensable injury," the burden shifts to the carrier to prove that the exception applies.

I find nothing in the text or context of ORS 656.005(7)(b)(A) to indicate that the legislature intended to shift the burden of proof once a claimant has established a prima facie case of compensability. ORS 656.266 provides that the worker has the burden of proving that an injury or occupational disease is compensable. I find no textual or contextual evidence indicating that we do not follow ORS 656.266 in applying ORS 656.005(7)(b)(A).

The majority's approach violates a principle of construction to be applied in the first level of statutory analysis: We are "not to insert what has been omitted, or to omit what has been inserted[.]" ORS 174.010; *PGE v. Bureau of Labor and Industries*, 317 Or 606, 611 (1993). The legislature knows how to shift the burden of proof when it chooses to do so. For example, ORS 656.262(6)(a) expressly provides that a carrier has the burden of proving, by a preponderance of the evidence, that a denial is for fraud, misrepresentation or other illegal activity. The statute provides that, upon such proof, the worker then has the burden of proving, by a preponderance of the evidence, the compensability of the claim. If the legislature had wanted to shift the burden of proof in ORS 656.005(7)(b)(A), it easily could have done so by including such a reference in the statute. *See also Grace L. Walker*, 45 Van Natta 1273 (1993) (legislative history of ORS 656.005(7)(b)(C) indicated the legislature intended to shift the burden of proof to the carrier to prove the "alcohol/drug consumption" exception after the claimant has established a prima facie case of compensability), *aff'd mem Walker v. Danner Shoe Manufacturing*, 126 Or App 313 (1994).

Furthermore, I disagree with the majority's determination that claimant's assault was connected to his job assignment. I acknowledge that the July 1996 dispute initially began as part of claimant's

supervisory responsibilities concerning the quality of his employee's work. Nevertheless, I would find that claimant's verbal abuse and fighting on the job were *not* connected with his job assignment and deviated from his customary duties. Claimant had been warned on previous occasions that the employer did not condone claimant's verbal abuse of employees and that further occurrences of abusive language could result in removal from his supervisory position. (Exs. A, B). Nevertheless, on July 11, 1996, claimant verbally abused Mr. Cornell on more than one occasion.

Moreover, I would find that claimant's fighting on the job was not connected with his work activities. After verbally abusing Mr. Cornell, claimant hit Cornell's safety glasses out of his hand, which provoked Cornell to assault claimant. Mr. Dodd testified that claimant "reached out and smacked the safety glasses out of [Cornell's] hand." (Ex. 27-9). Both Mark Weyhrich and Mr. Lomas testified that the employer's policy was that fighting on the job would lead to termination. (Tr. 56, 68-69).[1] Claimant's act of "smacking" Cornell's safety glasses out of his hand violated the employer's policy that prohibited fighting and constituted a deviation from his customary supervisory duties. Furthermore, that physical action was *not* connected with claimant's job assignment. Claimant's aggressive conduct, including yelling and swearing at Cornell, as well as knocking Cornell's safety glasses out of his hand, was not only itself physical, but also invited a physical response from Cornell. Under these circumstances, the assault was *not* connected to claimant's job assignment. For the same reasons, I would conclude that claimant also deviated from his customary duties by fighting on the job.

I find support for my analysis in *Andrews v. Tektronix, Inc.*, 323 Or 166 (1996). In that case, the court held that an employee's violation of an employment rule does not render his or her claim *per se* noncompensable. *Id.* at 166. The fact finder must decide whether the claimant was engaged in an activity that was within the boundaries of his or her ultimate work. *Id.* That determination is made by evaluating all the factors that are pertinent to the question of work-connectedness, and weighing those factors in the light of the policy underling the Workers' Compensation Act. *Id.*

Here, Mark Weyhrich and Mr. Lomas testified that the employer's policy was that fighting on the job would lead to termination. (Tr. 56, 68-69). Claimant's injury occurred when he struck the first blow by "smacking" Mr. Cornell's safety glasses. Claimant's supervisory duties did not include physically assaulting employees, and his job assignment certainly did not include initiating the first blow. Under these circumstances, I conclude that claimant was *not* engaged in an activity that was within the boundaries of his ultimate work at the time he was injured.

The facts in this case are similar to the "aggressor defense" theory applied in *Kessen v. Boise Cascade Corp.*, 71 Or App 545 (1984). In that case, the claimant, a truck driver, was angered when his supervisor refused to give him a night off from work. The claimant left his supervisor's office and slammed the door. The supervisor called the claimant back, and told him to close the door properly. The claimant came back and began complaining to his supervisor, claiming that he favored the day shift drivers. The claimant then accused a coworker of receiving preferential treatment. The claimant grabbed the coworker's bandaged left arm, which had only recently been removed from a cast. The coworker rose from his chair and hit the claimant's jaw. The court affirmed the Board's conclusion that the claimant's injuries were not compensable on the ground that he was an "active participant" in an assault under *former* ORS 656.005(8)(a).[2] In addition, the court reasoned:

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[1] Although claimant was not terminated, he was relieved from his supervisory capacities and his wages were reduced. (Tr. 9, Ex. 26). Mr. Weyhrich, vice president in charge of production, testified that claimant was subsequently demoted because the employer did not want to have a supervisor who would continue to verbally abuse the employees. (Tr. 56). Mr. Lomas, the employer's shop superintendent who investigated the July 11, 1996 incident, said that claimant was receiving medical treatment during his investigation and he did not feel that he should terminate a person under those circumstances. (Tr. 63-64, 69). Mr. Lomas testified that it was unclear to him whether claimant had struck Mr. Cornell, but, if that were true, he would have terminated claimant. (Tr. 69, 72). Mr. Lomas had not interviewed Mr. Dodd during the investigation. (Tr. 66).

[2] *Former* ORS 656.005(8)(a) provided, in part:

"* * * However, 'compensable injury' does not include injury to any active participant in assaults or combats which are not connected to the job assignment and which amount to a deviation from customary duties."

That provision has since been renumbered ORS 656.005(7)(b)(A). *See Liberty Northwest Ins. Corp. v. Johnson*, 142 Or App 21, 27 n.1 (1996).

> "The assault was not *connected* to claimant's job assignment; it was clearly a deviation from his *customary* duties. Unlike a boxing instructor or a bouncer, whose job may entail assaultive conduct, claimant's job was to drive a truck, along with the incidental duties of loading and unloading and checking in and out of the office. His confrontation with Huff was a deviation from those duties. We conclude that claimant did not sustain a compensable injury." *Id.* (emphasis in original).

The majority attempts to distinguish the *Kessen* case on the basis that the court determined that the claimant's confrontation with his coworker was not connected to his job assignment as a truck driver, with its incidental duties of loading and unloading and checking in and out of the office. I do not agree that the *Kessen* case is so limited. In concluding that the claimant's injury claim was not compensable, the *Kessen* court did not focus on the *reason* or *motive* for the assault that resulted in the claimant's injury. Instead, the court's analysis was premised on whether the assault itself was connected to the claimant's employment. The court unambiguously answered this inquiry in the negative, by reasoning that, because the claimant was not a boxing instructor or bouncer, his assaultive conduct was not connected to his job assignment as a truck driver.

Thus, whether the assaultive conduct is initiated by disagreements over assigned tasks or personnel-related matters such as leave requests, the assault itself is not connected to a worker's job assignment unless the worker's employment entails such conduct, as with a bouncer or boxing instructor. In other words, regardless of the genesis of the dispute leading to the physical confrontation, the precise inquiry is whether the "assault" or "combat" was "not connected to the job assignment."

Here, although the dispute that led to the assault initially began as part of claimant's supervisory responsibilities, I conclude that claimant's verbal abuse, aggressive behavior and fighting on the job were not connected to his job assignment. Thus, where claimant's assaultive conduct goes beyond his specified employment duties and, as in this case, constitutes a violation of an express policy prohibiting fighting on the job, the assault is not *connected* to the job assignment.

I am also persuaded that claimant's conduct constitutes a deviation from his customary duties. Claimant had been warned on previous occasions that the employer did not condone his verbal abuse of employees and that further occurrences of abusive language could result in removal from his supervisory position. He nevertheless verbally abused Mr. Cornell on July 11, 1996. Further, despite the employer's "no fighting" policy, claimant physically "smacked" the safety glasses out of Mr. Cornell's hand, provoking the assault.

Because the majority's interpretation of the statutory scheme is neither expressly nor implicitly mandated by any controlling legal authority and is inconsistent with existing judicial case precedent, I decline to analyze the statutory exception in a manner that would effectively eviscerate its application. Instead, I interpret ORS 656.005(7)(b)(A) in a manner that is first and foremost consistent with the *Kessen* holding, but also permits Oregon employers to utilize the statute in defense of those few claims where a worker's injuries arise from active participation in assaultive conduct that is not connected to the worker's job assignment and amounts to a deviation from customary duties.

In conclusion, because I would find that, in addition to being an active participant in an assault, the assault was *not* connected to claimant's job assignment *and* amounted to a deviation from his customary duties, I would adhere to the Board's original determination that the claim was not compensable under ORS 656.005(7)(b)(A). Accordingly, after reconsidering the case under *Redman Industries, Inc. v. Lang*, I would affirm the ALJ's order.

In the Matter of the Compensation of
DONALD D. LAMM, Claimant
Own Motion No. 95-0486M
OWN MOTION ORDER OF DISMISSAL
Employers Insurance of Wausau, Insurance Carrier

Claimant requests that the Board enforce its September 25, 1995 Own Motion Order which authorized the insurer's voluntary reopening of claimant's claim to provide temporary disability compensation beginning June 26, 1995, the date he was hospitalized for surgery.

FINDINGS OF FACT

On September 25, 1995, we issued our Own Motion Order authorizing the payment of temporary disability compensation for claimant's compensable protruded lumbar intervertebral disc injury. Our order authorized the payment of temporary disability compensation beginning the date claimant was hospitalized for surgery. In addition, the insurer was ordered to close the claim pursuant to OAR 438-012-0055 when claimant became medically stationary.

On June 17, 1998, claimant requested we enforce our September 25, 1998 Own Motion Order. Specifically, claimant requested enforcement "of the law which states that time-loss shall be paid until medically stationary or closure of claim."

On June 22, 1998, the insurer issued its Notice of Closure, which closed his claim with an award of temporary disability compensation from June 26, 1995 through June 3, 1998. The insurer declared claimant medically stationary as of May 12, 1998.

CONCLUSIONS OF LAW AND OPINION

In seeking enforcement of our prior order, claimant requests "time-loss" that "shall be paid until [he's] medically stationary or closure of claim." In response, the insurer reports that it has closed claimant's claim on June 22, 1998, declaring him medically stationary on May 12, 1998 and awarding him temporary disability compensation through June 3, 1998. Claimant has not contested the insurer's representations.

Under such circumstances, we find that claimant has been awarded "time-loss" to the medically stationary date and claim closure. Inasmuch as claimant has been awarded the temporary disability compensation to which he is entitled, no "enforcement" action is required. Accordingly, claimant's request for relief is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
LJUBICA MATOSIN, Claimant
WCB Case No. 97-05656
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Podnar's order that upheld the self-insured employer's denial of her right shoulder injury claim. In her brief, claimant also contends that the ALJ should have awarded an assessed fee pursuant to ORS 656.386(1). On review, the issues are compensability and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt and affirm the ALJ's reasoning and conclusion.

Attorney Fee

Claimant sustained a compensable right hand injury on February 21, 1997, which was accepted as a nondisabling claim for right hand third metacarpal fracture and right hand abrasion. (Ex. 7). On April 24, 1997, claimant complained of right shoulder pain, which the attending physician, Dr. Weintraub, opined was probably due to a "hand-shoulder" syndrome. (Ex. 9).

On May 16, 1997, the employer issued a "partial denial" on the ground that claimant's "current condition" did not arise in the course and scope of her employment. The denial letter further stated that claimant's "claim for workers' compensation benefits" was denied, but that the claim was not denied in its entirety, only that portion not related to the compensable injury. (Ex. 15-1). While unrepresented, claimant filed a hearing request on July 8, 1997, appealing the May 16, 1997 denial.

On August 1, 1997, claimant's attorney advised the Hearings Division that he was representing claimant. In addition to the issue raised by claimant's hearing request, claimant's counsel raised the issue of penalties and attorney fees.

On September 4, 1997, the employer issued an "amended" denial. (Ex. 24). It denied compensability of "bursitis of the right shoulder" on the ground that the condition was not related to the accepted conditions. On September 24, 1997, claimant's attorney filed a hearing request, appealing the September 4, 1997 denial.

At the hearing, the employer's counsel stated that, based on his conversations with the employer, the initial May 1997 denial was not intended to be a "current condition" denial, but was rather intended to be a denial of claimant's right shoulder condition. According to counsel, the denial was amended to reflect the "true intent" of the employer. However, counsel stated that no testimony would be presented regarding this issue. (Tr. 3).

The ALJ upheld both the May 16, 1997 and September 4, 1997 denials to the extent that they denied the compensability of claimant's right shoulder condition. However, the ALJ found the May 16, 1997 denial to be so ambiguous and "all encompassing" that it was unreasonable. Thus, the ALJ assessed a 25 percent penalty on any compensation that was withheld from the date of that denial through September 16, 1997.

The employer does not contest the ALJ's penalty assessment. However, claimant on review contends that the ALJ should have awarded an assessed fee pursuant to ORS 656.386(1) for prevailing against the May 16, 1997 denial. For the following reasons, we find that claimant's attorney is entitled to an assessed fee.

ORS 656.386(1) provides in part: "In such cases involving denied claims where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge, a reasonable attorney fee shall be allowed." In this case, the employer issued a May 16, 1997 denial of claimant's "claim for workers' compensation benefits." We agree with the ALJ's uncontested finding that the denial was overbroad and ambiguous. Perhaps recognizing the inartful phrasing of the May 16, 1997 denial, the employer amended the denial on September 4, 1997 to clarify the denied condition as being claimant's right shoulder condition. However, we find that this action amounted to a rescission of the May 16, 1997 denial to the extent that the September 4, 1997 denial clarified that the only denied condition was the right shoulder "bursitis" condition. Because claimant's attorney was instrumental in obtaining a rescission of a denial prior to a decision by an ALJ, we conclude that claimant's attorney is entitled to an attorney fee pursuant to ORS 656.386(1) for services prior to hearing regarding clarification of the inartfully phrased May 16, 1997 denial.[1] *See Marsha K. Flanary*, 44 Van Natta 393, 394 (1992) (attorney fees may be awarded for services rendered in clarifying inartfully-phrased or overbroad denials); *Mickey L. Wood*, 40 Van Natta 1860, 1867 (1988) (same).

Under such circumstances, and after considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services regarding the rescission of the denial prior to a decision by the ALJ is $500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated. Claimant is not entitled to an attorney fee for services at Hearing or on review concerning the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986); *Amador Mendez*, 44 Van Natta 736 (1992).

ORDER

The ALJ's order dated June 1, 1998 is modified in part and affirmed in part. Claimant's attorney is awarded an assessed fee of $500 for services provided in obtaining the partial rescission of the May 16, 1997 denial, to be paid by the employer. The remainder of the ALJ's order is affirmed.

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[1] We recognize that claimant filed a request for hearing appealing the May 16, 1997 denial prior to obtaining representation. However, claimant's counsel undertook representation of claimant and supplemented her hearing request prior to the employer's issuance of the September 4, 1997 denial that clarified the denied condition. Under these circumstances, we conclude that claimant's counsel was "instrumental" in obtaining a rescission of a denial prior to a decision by an ALJ.

In the Matter of the Compensation of
MICHAEL IZUCHUKWU, Claimant
WCB Case No. 98-01481
ORDER ON REVIEW
Mark W. Potter, Claimant Attorney
Reinisch, Mackenzie, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Tenenbaum's order that decreased claimant's unscheduled permanent disability award from 15 percent (48 degrees), as awarded by an Order on Reconsideration, to 3 percent (9.6 degrees). On review, the issue is extent of unscheduled permanent disability.

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

Claimant contends that his skin disorder falls between a Class 1 impairment and a Class 2 impairment because his condition requires intermittent treatment. *See* OAR 436-135-0440(2). The employer responds that claimant's non-prescribed use of a lotion for his dry, itchy skin does not amount to "treatment" as that term is used in the rule. We do not resolve that issue because, even if claimant's use of a lotion is "treatment" under the rule, Class 1 impairment expressly contemplates the occurrence of treatment.

ORDER

The ALJ's order dated May 19, 1998 is affirmed.

September 29, 1998 Cite as 50 Van Natta 1842 (1998)

In the Matter of the Compensation of
GARNET D. TOLL, Claimant
WCB Case No. 97-07872
ORDER ON REVIEW
Emmons, Kropp, Kryger, et al, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Nichols' order that: (1) declined to admit Exhibits 14 and 15 into evidence; and (2) set aside its denial of claimant's occupational disease claim for a left elbow condition. On review, the issues are evidence, remand and compensability.

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

Evidence/Remand

After the hearing, the insurer sought admission of Exhibits 14 and 15. Exhibit 14 is a release to regular work from Dr. Watanabe dated May 7, 1998. Exhibit 15 is a note from Dr. Watanabe dated May 13, 1998 referring to claimant's *right* elbow condition; he decreased her work to four hours for two weeks, then increased it to 6 hours a day for 2 weeks. The ALJ found that Exhibit 15 pertained to the right elbow condition and Exhibit 14 did not specify which elbow was the subject of the document. The ALJ reasoned that Exhibit 15 was not relevant to the question of compensability of claimant's left elbow condition and the value of Exhibit 14 was so uncertain as to not warrant reopening of the record. The ALJ declined to admit either Exhibit 14 or 15.

On review, the insurer argues that Exhibits 14 and 15 should be admitted because they clarify the medical condition and are very probative on the issue of compensability. According to the insurer, Dr. Watanabe's release of claimant to regular work belies his belief that work is injurious to the left elbow. The insurer requests that the Board remand the case for further 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. 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).

Although Dr. Watanabe's May 1998 work releases (Exhibits 14 and 15) did not exist at the time of the April 15, 1998 hearing, the general information from those work releases was available at the time of the hearing. Claimant testified that she was released to go back to work after the January 1998 right elbow surgery. (Tr. 35). She said she was off work from January 13, 1998 until April 10, 1998 and then took some vacation time. (Tr. 17). Claimant returned to light duty with restrictions. (Tr. 18). Although she was originally released to eight hours per day, her hours were reduced to six hours per day because of her pain. (*Id.*) In light of claimant's testimony, the proffered evidence from Dr. Watanabe's work releases is cumulative.

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 the insurer submitted, we would still agree with the ALJ that claimant has established the compensability of her left elbow condition. 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.

Compensability

We adopt and affirm the ALJ's reasoning and conclusion regarding compensability of claimant's left elbow condition.

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

ORDER

The ALJ's order dated May 6, 1998, as reconsidered June 2, 1998, is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the insurer.

In the Matter of the Compensation of
BLAINE P. HOSEY, Claimant
WCB Case No. 97-01164
ORDER ON REMAND
Ransom & Gilbertson, Claimant Attorneys
David L. Runner (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Pursuant to the court's September 24, 1998 order, we have been directed to consider the parties' settlement. The parties have submitted a proposed "Stipulation and Order," 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 to resolve their dispute regarding the SAIF Corporation's calculation of claimant's average weekly wage and SAIF's asserted overpayment. Specifically, the parties stipulate that claimant accepts a particular sum in full settlement of the permanent disability awards and disputed unpaid temporary disability awards granted by the September 26, 1996 Notice of Closure and January 6, 1997 Order on Reconsideration. The agreement further provides that claimant's average weekly wage is "fixed at $500" and that "SAIF's claimed overpayment is reduced to zero." Finally, the stipulation states that "[c]laimant's Request for Hearing in this matter shall be dismissed with prejudice."

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

IT IS SO ORDERED.

In the Matter of the Compensation of
GEORGE L. ALLENBY, Claimant
WCB Case No. 97-02663
ORDER ON REVIEW
Thomas J. Dzieman, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by the Board *en banc*.

The insurer requests review of Administrative Law Judge (ALJ) Mongrain's order that: (1) affirmed a March 20, 1997 Order on Reconsideration that found claim closure premature; (2) directed the insurer to reinstate payment of "procedural" temporary disability benefits; and (3) assessed a penalty for the insurer's allegedly unreasonable unilateral termination of those benefits. In his brief on review, claimant requests sanctions against the insurer under ORS 656.390. On review, the issues are jurisdiction, validity of the reconsideration order, premature closure, entitlement to procedural temporary disability benefits, penalties and sanctions. We reverse in part, modify in part, affirm in part, and decline to impose sanctions.

FINDINGS OF FACT

Claimant has an accepted claim with the employer for a May 5, 1995 logging injury. The claim was closed by a September 16, 1996 Notice of Closure, and claimant filed a request for reconsideration which the Department received on November 15, 1996. On December 10, 1996, the Department issued a notice of review by a medical arbiter and postponed the reconsideration for an additional 60 calendar days. In an Order on Reconsideration issued on February 6, 1997, the Department concluded that the claim closure was not premature and awarded additional scheduled permanent partial disability.

Thereafter, the insurer accepted additional medical conditions that were not considered in issuing the February 6, 1997 Order on Reconsideration. The Department then abated that order on March 4, 1997 to consider these newly accepted conditions. In a subsequent Order on Reconsideration issued on March 20, 1997, the Department declared that the September 16, 1996 Notice of Closure was rescinded as premature and that the claim remained in open status. On March 31, 1997, the insurer filed a request for hearing from the March 20, 1997 Order on Reconsideration. On April 25, 1997, the insurer advised claimant that it was suspending payment of procedural temporary disability benefits on the ground that the March 20, 1997 Order on Reconsideration was invalid. On May 13, 1997, claimant filed a cross-request for hearing challenging the insurer's suspension of procedural temporary disability benefits.

CONCLUSIONS OF LAW AND OPINION

In affirming the March 20, 1997 Order on Reconsideration, the ALJ rejected the insurer's argument that the reconsideration order was void pursuant to *former* ORS 656.268(6)(d)[1], which provides in pertinent part:

> "Reconsideration shall be completed within 18 working days from the date of receipt of the request therefor * * *. The deadline of 18 working days may be postponed by an additional 60 calendar days if within the 18 working days the department mails notice of review by a medical arbiter. If an order on reconsideration has not been mailed on or before 18 working days from the date of the receipt of the request for reconsideration, or within 18 working days plus the additional 60 calendar days where a notice for medical arbiter review was timely mailed, reconsideration shall be deemed denied and any further proceedings shall occur as though an order on reconsideration affirming the notice of closure or the determination order was mailed on the date the order was due to issue." (Emphasis supplied).

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[1] ORS 656.268(6)(d) was amended in 1997. Or Laws 1997, ch 111, sec 1. Whether or not the amendments apply to this case, they do not affect our analysis.

Here, the ALJ reasoned that the "deemed denied" provision of the statute was not applicable because the Department issued the initial February 6, 1997 Order on Reconsideration within the "18 days plus 60 days" period. The ALJ further reasoned that there was no other statutory time limit on the Department's authority to abate and reissue reconsideration orders. Thus, the ALJ ultimately concluded that the Department had the authority to issue the March 20, 1997 Order on Reconsideration. Inasmuch as that order rescinded the closure of the claim, the ALJ further directed the insurer to reinstate claimant's temporary disability effective the date the insurer had previously terminated the benefits. Finally, finding no legitimate basis for the insurer's termination of claimant's temporary benefits (in light of the March 20, 1997 reconsideration order), the ALJ assessed a penalty for unreasonable claim processing.

On review, the insurer renews its contention that the March 20, 1997 Order on Reconsideration was a nullity because it issued after the 78 day "deemed denied" period of *former* ORS 656.268(6)(d). Thus, the insurer argues that the Department lacked subject matter jurisdiction to issue the March 20, 1997 reconsideration order. Based on similar reasoning, the insurer asserts that the Department's March 4, 1997 Order of Abatement was also invalid because it issued after the aforementioned 78 day "deemed denied" period. In light of such circumstances, the insurer argues that it was under no obligation to recommence payment of temporary disability benefits, and that its failure to do so was not unreasonable. Alternatively, considering the ambiguity of the statutory scheme regarding this claim processing issue, the insurer contends that a penalty is not warranted.

Jurisdiction/Validity of Department Orders

We disagree with the insurer that the Department lacked subject matter jurisdiction to issue the March 20, 1997 Order on Reconsideration.[2] The legislature has invested the Department with authority to reconsider claim closures under ORS 656.268, and the fact that the Department issued its reconsideration order after the statutory deadline for reconsideration did not divest the Department of its reconsideration authority. The result is a voidable order that is enforceable unless the order is reversed on direct appeal.

This conclusion is consistent with the court's rationale in *SAIF v. Roles*, 111 Or App 597, *rev den* 314 Or 391 (1992). In *Roles*, a carrier failed to comply with an ALJ order modifying a Determination Order that had become final as a matter of law. The *Roles* court explained that a judgment is void only when the tribunal rendering it has no jurisdiction of the parties or the subject matter. The court further explained that subject matter jurisdiction exists when a statute authorizes the tribunal to make an inquiry about the dispute. The court concluded that, even though the ALJ's order incorrectly modified the final Determination Order, the ALJ had the statutory authority to issue the order because it fell within his subject matter jurisdiction. Thus, the court ultimately concluded that the carrier had an obligation to comply with the ALJ's valid order until and unless it was overturned.

Thus, the ALJ in *Roles* erroneously exercised authority involving subject matter over which he generally had jurisdiction. Nevertheless, the court concluded that the ALJ's order was enforceable. Our conclusion should be the same in this case. That is, because the Department has the authority to make an inquiry into the propriety of claim closures in general, its March 20 order rescinding the claim closure in this case was enforceable, notwithstanding the fact that it was issued after the reconsideration deadline. For this reason, the insurer was required to comply with the order and pay prospective temporary disability benefits due under the claim payable from the date of the reconsideration order until either the order was reversed on appeal or until termination of such benefits was authorized by law, whichever event first occurs. ORS 656.313(1)(a)(A).

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[2] We also reject claimant's contention that the ALJ lacked authority to consider the March 20, 1997 Order on Reconsideration. Inasmuch as the insurer's challenge to the validity of the reconsideration order constitutes a "matter concerning a claim," the Board's Hearings Division is authorized to consider that question. *See* ORS 656.268(6)(g); 656.704(3); *Jordan v. Brazier Forest Products*, 152 Or App 15 (1998).

In addition, we disagree with claimant's assertion that, because this "validity" issue was not first raised during the reconsideration proceeding, the insurer is prohibited from presenting the argument at hearing. Because the validity of the March 20, 1997 Order on Reconsideration was a question that could not arise until issuance of the order, we find that the issue could be addressed at hearing because it arose out of the reconsideration order itself. *See* ORS 656.283(7); *Donald L. Halvorsen*, 50 Van Natta 284 (1998).

Our conclusion that the March 20 order was voidable and enforceable inevitably leads us to reconsider our ultimate ruling in *Jenny L. Boydston*, 50 Van Natta 691 (1998), that a Department order issued after the statutory deadline for reconsideration was not appealable to the Board's Hearings Division. In *Boydston*, the claimant requested reconsideration from a Determination Order, no medical arbiter was appointed, and the Department issued an initial Order on Reconsideration within the statutory deadline of 18 days. Then, after the expiration of the 18-day period, the Department issued an order abating and withdrawing the initial reconsideration order to consider additional medical evidence. The Department then issued a second order on reconsideration, and the claimant requested a hearing from that order within 30 days.

In *Boydston*, we concluded that, in enacting *former* ORS 656.268(6)(d), the legislature intended to both limit the time within which the Director could act on a reconsideration request, and provide the parties with an appeal mechanism when the Department did not fulfill its statutory obligation within the designated time period. In so doing, we discussed the text and context of ORS 656.268(6)(d) and the relevant legislative history. In particular, we noted the express statutory requirement that "[r]econsideration shall be completed" within the statutory deadline. (Emphasis supplied). We further noted that the legislature enacted *former* ORS 656.268(6)(c) in response to problems created when the Director did not issue a reconsideration order within the former statutory time limit.

Thus, we concluded in *Boydston* that *former* ORS 656.268(6)(d) is a statutory limitation on the Department's plenary authority to withdraw an order and reconsider the decision embodied in the order. *SAIF v. Fisher*, 100 Or App 288, 291 (1991). Consequently, we held that the Department's authority to issue any reconsideration order ended 18 working days from receipt of the claimant's request for reconsideration. From that conclusion, we reasoned that the claimant's request for hearing was untimely because it was filed more than 30 days after the expiration of the statutory 18-day deadline. *See* ORS 656.268(6)(f).

After further consideration of the rationale expressed in *Boydston*, we continue to hold that the Department's *authority* to issue any reconsideration order ends after the expiration of the applicable statutory deadline for reconsideration. However, we no longer take the position that a reconsideration order issued after the statutory deadline is not appealable. We, instead, conclude that it would be fundamentally unfair to rule that a Department order issued after the statutory deadline was enforceable and voidable, but not appealable.

Accordingly, consistent with *Roles*, we ultimately conclude that a Department reconsideration order issued after the reconsideration deadline is *appealable* to the Hearings Division, and that the failure to appeal the order will result in a final (and enforceable) order. However, if the Department order is appealed to the Hearings Division, it may then be set aside as invalid because of its untimely issuance. For the same reason, any order of abatement issued after the reconsideration deadline also may be set aside as invalid because of its untimely issuance. To the extent that our conclusions are inconsistent with the reasoning expressed in *Boydston*, such reasoning is disavowed.[3]

Turning to the present case, we conclude that the Department had subject matter jurisdiction to issue the March 20 Order on Reconsideration. Accordingly, the ALJ properly reviewed the merits of that order pursuant to the insurer's timely request for hearing. On the merits, we disagree with the ALJ's decision to affirm the March 20 order. Instead, for the reasons discussed in *Boydston*, we conclude that the order was invalid because it issued after the statutory time period allowed for reconsideration.[4]

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[3] Because this opinion has been signed by two members, we recognize that this opinion represents a plurality decision. Nonetheless, because Member Hall also disagrees with the *Boydston* rationale (for the reasons expressed in his dissenting opinion in *Boydston* and in his concurring and dissenting opinion in this case), a majority of this Board disavows the *Boydston* reasoning.

[4] We recognize that Member Haynes and Chair Bock would adhere to the *Boydston* rationale and conclude that the Hearings Division lacked authority to review what they consider to be the null and void Order on Reconsideration. Nonetheless, because their opinion is based on a conclusion that any order issued after the expiration of the 78 "deemed denied" period is invalid, a majority of this Board holds (for different reasons) that the February 6, 1997 Order on Reconsideration stands as a valid and final order.

We further conclude that the March 4, 1997 Order of Abatement also must be set aside as invalid because it issued after the statutory deadline, leaving the initial February 6, 1997 Order on Reconsideration in effect. Finally, as neither party filed a timely hearing request from the February 6, 1997 order, we ultimately conclude that this order became final by operation of law.[5]

Procedural Temporary Disability Benefits/Penalties/Sanctions

Notwithstanding our conclusions regarding the ultimate invalidity of the March 20, 1997 Order on Reconsideration, the fact remains that the order rescinded the closure of the claim. Inasmuch as the claim returned to open status, the insurer is statutorily obligated to pay "prospective" temporary disability pending its appeal of the reconsideration order, until closure under ORS 656.268, or until the appealed order is reversed, whichever event first occurs. ORS 656.313(1)(a)(A); *Foster Wheeler Constructors, Inc. v. Parker*, 148 Or App 6 (1997); *Anodizing, Inc. v. Heath*, 129 Or App 352 (1994); *Pascual Zaragoza*, 45 Van Natta 1221 (1993), *aff'd mem* 126 Or App 544, *rev den* 319 Or 81 (1994). This obligation attaches even if the appealed order that awarded the compensation is subsequently determined to be invalid. *See Glen D. Roles*, 45 Van Natta 282, *on recon* 45 Van Natta 488 (1993). Accordingly, we conclude that claimant is entitled to the payment of "prospective" temporary disability benefits until claim closure or the date of this order setting aside the March 20 reconsideration order, whichever comes first.[6]

However, we are not persuaded that claimant is entitled to a penalty for the carrier's failure to pay those benefits.[7] A penalty can be assessed under ORS 656.262(11)(a) if the carrier's failure to pay benefits was unreasonable. Whether a carrier's actions are unreasonable is determined by whether it had a legitimate doubt, from a legal standpoint, about its liability. *Brown v. Argonaut Insurance Co.*, 93 Or App 588 (1988). Here, we find that the insurer had a legitimate doubt regarding its liability to pay temporary disability following the March 20, 1997 Order on Reconsideration. As discussed above, carriers are required to comply with enforceable orders on reconsideration in accordance with their statutory and regulatory obligations. Nonetheless, as evidenced by our prior decision in *Boydston*, it was not unreasonable for the insurer to take the position that, pursuant to ORS 656.268(6)(d), the March 20 reconsideration order was unenforceable because it issued after the expiration of the statutory "18 days plus 60 days" period. Thus, the insurer had a legitimate doubt regarding its duty to pay the temporary disability awarded by the March 20 order. Consequently, we reverse the ALJ's penalty assessment.

Finally, we deny claimant's request for sanctions under ORS 656.390(1).[8] Pursuant to that provision, the Board may impose an appropriate sanction if the insurer'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. Because the insurer has raised colorable arguments on Board review (some of which have resulted in a successful challenge to portions of the ALJ's order), we conclude that its appeal was not frivolous and that sanctions are not warranted.

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[5] In reaching this conclusion, we note that the insurer remains responsible for the processing of those portions of the claim which pertain to the conditions that were accepted following claim closure. *See* ORS 656.262(7)(c); *Daniel I. Vanwechel, 50 Van Natta 844 (1998); Mario R. Castaneda 49 Van Natta 2135 (1997); Ronald D. Smith*, 49 Van Natta 1807 (1997); *Bernard G. Hunt*, 49 Van Natta 223 (1997); *Anthony J. Telesmanich*, 49 Van Natta 49, *on recon* 49 Van Natta 166 (1997).

[6] Because Member Hall believes that the March 20th order was valid for the reasons expressed in his concurring and dissenting opinion, a majority of this Board finds that the insurer was obligated to provide "prospective" temporary disability benefits payable from the date of the March 20th order until such benefits could be terminated in the manner described above.

[7] We acknowledge that Member Haynes and Chair Bock would adhere to the *Boydston* rationale and conclude that the Hearings Division lacked authority to review what they consider to be the "null and void" Order on Reconsideration. Nonetheless, because their opinion is based on a conclusion that any order issued after the expiration of the 78 "deemed denied" period is invalid, a majority of this Board holds (for different reasons) that the insurer's failure to comply with the March 20th Order on Reconsideration was not unreasonable.

[8] Albeit for different reasons, all members agree that the insurer's request for review raises colorable arguments. Consequently, the entire Board holds that sanctions under ORS 656.390 are not warranted.

Claimant is entitled to a carrier-paid attorney fee award for his counsel's services on review regarding the temporary disability issue.[9] *See* ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable attorney fee for claimant's counsel's services on review regarding the temporary disability issue is $750, 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, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. We have not considered claimant's counsel's services regarding the subject matter jurisdiction, penalties, and sanctions issues.

ORDER

The ALJ's order dated August 4, 1997 is modified in part, reversed in part, and affirmed in part. Those portions of the ALJ's order that affirmed the March 20, 1997 Order on Reconsideration and assessed penalties are reversed. The March 20, 1997 Order on Reconsideration and March 4, 1997 Order of Abatement are vacated as invalid. The insurer is directed to pay "prospective" temporary disability benefits payable from the date of the March 20, 1997 Order on Reconsideration until claim closure under ORS 656.268 or the date of this order, whichever occurred first. The remainder of the ALJ's order is affirmed. For services on review, claimant's counsel is awarded $750, payable by the insurer.

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[9] Because Member Hall has agreed with this opinion (albeit for different reasons) that the ALJ correctly awarded temporary disability, a majority of this Board finds that claimant's counsel is entitled to an attorney fee for services on Board review regarding that issue.

Board Member Hall concurring in part and dissenting in part.

I agree with Member Moller's and Member Biehl's ultimate opinion that the ALJ was authorized to consider the parties' requests for hearing concerning the March 20, 1997 Order on Reconsideration and the insurer's noncompliance with that order. However, I do so based on the following reasoning.

As I discussed in my dissenting opinion in *Boydston*, 50 Van Natta at 693, there are no statutory time limits on the Department's authority to abate and reissue a reconsideration order that is initially issued within the statutory time period set forth in ORS 656.268(6)(d). Here, the initial February 6, 1997 Order on Reconsideration issued within the statutory time limit. Consequently, the subsequent expiration of that time limit had no effect on the Department's authority to withdraw and reconsider that order. For this reason, I would affirm the ALJ's ultimate decision to uphold and enforce the March 20 order, as well as the ALJ's penalty assessment for the insurer's failure to comply with the March 20 order.

In light of this reasoning, I concur with the conclusion ultimately reached by Members Moller and Biehl (albeit for different reasons) that the March 20 Order on Reconsideration is reviewable. I also agree with their determinations that: (1) the insurer was required to pay "prospective" temporary disability benefits from the date of the March 20 order; (2) sanctions are not warranted; and (3) claimant is entitled to a carrier-paid attorney fee award under ORS 656.382(2) for his counsel's services on review regarding the temporary disability issue.

However, for the reasons expressed in my dissenting opinion in *Boydston*, I disagree with my fellow members' majority holding that the March 20 Order on Reconsideration is invalid (either as void ab initio or as voidable). Likewise, consistent with that analysis of the statutory scheme, I consider the insurer's refusal to comply with the March 20 Order on Reconsideration to have been unreasonable. Therefore, I respectfully dissent from those portions of the "majority" opinion.

Board Member Haynes and Chair Bock concurring in part and dissenting in part.

As we understand the opinion from Members Moller and Biehl, they decide that: (1) the March 20 Order on Reconsideration was "voidable and enforceable" pursuant to *SAIF v. Roles*, 111 Or App 597, *rev den* 314 Or 391 (1992); (2) although, under ORS 656.268(6)(d), the Department lacked *authority* to issue any reconsideration order after the deadline; (3) based on "fundamental fairness," an order issued

after the deadline is appealable to the Hearings Division; but (4) because the March 20 order and Order of Abatement were issued after the deadline and no party appealed the first Order on Reconsideration, the first Order on Reconsideration became final. Nevertheless, in conjunction with Member Hall's concurrence, Members Moller and Biehl, in effect, enforce the second Order on Reconsideration by awarding temporary disability.

We view this case a great deal more simply. The Department issued the first Order on Reconsideration, the Order of Abatement, and the second Order on Reconsideration pursuant to *former* ORS 656.268(6)(d). Thus, consistent with our appellate courts' mandate, we are required to determine the legislative intent of the statute according to the template provided in *PGE v. Bureau of Labor and Industries*, 317 Or 606, 611 (1993). Because this is the approach we took in *Jenny L. Boydston*, 50 Van Natta 691 (1998), we would continue to adhere with the reasoning and conclusions in that case.

Former ORS 656.268(6)(d) provides, in relevant part:

> "Reconsideration shall be completed within 18 working days from the date of receipt of the request therefor * * *. The deadline of 18 working days may be postponed by an additional 60 calendar days if within the 18 working days the department mails notice of review by a medical arbiter. If an order on reconsideration has not been mailed on or before 18 working days plus the additional 60 calendar days where a notice for medical arbiter review was timely mailed, reconsideration shall be deemed denied and any further proceedings shall occur as though an order on reconsideration affirming the notice of closure or the determination order was mailed on the date the order was due to issue."

In *Boydston*, an Order on Reconsideration issued on February 3, 1997, within 18 working days of the date of receipt of the request for reconsideration. On March 12, 1997, the Department issued an Order Abating and Withdrawing the Order on Reconsideration. On March 20, 1997, the Department issued a Second Order on Reconsideration.

Based on the text of the statute, we found "an express statutory limitation on the Department's authority to reconsider a Determination Order or Notice of Closure." 50 Van Natta at 692. Specifically, we concluded that "the Department's authority to issue an Order on Reconsideration ended on February 28, 1997, 18 working days from receipt of [the] claimant's request for reconsideration." *Id.* at 693. Because the claimant did not request a hearing within 30 days of the February 3, 1997 Order on Reconsideration, we found the request for hearing untimely and affirmed the ALJ's order of dismissal.

We continue to believe that *Boydston* is consistent with the legislative intent expressed in *former* ORS 656.268(6)(d). That is, because the statute provides that "[r]econsideration shall be completed within 18 working days from the date of receipt of the request" for reconsideration and that such deadline "may be postponed by an additional 60 calendar days" if the Department mails a notice of medical arbiter review within 18 working days, we find an express intent to limit the Department's review authority to 18 working days or, if there is a timely notice of medical arbiter review, 18 working days plus an additional 60 calendar days.

Here, a Notice of Closure issued on September 16, 1996 and the Department received claimant's request for reconsideration on November 15, 1996. On December 10, 1996, the Department issued a notice of review by a medical arbiter and postponed the reconsideration for an additional 60 calendar days. Thus, because the Department mailed its notice of review by a medical arbiter within 18 working days of the date of receipt of the request for reconsideration, it properly postponed reconsideration for an additional 60 calendar days.

On February 6, 1997, the Department issued an Order on Reconsideration. Because this order was within the postponement period of 60 calendar days, it also was timely under the statute.

The Department, however, then abated its order on March 4, 1997 to consider the insurer's acceptance of new conditions. A subsequent Order on Reconsideration issued on March 20, 1997 that rescinded the Notice of Closure as premature. On March 31, 1997, the insurer filed a request for hearing and, on May 13, 1997, claimant filed a cross-request for hearing.

Under *former* ORS 656.268(6)(d), the Department's "deadline" for reconsideration expired on February 9, 1997.[1] Consequently, the March 4, 1997 abatement and March 20, 1997 Order on Reconsideration issued after the Department's "deadline." Only the February 6, 1997 Order on Reconsideration was timely. Because no party requested a hearing within 30 days of this order, however, there was no timely filing of a request for hearing. *See* ORS 656.268(6)(f) (providing that a party may object to an order on reconsideration by requesting a hearing within 30 days from the date of the reconsideration order). Thus, we would conclude that the insurer's request for hearing should be dismissed and claimant's request for temporary disability and penalties should be denied.

In sum, we would continue to adhere to the reasoning in *Jenny L. Boydston* because we believe it provides statutory construction of legislative intent that is consistent with the text and context of *former* ORS 656.268(6)(d). As discussed above, because the February 6, 1997 Order on Reconsideration issued before the Department's reconsideration "deadline" and no party requested a hearing within 30 days of that order, we would dismiss the insurer's request for hearing and decline to award temporary disability or assess penalties.[2]

Finally, although we would base our decision on reasons different from those expressed by Members Moller and Biehl, we concur with their ultimate conclusion that the February 6, 1997 Order on Reconsideration constitutes a valid and final order because the ensuing abatement and reconsideration orders issued after the expiration of the 78 "deemed denied" period of *former* ORS 656.268(6)(d). Based on similar reasoning, we would likewise not consider the insurer's failure to comply with the March 20 Order on Reconsideration to have been unreasonable. Turning to the sanctions issue, because the insurer's request for Board review was based on colorable and partially successful arguments, we agree that sanctions for a frivolous appeal are not appropriate.

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[1] Because February 9, 1997 was a Sunday, the "deadline" actually fell on Monday, February 10, 1997.

[2] Because we believe that the ALJ was not authorized to award temporary disability, we dissent from the "majority" decision to award claimant a carrier-paid attorney fee for his counsel's services on review in defense of the insurer's appeal from the ALJ's temporary disability award.

In the Matter of the Compensation of
ROBERT E. ANDERSON, Claimant
WCB Case No. 97-08529
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Otto's order that: (1) concluded that claimant is not precluded from litigating the compensability of his current C4-5, C5-6 and C6-7 disk conditions; and (2) set aside the insurer's denial of the C6-7 disk condition. Claimant cross-requests review of that portion of the ALJ's order that upheld the insurer's denial of claimant's C4-5 and C5-6 disk conditions. On review, the issues are scope of review, *res judicata* 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

C6-7 Disk.

We adopt and affirm the ALJ's decision and rationale regarding claimant's C6-7 disk herniation. Consequently, 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 this issue is $1,200, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

C4-5 and C5-6 Disk.

The ALJ concluded that the claim for claimant's current C4-5 and C5-6 disk conditions was not precluded. However, the ALJ determined that the medical evidence did not establish a compensable relationship between these conditions and claimant's accepted injury. On review, claimant contends that the ALJ's compensability ruling was beyond the proper scope of his review. We agree.

An ALJ's scope of review is limited to the issues raised by the parties. *Saedeh K. Bashi*, 46 Van Natta 2253 (1994). Here, we find nothing in the language of the insurer's denial, the pre-hearing filings or the hearing transcript to indicate that claimant agreed to litigate compensability of the C4-5 and C5-6 conditions, or even had notice that the ALJ would be addressing these conditions.

Based on this record, we conclude that the ALJ acted beyond the proper scope of his review in setting aside the insurer's denial of the C4-5 and C5-6 conditions. Consequently, we vacate that portion of the ALJ's order.

ORDER

The ALJ's order dated March 17, 1998 is affirmed in part and vacated in part. That portion of the order the upheld the insurer's denial of claimant's C4-5 and C5-6 disk conditions is vacated. The remainder of the ALJ's order is affirmed. For services on review, claimant's counsel is awarded $1,200, payable by the insurer.

September 30, 1998 Cite as 50 Van Natta 1851 (1998)

In the Matter of the Compensation of
LEANN COALWELL, Claimant
WCB Case No. 97-10381
ORDER ON REVIEW
David B. Hydes, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that upheld the SAIF Corporation's denial of claimant's claim for a seizure episode. On review, the issue is compensability.

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

On review, claimant contends that this case presents an uncomplicated situation where medical evidence supporting causation is unnecessary. We disagree.

In *Barnett v. SAIF*, 122 Or App 279 (1993), the court reversed a Board order that upheld a back injury denial because no physician offered a medical opinion relating the claimant's back condition to her work activities. Citing *Uris v. Compensation Dept.*, 247 Or 420 (1967), the court listed five relevant factors for determining whether expert evidence of causation is required: (1) whether the situation is complicated; (2) whether the symptoms appear immediately; (3) whether the worker promptly reports the occurrence to a supervisor; (4) whether the worker was previously free from disability of the kind involved; and (5) whether there was any contrary expert evidence.

Here, we are not persuaded that the situation is uncomplicated. The employer manufactures circuit boards, which involves use of a wave solder machine and hand soldering. On the morning of December 2, 1997, claimant worked doing hand soldering and circuit board inspection. At lunch time, claimant went to the employer's cafeteria. While sitting in the cafeteria eating, claimant lost consciousness and suffered a seizure.

On February 12, 1998, an industrial hygienist did personal air sampling for lead, isopropyl alcohol, and ethanol. Samples were obtained from two employees doing hand soldering and from one operating the wave solder machine. Lead wipe samples were also taken. All samples were well below Oregon Occupational Safety and Health Standards (OSHA) for exposure. (Ex. 8).

Claimant contends that the seizure was caused by exposure to lead fumes created by during the soldering process at work. As the ALJ found, it is unclear whether claimant is asserting that the seizure episode is compensable as an injury or an occupational disease. However, we agree with the ALJ that, under either standard, claimant has failed to meet her burden of proof on this record.

The record contains very little medical evidence. Dr. Dodson, M.D., examined claimant in the Emergency Room shortly after her seizure. (Ex. 2). A CT scan was performed, which was normal. (Exs. 1, 2). Claimant was referred for an EEG, which was also normal. (Exs. 2, 4). Dr. Dodson did not render an opinion regarding the cause of claimant's seizure.

On December 10, 1997, Dr. Holland, claimant's family physician, examined claimant and diagnosed "[s]eizure times one with no specific etiology." (Ex. 4). Dr. Holland also stated:

> "Would recommend that we talk to OSHA as far as some of the products that she could be exposed to and whether there is any concern or not. Would recommend that we get a hold of them and f/u with this and see what they recommend doing at this time. Have not found any etiology for her seizures [sic] and would recommend that we look into this a little further." (*Id.*).

Dr. Holland provided no further opinion. As noted above, testing done at the work place a couple of months later showed that chemical exposure was well below OSHA standards. (Ex. 7, 8).

Given the fact that the only medical opinion regarding causation stated that no etiology had been found for claimant's seizure episode and recommended further investigation, we do not find that this case presents an uncomplicated situation where medical evidence supporting causation is unnecessary. Further complicating the situation is the fact that, following Dr. Holland's recommendation for further investigation, testing of the work place was done and showed levels of lead exposure well below OSHA standards.

In light of such circumstances, we are not convinced that this is an uncomplicated situation. Accordingly, we conclude that medical evidence is necessary to establish that claimant's seizure episode is causally related to work exposure. Inasmuch as Dr. Holland's opinion provides the only medical evidence regarding causation and, at most, it establishes only a possibility that the seizure arose out of claimant's employment, we agree with the ALJ that claimant has failed to establish compensability of her seizure claim. *Gormley v. SAIF*, 52 Or App 1055, 1060 (1981) (claimant must prove medical causation in terms of probability, not just possibility).

ORDER

The ALJ's order dated April 16, 1998 is affirmed.

In the Matter of the Compensation of
KATHERYN J. GEE, Claimant
WCB Case No. 97-07448
ORDER ON REVIEW
Pozzi, et al, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Howell's order that: (1) set aside the insurer's denial of claimant's degenerative cervical condition; and (2) awarded claimant's counsel an assessed attorney fee. Claimant cross-requests review of those portions of the ALJ's order that: (1) upheld the insurer's partial denial of claimant's thoracic spine condition; and (2) upheld the insurer's denial of claimant's bilateral carpal tunnel syndrome. On review, the issues are compensability and attorney fees.

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

Claimant contends that the insurer's denial was procedurally improper. However, we have recently held that a pre-closure denial may be issued, insofar as it applies to a "combined condition." *Tracey A. Blamires*, 50 Van Natta 1793 (1998). In *Blamires*, we held that, even if a carrier has not accepted a combined condition, so long as the medical evidence on an open claim establishes that the compensable injury combined with a preexisting condition to cause or prolong disability or need for treatment, the carrier is authorized to issue a denial. We concluded that the denial may be issued when the accepted injury is no longer the major cause of the worker's combined condition. Accordingly, because that is what the insurer did in the present case, the ALJ did not err in finding that the denial was proper pursuant to ORS 656.262(7)(b), and in proceeding to address the merits of the case.

Claimant's counsel is entitled to an assessed attorney fee for defending against the insurer's request for review on the issue of compensability of claimant's cervical condition. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability of the cervical condition 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 that portion of claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 5, 1998 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
BETTE L. PARKER, Claimant
WCB Case No. 98-01632
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order that affirmed an Order on Reconsideration awarding 29 percent (43.5 degrees) scheduled permanent disability for loss of use or function of the right hand. On review, the issue is extent of scheduled permanent disability. We modify in part and reverse in part..

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for "tenosynovitis of the right long finger." A Notice of Closure awarded 8 percent scheduled permanent disability. The Order on Reconsideration increased the award to 29 percent scheduled permanent disability.

Based on the medical arbiter panel's report, the ALJ affirmed the Order on Reconsideration. In particular, the ALJ determined that the report showed that impairment from other right hand fingers and significant limitation from repetitive activities of the right hand qualified as "direct medical sequelae" of the accepted condition and, thus, were properly rated. The employer challenges this conclusion, arguing that there is insufficient evidence showing that such impairment qualifies as "direct medical sequelae."

The attending orthopedic surgeon, Dr. Warren, indicated that claimant had "mild permanent partial disability relating to continued pain in the hand aggravated by activity, limited range of motion of the right middle finger at the proximal interphalangeal joint, and limited grip strength[.]" (Ex. 15).

Directions from the Department to the medical arbiter panel provided that "enclosed medicals * * * are to be reviewed for determining impairment due to the accepted condition(s), including any direct medical sequelae." (Ex. 18A). The directions further requested that the panel "perform a complete examination of the RIGHT HAND and describe any objective findings of permanent impairment resulting from the accepted condition(s)[.]" (*Id.*) (Emphasis in original.) Finally, the Department requested that the panel describe whether "findings are due to the accepted condition and due to other unrelated causes" and the percentage of "impairment due to the accepted condition." (*Id.*)

The medical arbiter panel's report provided measurements of the range of motion for all the fingers of the right hand. (Ex. 19-2). The panel's report stated that "100%" of "impairment of the right middle finger is due to the accepted condition." (*Id.* at 3). The panel also indicated that claimant was "limited in the ability to repetitively use the right hand due to the accepted condition." (*Id.*)

With regard to range of motion, we find insufficient evidence that impairment in any finger except the middle finger is due to the accepted condition or qualifies as direct medical sequelae of the accepted condition. Although the report also provided range of motion measurements of every finger, we note that such findings are consistent with the Department's direction to provide ranges of motion of the "fingers." Furthermore, because the panel's report indicated only that impairment from the middle finger was due to the accepted condition, and it was asked to "describe" findings of permanent impairment from the accepted conditions, we find that the range of motion measurements of the other fingers are insufficient to prove impairment "due to the accepted condition" or as "direct medical sequelae" of the accepted condition.

The panel, however, did explicitly attribute the limitation in repetitive use of the right hand to the accepted condition. Similarly, Dr. Warren indicated that claimant had permanent disability from continued pain of the "hand." Based on this evidence, we find that claimant proved entitlement to impairment for a chronic condition of the right hand. That is, because claimant showed that the chronic right hand condition was "due to the accepted condition," she proved entitlement to such impairment because it resulted from the accepted condition and, thus, it was not necessary for her to demonstrate that it was from "direct medical sequelae." *See Donald D. Davis*, 49 Van Natta 2100 (1997), *recon* 50 Van Natta 357 (1998) (ORS 656.268(16) applies when the record shows that an unaccepted condition is a "direct medical sequela" of the accepted condition, as opposed to the accidental injury from which the accepted condition arose).

In sum, claimant proved entitlement to 59 percent lost range of motion impairment for the right middle finger, *see* OAR 436-035-0060, which is 9 percent when converted to the right hand, *see* OAR 436-035-0070. Claimant also is entitled to 5 percent impairment for being significantly restricted in repetitive activities of the right hand. *See* OAR 436-035-0010(5). Adding that value to 9 percent results in a total of 14 percent scheduled permanent disability for the right hand. *See* OAR 436-035-0070(2).

Finally, because the employer had unsuccessfully requested a hearing seeking a reduction of the Order on Reconsideration's permanent disability award, the ALJ awarded claimant a carrier-paid award, we reverse the ALJ's attorney fee award.

ORDER

The ALJ's order dated May 4, 1998 is modified in part and reversed in part. In lieu of the Order on Reconsideration and ALJ's order awarding 29 percent (43.5 degrees) scheduled permanent disability for the loss of use or function of the right hand, claimant is awarded 14 percent (21 degrees) scheduled permanent disability for the loss of use or function of the right hand. The ALJ's attorney fee award is reversed.

In the Matter of the Compensation of
DENNIS C. VENABLE, Claimant
Own Motion No. 98-0356M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted claimant's request for temporary disability compensation for claimant's compensable right knee lateral meniscus tear. Claimant's aggravation rights expired on April 28, 1997. SAIF opposes the reopening of the claim on the grounds that no surgery or hospitalization has been requested. In addition, asserting that claimant has not submitted a claim for his current Baker cyst condition, SAIF reports that the condition has neither been accepted or denied.

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

SAIF represents that the compensability of claimant's current Baker's cyst condition is undetermined. Specifically, SAIF asserts that claimant has not formally requested acceptance or denial of this "new medical condition" (Baker's cyst), for which he sought treatment.

Inasmuch as the compensability dispute between the parties remains unresolved, we are not authorized to reopen claimant's 1990 injury claim for the payment of temporary disability benefits.[1] *See* ORS 656.278(1)(a). Should claimant's circumstances change, and claimant's current condition subsequently be determined to be compensably related to the accepted condition in the 1990 claim, claimant may again seek own motion relief.[2]

Accordingly, claimant's request for temporary disability compensation is denied.

Claimant's entitlement to medical expenses for his accepted condition under ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

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[1] Our jurisdiction extends only to the authorization of temporary disability compensation under the specific circumstances set forth in ORS 656.278. the Board, in its Own Motion authority, does not have jurisdiction to decide matters of compensability, responsibility or reasonableness and necessity of surgery or hospitalization (pre-1966 injuries expected). Rather, jurisdiction over these disputes rests either with the Hearings Division pursuant to ORS 656.283 to 656.295 or with the Director under ORS 656.245, 656.260 or 656.327. *See Gary L. Martin,* 48 Van Natta 1802 (1996).

[2] The Workers' Compensation Board is an agency of the State of Oregon and, as such, is an adjudicative body. In other words, it addresses issues presented to it from disputing parties. Because of that role, the Board is an impartial party. The Board cannot extend any advice or relief to claimant. However, because claimant is unrepresented, he may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in such matters. Claimant may contact the Workers' Compensation Ombudsman, free of charge, at 1-800-927-1271, or write to:

DEPT OF CONSUMER & BUSINESS SERVICES
WORKERS' COMPENSATION OMBUDSMAN
350 WINTER ST NE
SALEM OR 97310

WORKERS' COMPENSATION CASES

Decided in the Oregon Supreme Court:

Decided in the Oregon Court of Appeals:

Cite as 327 Or 449 (1998) August 13, 1998

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Allen Coman, Claimant.

ALLEN COMAN, Petitioner on Review,
v.
CORRECTIONS DEPARTMENT and SAIF CORPORATION, Respondents on Review.
(WCB 95-12947; CA A95012; SC S44624)

On review from the Court of Appeals.*
Argued and submitted March 6, 1998.
Richard M. Walsh, Salem, argued the cause and filed the petition for petitioner on review.
Robert M. Atkinson, Assistant Attorney General, Salem, argued the cause for respondents on review. With him on the brief were Hardy Myers, Attorney General, and Michael D. Reynolds, Solicitor General.
Before Carson, Chief Justice, and Gillette, Van Hoomissen, Durham, and Leeson, Justices.**
GILLETTE, J.
The decision of the Court of Appeals is reversed. The order of the Workers' Compensation Board is reversed. The case is remanded to the Workers' Compensation Board for further proceedings.

* On judicial review of an order of the Worker's Compensation Board. 149 Or App 496, 942 P2d 304 (1997).

** Graber, J., resigned March 31, 1998, and did not participate in this decision; Kulongoski, J., did not participate in the consideration or decision of this case.

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327 Or 451> The issue in this workers' compensation case involving an occupational disease claim is whether petitioner, an employee of the Oregon Corrections Department (Department) who claimed that he had contracted tuberculosis (TB) while on the job, properly was denied access to certain medical records of prisoners in the custody of his employer. Petitioner asserts that those records may help him meet his burden of proof with respect to an occupational disease claim under ORS 656.266. An administrative law judge (ALJ) denied petitioner access to the records, a divided Workers' Compensation Board (Board) affirmed that ruling, and the Court of Appeals affirmed the order of the Board without opinion. *Coman v. Department of Corrections*, 149 Or App 496, 942 P2d 304 (1997). We allowed petitioner's petition for review and now reverse the decision of the Court of Appeals.

Petitioner is employed as a correctional sergeant at the Oregon State Correctional Institution (OSCI). A September 1995 skin test indicated that he had been exposed to the organism that causes TB. Petitioner had tested negative for TB the previous year. He filed a workers' compensation claim, alleging that he had been exposed to at least one infectious case of TB while working at OSCI. (The record indicates that a person can contract TB only from another person who has an active case of the disease.) The workers' compensation insurance carrier for the Department investigated and determined that several staff members[1] and inmates at OSCI also had tested positive for TB in 1995. The carrier nonetheless concluded that there were no active TB cases at OSCI during 1995 and, therefore, denied the claim.

At a hearing before the ALJ, petitioner requested an order to compel the production of medical records of a certain prisoner whom petitioner believed to have had active TB while under petitioner's direct supervision at OSCI, together with the medical records of other inmates who had tested positive for TB in 1995. The Department responded that the medical records of inmates are confidential under Oregon statutory law and that, in any event, the Department had **<327 Or 451/452>** determined that the records that petitioner sought were irrelevant, because it had determined, based on those and other records, that there were no active cases of TB at OSCI.

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[1] Records of staff members are not at issue in the case before us.

Ultimately, the ALJ appears to have accepted the Department's oral assurances through counsel that the medical records would not help petitioner. The ALJ ruled:

> "At this point in time I'm not sure that -- *unless you can show me that -- that [counsel for the Department's] determination that there is no indication the cases are active and therefore nonactive cases can't transmit that that his decision that these were irrelevant is inappropriate.* If you can show me that, then perhaps we can do some kind of an in-camera or -- or something of that nature to determine. But at this point in time, I'm not willing to say they need to turn everything over to you. That may be developed by further testimony from the medical staff or from [a medical witness on behalf of petitioner]."

(Emphasis added.)

As the foregoing makes clear, the ALJ's ruling was confined to the issue of relevancy; she did not attempt to determine whether, or how, she might deal with issues surrounding the confidentiality of any records that she otherwise might determine to be discoverable. Without the records or other evidence corroborating his theory that he had contracted TB at OSCI, the ALJ held that petitioner's claim failed for lack of proof. As noted, a divided Workers' Compensation Board affirmed, and the Court of Appeals affirmed that ruling.

On review before this court, the Department does not attempt to defend the ALJ's decision on relevancy grounds. Instead, it focuses entirely on an alternative argument that it had made to the ALJ, *viz.*, the confidentiality of the records that petitioner sought.

That is the appropriate inquiry. The record establishes that the records that petitioner sought were relevant: Other persons at the prison had tested positive for TB for the first time during the same period in which petitioner tested positive for the first time; at least one inmate had been transferred to another institution after testing positive for TB -- **<327 Or 452/453>** the standard way in which active cases of the disease were handled by the Department; and the Department and its insurance carrier had used the very records that petitioner sought to make their own determination whether there were active cases of TB at the prison, thereby demonstrating that they regarded those records as relevant to that inquiry. It follows that, absent some legal barrier to their disclosure, the ALJ erred in failing to order that the records be turned over in some form to petitioner as discoverable material.[2]

We believe that the following summary accurately describe's the Department's position in this case: (1) By statute, the records that petitioner sought were confidential; (2) because the records were confidential, the Department would have declined to produce them, even had the ALJ ordered their production; and (3) because the ALJ could not have allowed petitioner to have access to the records, she could not have committed reversible error in declining to order production of those records in the first place.

It is true, as the Department argues, that it is required to keep the medical records of inmates confidential. ORS 179.495 provides:

> "(1) Medical case histories, clinical records, X-rays, treatment charts, progress reports and other similar written accounts of the inmates of any Department of Corrections institution * * *, maintained in such institution by the officers or employees thereof who are authorized to maintain such histories, records, X-rays, charts, reports and other accounts within the official scope of their duties, shall not be subject to inspection except upon * * * *order of a court of competent jurisdiction.* The restriction contained in this section shall not apply to inspection or release of written accounts made * * * with the consent of the individual concerned, or in case of the incompetence of the inmate, by the legal guardian of the inmate."

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[2] The materials at issue are crucial to petitioner's case, and the Department does not argue that, if the Department's confidentiality argument is incorrect, then the ALJ nonetheless retained discretion to deny discovery. We thus are not faced with a case in which it is argued that relevant material should not be disclosed, because the party seeking the material has not shown a need for it sufficient to overcome policy reasons that favor nondisclosure.

327 Or 454> (Emphasis added.) "Inspection," the Department argues, is a term of common usage and should be given its "plain, natural, and ordinary meaning." *See PGE v. Bureau of Labor and Industries*, 317 Or 606, 611, 859 P2d 1143 (1993) (prescribing that standard for construing words of common meaning in statutes). The word "inspect" means to look at or examine closely. *Webster's Third New Int'l Dictionary*, 1170 (unabridged ed 1993). Thus, the Department reasons, it may not be required to disclose inmates' medical records -- period.

That premise is mistaken. As the emphasized wording shows, the statutory prohibition is not absolute. The statute declares that inspection of such records may be directed "upon order of a court of competent jurisdiction." The question thus arises: Is there a way in which a court of competent jurisdiction might issue such an order? There is.

An ALJ has statutory authority to administer oaths, ORS 656.724(4); 656.726(2)(b), and to "[i]ssue * * * subpoenas for the attendance of witnesses and the production of papers, contracts, books, accounts, documents and testimony." ORS 656.724(4); 656.726(2)(c). If any such subpoena is disobeyed -- as the Department posits that it would have disobeyed a subpoena for the medical records at issue in this case -- then the ALJ may apply to a circuit court for enforcement of the subpoena. ORS 656.732.[3] An order of a circuit court, issued pursuant to the procedure contemplated by ORS 656.732, would satisfy the requirement in ORS 179.495 of "an order of a court of competent jurisdiction."

The foregoing discussion deals with all three parts of the Department's argument: (1) The records are not absolutely undiscoverable; (2) there is a method by which an ALJ's order to produce the records for inspection could be enforced by a court of competent jurisdiction; and, therefore, **<327 Or 454/455>** (3) the ALJ would have been in error, had she declined to order their disclosure in these circumstances.

Because the Department's confidentiality argument fails, we are left with the ALJ's relevancy ruling. As we have indicated, that ruling was erroneous. Petitioner was prejudiced, because he was unable to produce corroborating evidence (in addition to his own testimony and the surrounding circumstances) to show that he had contracted TB on the job, and his failure to do so was the basis on which his claim was denied on the merits. Petitioner is entitled to some form of disclosure of the medical records at issue and, if those records contain any evidence supporting his claim, to a new hearing at which that evidence can be introduced.

We have held that the records in question are relevant and discoverable and that there is a legally efficacious way in which the ALJ could order, and the Department could be required to provide, those records. The foregoing conclusion requires that the case be remanded to the Board with instructions to remand the case to the ALJ to grant discovery of the requested medical records under such circumstances as the ALJ shall find to be appropriate.

The decision of the Court of Appeals is reversed. The order of the Workers' Compensation Board is reversed. The case is remanded to the Workers' Compensation Board for further proceedings.

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[3] ORS 656.732 provides:

"The circuit court for any county, or the judge of such court, on application of * * * [an] Administrative Law Judge * * *, shall compel obedience to subpoenas issued and served pursuant to ORS 656.726 and shall punish disobedience of any such subpoena or any refusal to testify at any authorized session or hearing or to answer any lawful inquiry of the * * * Administrative Law Judge[] * * *, in the same manner as a refusal to testify in the circuit court or the disobedience of the requirements of a subpoena issued from the court is punished."

Cite as 154 Or App 503 (1998) June 24, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Order Denying Further Reconsideration.

THOMAS A. FRANZEN, Petitioner,
v.
LIBERTY MUTUAL FIRE INSURANCE COMPANY and SUPERVALU, INC., Respondents, and
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, Intervenor-Respondent.
(H95-236; CA A94105)

Judicial Review from Department of Consumer and Business Services.
Argued and submitted May 12, 1997.
Linda C. Love argued the cause and filed the briefs for petitioner.
Alexander D. Libmann argued the cause and filed the briefs for respondents.
Mary H. Williams argued the cause for intervenor-respondent. With her on the brief were Hardy Myers, Attorney General, and Virginia L. Linder, Solicitor General.
Hardy Myers, Attorney General, Michael D. Reynolds, Solicitor General, and Denise J. Fjordbeck, Assistant Attorney General, filed the supplemental brief for intervenor-respondent.
Before Deits, Chief Judge, and De Muniz and Haselton, Judges.
DEITS, C. J.
Reversed and remanded.

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154 Or App 505> Claimant seeks review of the order of the Director of the Department of Consumer and Business Services (Director) denying his request for reconsideration of a determination order issued by the Department. We reverse and remand.

Claimant was awarded permanent partial disability by a determination order issued on May 22, 1995. That order found him to be medically stationary on April 18, 1995. Pursuant to ORS 656.268(5) (1993) and ORS 656.268(6)(b) (1993),[1] the insurer, Liberty Mutual Fire Insurance Company (Liberty), requested reconsideration of the order within 180 days of its issuance. On June 27, 1995, the Department issued an order on reconsideration reducing claimant's permanent disability award. On October 25, 1995, claimant requested reconsideration of the May 22 determination order. That request also was made within 180 days of issuance of the determination order. The Department denied that request on the ground that it did not have jurisdiction to consider the request because, under OAR 436-30-115(3), which the Department had adopted as a temporary rule,[2] only one reconsideration proceeding could be held on each determination order. The Director affirmed the order denying reconsideration, and claimant seeks review of that order.

Claimant argues, relying on our decision in *Guardado v. J. R. Simplot Co.*, 137 Or App 95, 902 P2d 1225 (1995), *rev dismissed* 324 Or 177 (1996), that the Department **<154 Or App 505/506>** has jurisdiction to consider more than one request for reconsideration so long as each request made is within the time period that the statute allows. He asserts that the Department's rule limiting requests for reconsideration is invalid because it is inconsistent with ORS 656.268(5) (1993).

ORS 656.268(5) (1993) provided in part:

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[1] This statute was amended by Oregon Laws 1995, chapter 332, section 30 to provide that requests for reconsideration must be made within 60 days of the date of the determination order. However, that amendment does not apply here because, under section 66 of chapter 332, amendments that affect procedural time periods do not apply to actions taken before the effective date of the Act. *Motel 6 v. McMasters*, 135 Or App 583, 587, 899 P2d 1212 (1995). This statute was again amended in 1997. Or Laws 1997, ch 111, section 1. We discuss the relevance of that amendment to this case later in this opinion. 154 Or App at 508-09.

[2] This temporary rule was effective August 23, 1995, and thus applies to claimant's request for reconsideration which, as we noted above, was filed on October 25, 1995. That rule has now been superseded by a permanent rule, OAR 436-030-0115(4), which applies to requests for reconsideration filed after the effective date of the permanent rule, February 17, 1996.

> "If the worker, the insurer or self-insured employer objects to a determination order issued by the department, the objecting party must first request reconsideration of the order. At the reconsideration proceeding, the worker or the insurer or self-insured employer may correct information in the record that is erroneous and may submit any medical evidence that should have been but was not submitted by the physician serving as the attending physician at the time of claims closure."

ORS 656.268(5) (1993) did not specify a time period for filing a request for reconsideration. However, ORS 656.268(6)(b) (1993) provided that a request for reconsideration must be filed within 180 days from the mailing of the determination order.

In *Guardado*, we considered the same question presented here. We concluded in that case that the statutes did not limit the number of requests for reconsideration. We explained:

> "In this case, claimant submitted her requests for reconsideration within 180 days of the mailing of the determination order. If claimant had been the only party to request reconsideration in this case, her request on March 18, 1993, and her supplemental request on April 5, 1993, clearly would have been timely. The issue is the effect, if any, on claimant's reconsideration rights of employer's request for reconsideration on October 22, 1992. Resolution of the issue is a matter of statutory construction. We begin with the text and context of the statute. *P.G.E. v. Bureau of Labor and Industries*, 317 Or 606, 610, 859 P2d 1143 (1993).
>
> "The text of ORS 656.268(5) [(1993)] is clear: A party that objects to a determination order must request reconsideration of the order. If a party fails to raise an issue on reconsideration, it is foreclosed from objecting to the determination order for the first time at hearing. ORS **<154 Or App 506/507>** 656.268(5); *Duncan* [*v. Liberty Northwest Ins. Corp*, 133 Or App 605, 611, 894 P2d 477 (1995)]. *The statute does not state that there can be only one request for reconsideration.* Neither does it state that if one party requests reconsideration, any other party must raise its objections to the determination order at that time or be precluded from doing so subsequently, even if its request is made within the 180-day period. ORS 656.268(5) [(1993)] also provides that at the reconsideration proceeding 'the worker or the insurer or self-insured employer *may* correct information in the record.' (Emphasis supplied.) That language is permissive: it allows a party not seeking reconsideration to raise issues before the Appellate Review Unit, but does not require that party to do so or state that failure to do so will preclude that party from making an otherwise timely request for reconsideration. In order to affirm the department's interpretation of the statute and its rule, we would be required to read into the statute words that are not there. We are prohibited from doing so. ORS 174.010." *Guardado*, 137 Or App at 99-100. (Emphasis supplied.)

Liberty and intervenor Department argue that *Guardado* is not applicable here. They contend that *Guardado* is not controlling because, at the time that *Guardado* was decided, the Director had not adopted OAR 436-30-115(3), the temporary rule on which the decision here was based. That rule provided:

> "Only one reconsideration proceeding may be completed on each Determination Order or Notice of Closure and the Department will do a complete review of that closure; however, pursuant to OAR 436-30-008(1), at the Director's discretion, an Order on Reconsideration can be abated, withdrawn and/or amended."

It is the position of Liberty and the Department that this rule is not inconsistent with the statute. They argue that the rule is clearly within the broad grant of authority given to the Director under ORS 656.726(3) to adopt all rules necessary to the efficient administration of the workers' compensation system.

We agree that the Director has broad authority to adopt rules necessary to the efficient administration of the workers' compensation program. Nonetheless, that authority **<154 Or App 507/508>** does not include the power to adopt rules that are inconsistent with statutes. *Lane County v. LCDC*, 325 Or 569, 582, 942 P2d 278 (1997). It is correct that the Director had not adopted the rule at the time of our decision in *Guardado* and, thus, we did not specifically address whether the Director had the authority to adopt a rule limiting the number of permissible requests for reconsideration. Nonetheless,

the reasoning of our decision in Guardado is directly applicable here. We held in that case that the language of the statute "is permissive: It allows a party not seeking reconsideration to raise issues before the [Department], but does not require that the party do so or state that failure to do so will preclude the party from making an otherwise timely request for reconsideration." *Guardado*, 137 Or App at 99-100. We further stated that in order to affirm the Department's interpretation of the statute we would have to read words into the statute that are not there, which we are not authorized to do. *Guardado*, 137 Or App at 100. The Department's adoption of a policy limiting the number of requests for reconsideration in the form of a rule does not change the fact that the policy is inconsistent with the statute and, thus, in excess of the Director's authority. *See* ORS 183.400(4)(a);[3] *see also Lane County*, 325 Or at 582 (an agency may not adopt rules inconsistent with an applicable statute.)

The Department argues alternatively that our holding in *Guardado* is wrong and that we should reconsider it. It asserts, relying on the context of ORS 656.268 (1993), that its reading of the statute is consistent with the legislature's intent to create a more efficient and simple review process. The Department asserts that to allow multiple requests for reconsideration "creates a complicated and uncertain review process." However, as we concluded in *Guardado*, in response to the same point made in the dissenting opinion in that case, a desire for administrative simplicity is no justification for reading into the statute a requirement that the statute does not include. *Guardado*, 137 Or App at 100.

In 1997, ORS 656.268(6)(a)[4] was amended to provide that only one reconsideration proceeding may be held on each **<154 Or App 508/509>** determination order or notice of closure. Or Laws 1997, ch 111, section 1. The Department argues that this change in the statute applies retroactively. The Department recognizes that there is no express provision for retroactive application of this statute but argues that the "general structure of the statute" and the legislative history indicate that the legislature intended the amendment to apply retroactively. Specifically, the department argues that the clause, "[n]otwithstanding any other provision of law," indicates that the legislature intended the amendment to apply as broadly as possible, which, it argues, "is consistent with applying the amendment to all matters that had not become final at the time the statute was enacted."

However, we have never held that a "notwithstanding" clause can substitute for an express retroactivity clause and we find no reason to do so here. The legislature knows how to make amendments apply retroactively, *see e.g.*, Or Laws 1997, ch 605 section 2 (making that Act "fully retroactive"), but it did not choose to do so here. We may not insert into a statute words that were not put there by the legislature. ORS 174.010. We conclude that the text and the context of the statute indicate the legislature's intent that the statute apply only prospectively. *See Barnes v. City of Portland*, 120 Or App 24, 852 P2d 265, *rev den* 317 Or 583 (1993) ("Unless the legislature expressly provides that a statute applies retroactively, the general rule is that the rights and liabilities of a person who is affected by an event are defined and measured by the statutes in effect at the time of the event."). Accordingly, the 1993 version of ORS 656.268 applies here.

In this case, it is undisputed that claimant filed a request for reconsideration within the 180 days allowed by the statute in effect in 1993. We hold that the Director erred **<154 Or App 509/510>** in concluding that he did not have jurisdiction to consider claimant's request.

Reversed and remanded.

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[3] ORS 183.400(4)(a) provides: "The court shall declare the rule invalid only if it finds that the rule [e]xceeds the statutory authority of the agency."

[4] ORS 656.268(6)(a) (1997) provides:

"Notwithstanding any other provision of law, only one reconsideration proceeding may be held on each determination order or notice of closure. However, following a request for reconsideration pursuant to subsection (5)(b) of this section by one party, the other party or parties may file a separate request. At the reconsideration proceeding, the worker or the insurer or self-insured employer may correct information in the record that is erroneous and may submit any medical evidence that should have been but was not submitted by the physician serving as the attending physician at the time of claim closure."

Cite as 154 Or App 511 (1998) June 24, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Christine M. Falconer, Claimant.

SAIF CORPORATION and TWIN OAKS CARE CENTER, Petitioners,

v.

CHRISTINE M. FALCONER, Respondent.

(95-06207; CA A94278)

In Banc*
Judicial Review from Workers' Compensation Board.
Argued and submitted June 26, 1997; resubmitted in banc April 8, 1998.
David L. Runner, Appellate Counsel, argued the cause and filed the brief for petitioners.
Greg Noble argued the cause and filed the brief for respondent.
DEITS, C. J.
Affirmed.
De Muniz, J., dissenting.
* Linder, J., not participating.

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154 Or App 513> Employer petitions for review of an order of the Workers' Compensation Board (Board) in which the Board held that claimant had proved that a neck condition, "torticollis," was compensable under ORS 656.802, the "mental disorder" provisions of the occupational disease law. We affirm.

Claimant worked as a certified nursing assistant at employer's residential care facility in eight-hour shifts. Her schedule was three days on and three days off. She normally cared for eight to 10 residents per shift. On March 19, 1995, one of the nurses scheduled to work was absent, but a new employee was there. Claimant was assigned to train the new employee, and the two were assigned a double section consisting of 14 residents. Because the new employee had to be shown the proper procedures, she had to remain with claimant and could not care for any of the residents on her own. Thus, claimant had to complete all necessary duties for 14 residents in the same time that it would normally take to care for eight to 10 residents, while completing the new employee's checklist of things to learn. By the end of the day, claimant felt exhausted, tense, irritable and achy. The following day she complained to her supervisor, saying she felt that she and the new employee had been treated unfairly and expressing concern that the new employee might be "scared off."

Claimant had the next three days off and took the time to rest. On the morning of the third day when claimant woke up and rolled over in bed, she felt a sharp stabbing pain in her neck and shoulder. She sought treatment in the emergency room, where she was diagnosed with acute right neck strain and spasm. Claimant was unable to return to work the following day and did not work her scheduled three days or the next three days, which were her scheduled days off. She returned to work and resumed her normal duties after having been off a total of nine days. During this time period, she began treatment with a chiropractor, which lasted about two months, and she filed a workers' compensation claim.

154 Or App 514> On August 4, 1995, Dr. Arbeene, an orthopedic specialist, conducted an independent medical examination of claimant at employer's request. Claimant reported to him that she had had another incident of neck pain in July when more new employees joined the staff and she had an increased workload. She was treated by her family physician and missed approximately three weeks of work. Arbeene diagnosed "torticollis," a cramping and spasmodic contracture of the neck muscles, which he associated with mental stress and tension from claimant's work environment. In a post-hearing deposition, Arbeene acknowledged that his diagnosis was not a diagnosis of a mental condition or mental disorder, stating that he was not a psychiatrist and had not done any kind of psychiatric examination. He also stated that claimant had other stress factors in her life besides work, but that he had not undertaken any weighing of the relative importance of those stress factors versus the work stress factors in the cause of her condition.

Employer denied claimant's claim for compensability of the torticollis condition. Claimant requested a hearing on the denial. After hearing, the Administrative Law Judge (ALJ) set aside employer's denial. With one member dissenting, the Board affirmed the ALJ's order.

The critical statute is ORS 656.802, which provides in relevant part:

"(1)(a) As used in this chapter, '*occupational disease*' means any disease or infection arising out of and in the course of employment * * *, including:

"* * * * *

"(B) Any mental disorder, whether sudden or gradual in onset, which requires medical services or results in physical or mental disability or death.

"* * * * *

"(b) As used in this chapter, '*mental disorder*' includes any physical disorder caused or worsened by mental stress.

"* * * * *

154 Or App 515> "(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." (Emphasis supplied.)

The issue here is what a claimant with a physical disorder must prove to satisfy the requirements in ORS 656.802(3)(c) that there must be "a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community." The Board concluded that the plain language of the statute provides the answer to the statute's meaning. It explained:

"It is a fundamental rule of statutory construction that when a word or phrase is used repeatedly in the same statute it is presumed to have the same meaning throughout absent clear indication of a contrary intent. *Pense v. McCall*, 243 Or 383, 389[, 413 P2d 722] (1966); *Cherry Growers v. Emp. Div.*, 25 Or App 645, 649, [550 P2d 1250,] *rev den* (1976). *See also PGE v. Bureau of Labor and Industries*, 317 Or 606, 611[, 859 P2d 1143] (1993) (use of the same term throughout a statute indicates that the term has the same meaning throughout the statute). With regard to *amended* ORS 656.802, we find no clear indication in the plain language of the statute that the words 'mental disorder' should carry a different meaning in paragraph (3)(c) than they do in paragraph (1)(b). On the contrary, *amended* ORS 656.802(1)(b) provides '*[a]s used in this chapter,* " **<154 Or App 515/516>** 'mental disorder'" includes * * *' (emphasis added), indicating that the statutory definition of 'mental disorder' that follows means the same throughout all of Chapter 656.

"Relying on the plain language of the statute, we construe paragraph (3)(c) of ORS 656.802 in light of, rather than independent of, the definition of 'mental disorder' in paragraph (1)(b). Thus, where the claim is for a mental stress-caused physical disorder, the 'diagnosis' requirement of paragraph (3)(c) may be satisfied by a diagnosis of a stress-caused physical condition that is generally recognized in the medical or psychological community."

The Board held that claimant had proved that her torticollis was a physical disorder caused by mental stress that is generally recognized in the medical or psychological community and that, therefore, claimant had established a diagnosis that satisfied ORS 656.803(3)(c).

Employer assigns error to the Board's conclusion, arguing that, "[i]n essence" the Board concluded that ORS 656.802(3)(c) is automatically satisfied in cases of physical conditions allegedly caused by mental stress and that no psychiatric or psychological diagnosis is required in such cases. Employer contends that that construction of ORS 656.802(3)(c) overlooks the opening clause of ORS 656.802(3), which states: "*Notwithstanding any other provision of this chapter,* a mental disorder is not compensable under this chapter unless the worker establishes all of the following[,]" including a diagnosis of a mental or emotional disorder generally recognized in the medical community. (Emphasis supplied.) Thus, employer argues, proof of a "mental disorder" does not automatically establish that the worker has satisfied the diagnosis requirement of ORS 656.802(3)(c). Instead, employer contends, the statute requires not just a diagnosis that identifies a condition as a "mental disorder" under the statute, but a "particular *quality* of diagnosis" (emphasis employer's)--that establishes that the condition is one generally recognized in the medical or psychological community as a mental or emotional disorder.

We conclude that the text of ORS 656.802 supports the Board's reading of the statute. It clearly states that, "[a]s used *in this chapter,*" the term "'mental disorder' includes **<154 Or App 516/517>** any physical disorder caused or worsened by mental stress." ORS 656.802(1)(b) (emphasis supplied). It follows that when the term "mental disorder" is used in ORS 656.802(3)(c), the definition of mental disorder that is to be used in chapter 656 must be applied. Thus, essentially, ORS 656.802(3)(c) reads:

> "There is a diagnosis of a mental or emotional disorder [including any physical disorder caused or worsened by mental stress] which is generally recognized in the medical or psychological community."

As noted above, employer's and the dissent's position is that subsection (3)(c) requires "not just a diagnosis that identifies a condition as a 'mental disorder' under the statute, but a 'particular quality of diagnosis;'" namely one "generally recognized in the medical or psychological community as a mental or emotional disorder." 154 Or App 521. However, as explained above, that is simply not what the statute says. The purpose of the notwithstanding clause is to make it clear that more than a diagnosis of a mental disorder is needed to establish the compensability of a claim. The requirements of subsections (a) through (d) of section 3 must be satisfied. The notwithstanding clause does not preclude using the definition of "mental disorder" in ORS 656.802(1)(b) in ORS 656.802(3)(c). Under that reading, subsection (3)(c) may be satisfied by a showing that a claimant has been diagnosed with a stress-caused physical disorder that is generally recognized in the medical community. Claimant here established that she was diagnosed with torticollis, which is a physical condition brought on by mental stress and is a diagnosis generally recognized in the medical community. Consequently, the Board was correct in holding that claimant satisfied all of the requirements of ORS 656.802(3).

Although, as discussed above, the text and context of the statute resolves this question, the legislative history and purpose of the statute also support the same conclusion. As the Board notes, the language of subsection (1)(b) that includes a "physical disorder caused or worsened by mental stress" as a "mental disorder" was added by the 1993 legislature to overrule the Supreme Court's decisions in *DiBrito v. SAIF*, 319 Or 244, 875 P2d 459 (1994), and *Mathel v. Josephine County*, 319 Or 235, 875 P2d 455 (1994). Those cases **<154 Or App 517/518>** held that stress-caused physical disorders should be analyzed as accidental injuries under ORS 656.005(7). The legislature added the language to ORS 656.802 to ensure that stress- caused physical disorders were analyzed under the more stringent requirements for an occupational disease claim. Under the dissent's reading of ORS 656.802(3), it would be impossible to establish a compensable claim for a *physical* disorder based on mental stress without there also being a diagnosis of a generally recognized psychological condition. Essentially, this reading of the statute would make subsection (1)(b) meaningless.

The remaining questions that must be addressed in this case are whether the requirements of subsections (b) and (d) of ORS 656.802(3) are met. Employer contends that they are not. It asserts that the Board erred in concluding that claimant's increase in workload was not a condition "generally inherent in every working situation" and that the Board erred by failing to apply the requirement that claimant prove by clear and convincing evidence that her mental disorder arose out of and in the course of her employment.

We agree with the Board's conclusions on these issues as well. As the Supreme Court held in *Fuls v. SAIF*, 321 Or 151, 894 P2d 1163 (1995), the proper inquiry regarding whether a claimant's mental disorder is the result of "conditions generally inherent in every working situation" is whether the Board's decision is "within the legislative policy that inheres in the statutory term." The Board's assessment of claimant's situation here is consistent with the legislative policy underlying the statute. We also agree with the Board's conclusion that claimant proved that her condition "arose out of and in the course of employment." Accordingly, the Board did not err in concluding that claimant's claim was compensable.

Affirmed.

DE MUNIZ, J., dissenting.

The majority holds that a "stiff neck"[1] is compensable as a mental disorder under the occupational disease law. **<154 Or App 518/519>** Although Workers Compensation Law is often "a world unto itself," I cannot agree that the legislature intended the majority's holding, and, therefore, I respectfully dissent.

Although the majority adequately states the facts, I begin with a brief quote from the majority's factual summary simply to provide an immediate factual context for my analysis of the pertinent statutes.

> "On August 4, 1995, Dr. Arbeene, an orthopedic specialist, conducted an independent medical examination of claimant at employer's request. Claimant reported to him that she had had another incident of neck pain in July when more new employees joined the staff and she had an increased workload. She was treated by her family physician and missed approximately three weeks of work. Arbeene diagnosed 'torticollis,' a cramping and spasmodic contracture of the neck muscles, which he associated with mental stress and tension from claimant's work environment. In a post-hearing deposition, Arbeene acknowledged that his diagnosis was not a diagnosis of a mental condition or mental disorder, stating that he was not a psychiatrist and had not done any kind of psychiatric examination. He also stated that claimant had other stress factors in her life besides work, but that he had not undertaken any weighing of the relative importance of those stress factors versus the work stress factors in the cause of her condition."

The relevant portions of the occupational disease law, ORS 656.802, at issue provide:

> "(1)(a) As used in this chapter, '*occupational disease*' means any disease or infection arising out of and in the course of employment * * *, including:
>
> "* * * * *
>
> "(B) Any mental disorder, whether sudden or gradual in onset, which requires medical services or results in physical or mental disability or death.
>
> "* * * * *
>
> "(b) As used in this chapter, '*mental disorder*' includes any physical disorder caused or worsened by mental stress.
>
> "* * * * *
>
> "(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.

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[1] Torticollis is defined as a "stiff neck." *Stedman's Medical Dictionary*, 1460 (23rd ed 1976).

"(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." (Emphasis supplied.)

As the majority correctly asserts, the issue is what a claimant with a physical disorder allegedly caused by mental stress must prove to satisfy the requirement in ORS 656.802(3)(c) of "a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community." That issue presents a question of statutory interpretation in which we are required to seek the intent of the legislature by first considering the statute's text in context. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-11, 859 P2d 1143 (1993).

Claimant contends that "the plain language" of ORS 656.802(1)(b) provides that a "mental disorder" includes any physical disorder caused by mental stress. Therefore, she contends, a claim based on a generally recognized physical disorder caused by mental stress, "by statutory definition," satisfies the requirement for a diagnosis of a mental disorder under ORS 656.802(3)(c).

Employer argues that, "[i]n essence" the Board concluded that ORS 656.802(3)(c) is automatically satisfied in cases of physical conditions allegedly caused by mental stress and that no psychiatric or psychological diagnosis is required in such cases. Employer contends that the construction of **<154 Or App 520/521>** ORS 656.802(3)(c) by the Board and claimant overlooks the opening clause of ORS 656.802(3), which states: "*Notwithstanding any other provision of this chapter*, a mental disorder is not compensable under this chapter unless the worker establishes all of the following," including a diagnosis of a mental or emotional disorder generally recognized in the medical community. (Emphasis supplied.) Thus, employer argues, proof of a "mental disorder" does not automatically establish that the worker has satisfied the diagnosis requirement of ORS 656.802(3)(c). Instead, employer contends, the statute requires not just a diagnosis that identifies a condition as a "mental disorder" under the statute but a "particular *quality* of diagnosis" (emphasis employer's)--one that establishes that the condition is a condition generally recognized in the medical or psychological community as a mental or emotional disorder.

I agree with employer. The function of a "notwithstanding" clause is to make the statute an exception to the provision of law to which the clause refers. *Severy v. Board of Parole*, 318 Or 172, 178, 864 P2d 368 (1993); *O'Mara v. Douglas County*, 318 Or 72, 76, 862 P2d 499 (1993). The exception provided in ORS 656.802(3) is complete: "Notwithstanding *any* other provision of this chapter[.]" (Emphasis supplied.) Thus, irrespective of the provisions of ORS 656.802(1), ORS 656.802(3)(c) provides that a mental disorder is not compensable without a diagnosis of a generally recognized mental disorder.

Here, the only diagnosis of a mental condition was given by Arbeene, an orthopedic specialist. He acknowledged that he was not a psychiatrist and did not conduct a psychiatric examination and that his opinion was based on his "feeling about what happened to this individual." His evidence established only that claimant had a stress-induced stiff neck. It did not, as a matter of law, establish a "diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community." The majority is wrong and frustrates the legislative intent by its holding.

Warren, Edmonds, and Haselton, JJ, join in this dissent.

Cite as 154 Or App 544 (1998) June 24, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of William B. Hill, Claimant.

WILLIAM B. HILL, Petitioner,
v.
TRI-COUNTY METROPOLITAN TRANSIT DISTRICT OF OREGON (TRI-MET), Respondent.
(WCB 94-09247, 94-09245, 94-09246; CA A92343)

Judicial Review from Worker's Compensation Board.
Argued and submitted October 14, 1996.
Dennis O'Malley argued the cause and filed the brief for petitioner.
Travis Terrall argued the cause for respondent. With him on the brief was Terrall & Associates.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
EDMONDS, J.
Affirmed.
Armstrong, J., dissenting.

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154 Or App 546> Claimant seeks review of an order of the Worker's Compensation Board denying his occupational disease claim relating to his left shoulder. The only medical evidence that supports compensability is the opinion of claimant's treating physician. The Board found that opinion not persuasive and ruled that claimant had not carried his burden of demonstrating compensability. We review for substantial evidence and errors of law, ORS 183.482(7) and (8), and affirm.

Claimant has been a bus driver for employer since 1974. An occupational disease claim for his left shoulder was made in 1994 when plaintiff's treating physician sought authorization for surgery. Employer refused authorization, and the matter went to hearing. The Administrative Law Judge (ALJ) found that claimant had an accepted 1977 worker's compensation injury claim relating to his left shoulder. However, claimant testified that he has a problem with long-term memory as a result of a reaction to medication in 1978 and that he did not remember the disputed claim settlement agreement that settled his 1977 claim. Employer offered Exhibits A and B at the hearing. Exhibit A is a copy of a 1982 disputed claim settlement agreement between SAIF, employer's insurer at the time, and claimant regarding an aggravation claim relating to the 1977 injury. Exhibit B is a copy of a 1992 hospital admissions report regarding claimant's surgery for an umbilical hernia. The report states that claimant "had mild arthritis in his shoulders and thoracic spine."

Claimant objected to the admission of Exhibits A and B, contending that they should have been submitted to him in response to his prehearing discovery request. He argued that the failure of employer to provide discovery of the exhibits prevented him from obtaining medical evidence that might have supported his occupational disease claim. He requested an opportunity to review all the 1977 claim file material and to obtain additional medical evidence in light of that material. The ALJ admitted Exhibits A and B solely for purposes of impeachment and granted claimant's request to examine the 1977 claim file. She also denied claimant's request for leave to submit additional medical evidence, but **<154 Or App 546/547>** permitted him to submit information from the 1977 file. Ultimately, claimant submitted Exhibits C, D and E. Exhibit C is a worker's compensation 801 form dated May 20, 1977, in which claimant reported left shoulder strain. The 801 form indicates that the claim was accepted by employer's then insurer as a disabling injury on May 26, 1977. Exhibit D is a May 24, 1977, medical report in which claimant reported pain in his left shoulder.[1] Exhibit E is a November 22, 1978, settlement document regarding a civil action relating to a 1978 motor vehicle accident in which claimant was injured. Exhibit E makes no reference to any left shoulder injury resulting from the accident.

After the evidentiary record was closed, the ALJ upheld employer's denial of claimant's occupational disease claim. Claimant appealed to the Board, arguing that the ALJ erred in upholding employer's denial and in declining to permit claimant leave to present additional medical evidence.

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[1] Because claimant admitted Exhibits C and D for substantive purposes, the ALJ could properly rely on those documents to reverse or uphold the employer's denial of the claim.

Claimant also requested that the matter be remanded to the ALJ and that the evidentiary record be reopened. The Board agreed with the ALJ that claimant had not established a compensable occupational disease claim on the record before it and affirmed her rulings. In response to claimant's argument that the case should be remanded to the ALJ for reopening of the evidentiary record, the Board, in deference to claimant's argument, deemed the evidence from the 1977 file to be unfavorable to claimant's position and excluded Exhibits A, B, C, D and E from consideration as part of an alternative analysis of the evidence. Even after the evidence from employer's file regarding the 1977 injury claim was excluded, the Board remained unpersuaded that claimant had demonstrated a compensable claim. It said:

> "Dr. Schader [claimant's treating physician] provides no explanation for his opinion. Furthermore, the record establishes that claimant sought treatment over the years for left shoulder pain and was diagnosed with tendinitis and bursitis without any indication as to the cause of these conditions.
>
> **154 Or App 548>** "Dr. Schader did not address these left shoulder conditions; instead, he simply stated, without explanation, that claimant's current left shoulder condition was due to claimant's driving a bus for 19 years."

On review, claimant argues that the Board erred in not remanding the case to the ALJ and in refusing to permit the reopening of the hearing so that claimant would have an opportunity to obtain additional medical evidence based on the information about the 1977 claim. Claimant also focuses on the effect of the ALJ's rulings regarding Exhibits A, C and D, arguing that admitting them into the record was error. He first asserts that employer violated OAR 438-07-015(2) (1994),[2] which provides, in part:

> "Within 15 days of [the request for hearing] the insurer or self-insured employer shall furnish the claimant and other insurers, without cost, originals or legible copies of all medical and vocational reports, records of compensation paid, and all other documents pertaining to the claim(s)."

OAR 438-07-017 (1994) provides:

> "All medical or vocational material pertaining to, and created on or after the date of injury or exposure giving rise to, the claim(s) in issue at the hearing shall be disclosed under 438-07-015. Other documents reasonably believed relevant and material only for purposes of impeachment of a witness need not be disclosed in advance of hearing and may be offered and admitted solely for impeachment. Documents so offered shall not be considered by the referee as substantive evidence. Upon request, all such documents shall be disclosed prior to the close of the hearing, whether or not offered, at which time the other party may offer the documents as substantive evidence."

We do not agree with claimant's argument that the ALJ's rulings violated the above rules. Claimant objected to the admission of Exhibit A. That exhibit was received only for impeachment purposes. Under OAR 438-07-017, the ALJ did not err. Employer was not required to furnish discovery of Exhibit A under OAR 438-07-015(2) so long as it reasonably believed that the exhibit was relevant only for impeachment **<154 Or App 548/549>** of claimant's position that his left shoulder condition in 1993 was the result of his work for employer. Claimant testified that he never had any problems with his left shoulder before March or April 1993. Evidence of a 1982 disputed claim settlement of an aggravation claim relating to the 1977 injury is evidence that impeaches claimant's testimony in that respect. Exhibit A is not a document subject to disclosure under OAR 438-07-015. It is about an injury claim accepted by a former insurer that occurred 17 years before the occupational disease claim that is the subject of this case. Moreover, there is nothing in the record to demonstrate that employer lacked a reasonable belief that the document was relevant only for impeachment purposes. As to the admission of Exhibits C and D, claimant cannot be heard to complain about the consideration of them by the Board and the ALJ when he offered them into evidence and they were considered by the ALJ.

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[2] The hearing before the ALJ was held on October 31, 1994. We apply the administrative rules that were in effect at that time.

Claimant's next argument is that the ALJ's refusal to reopen the evidentiary record, thus preventing claimant from submitting additional medical evidence, was erroneous. In that regard, OAR 438-06-091(3) provides that the referee 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 or for any party to respond to an issue raised for the first time at a hearing[.]"

In light of the rule, claimant argues:

> "In this case, the new evidence was produced in the middle of the hearing having been withheld in violation of the Board's rules. * * * In this case the new evidence raised new evidence and changed the claimant's burden of proof. At the very least [claimant] was entitled to an opportunity to address that new evidence, those new issues and that new burden of proof."

On this record, we are unwilling to hold that the ALJ abused her discretion under OAR 438-06-091(3) when she refused to reopen the hearing. As we have held, there was no discovery violation. The claimant had the burden under the rule of showing due diligence regarding his failure to offer at the **<154 Or App 549/550>** hearing whatever new medical evidence he has in mind. The issue of the compensability of the 1993 claim was not a "new" issue that arose during the hearing, and Exhibits A, C and D were in existence before claimant went to hearing. Moreover, for all that the record suggests, claimant wanted the hearing reopened so that he could go on a "fishing expedition" with no guarantee that the new evidence would be relevant or material in an effort to try to generate additional medical evidence. Also, although claimant testified that he suffered no problems with his left shoulder before March or April 1993, the ALJ found that testimony was not credible. In light of all of these circumstances, there is nothing in the record that convinces us that claimant made the required showing of due diligence under OAR 438-06-091 and that the ALJ abused her discretion in denying the motion to reopen the record.

For the most part, claimant's other arguments assert in a number of different ways that the ALJ and the Board erred because claimant was deprived of the opportunity to introduce additional medical evidence. They are resolved by reference to the applicable rules and do not warrant further discussion. Claimant's remaining arguments that are unrelated to the refusal to reopen the record also do not warrant discussion.

In summary, we hold that the ALJ did not err in admitting Exhibit A for purposes of impeachment and in denying claimant's request to reopen the hearing to provide additional medical evidence. In that light, the Board's review of the record including Exhibits A, C and D and alternatively without them, was not error. Even without the contested exhibits, the Board was unpersuaded that claimant's 1994 occupational disease claim was compensable. The Board's reasons for rejecting Dr. Schader's medical opinion are reasonable, and it was not required to accept his opinion. It follows that claimant failed to carry his burden of persuasion.

Affirmed.

ARMSTRONG, J., dissenting.

Because I conclude that employer violated OAR 438-07-015(2) (1994) by failing timely to provide claimant with **<154 Or App 550/551>** documents in its claims file, including Exhibits A, B, C and D, I dissent.

OAR 438-07-015(2) required employer to furnish claimant, within 15 days of his hearing request, "all medical and vocational reports, records of compensation paid, *and all other documents pertaining to the claim(s).*" (Emphasis supplied.) Claimant submitted a claim for an occupational disease. An occupational disease is defined by ORS 656.802(1) to be

> "[a]ny disease * * * arising out of and in the course of employment caused by * * * activities to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein, and which requires medical services or results in disability or death, including:

"* * * * *

"(C) Any series of traumatic events or occurrences which requires medical services or results in physical or mental disability or death."

Reading the discovery rule with that definition in mind, it is clear that the withheld documents pertain to the present claim and, therefore, that employer was *required* to disclose those documents. The withheld documents track a series of injuries to claimant's left shoulder that may have been caused by his employment. As such, they pertain to his claim that, over the period of his employment, he was subjected to conditions resulting in an injury to his left shoulder.

Because the disputed documents were subject to discovery under OAR 438-07-015(2), the majority's interpretation and application of OAR 438-07-017(4) (1994) is irrelevant. The discovery violation occurred, and the only remaining question is whether the Board properly addressed the violation. I conclude that it did not.

Under OAR 438-07-015(5), failure to comply with the discovery requirement may be considered grounds for a continuance or for exclusion of the objectionable evidence. The ALJ refused to grant a continuance. The Board concluded that it did not have to decide the discovery issue, because, even if it were to exclude the disputed evidence, **<154 Or App 551/552>** claimant could not prove his claim.[1] The Board apparently assumed that the disputed evidence could only hurt claimant's claim, so it was not necessary to determine whether there was a discovery violation and, if there was, whether a continuance to permit claimant to address the newly disclosed evidence would be appropriate. Because the withheld evidence could support claimant's claim, the Board must determine whether employer violated OAR 438-07-015 by withholding the claims file from claimant.

The Board rejected the opinion of claimant's treating physician, in part, because the opinion failed to explain the relationship between the left shoulder conditions that were the subject of claimant's occupational disease claim and previously diagnosed tendinitis and bursitis conditions affecting the same shoulder. Significantly, the tendinitis and bursitis conditions were diagnosed *after* the injury to claimant's shoulder that was the subject of the accepted 1977 claim. Because of employer's failure to disclose its claims file, claimant and his treating physician did not know of the accepted 1977 injury and that claimant had complained of back and shoulder injuries in connection with his work for over a decade. The disclosure of that information could well have enabled claimant's treating physician to link the tendinitis and bursitis conditions to claimant's work and, hence, to the development of the conditions that were the subject of the occupational disease claim.

Because employer violated the disclosure requirements of OAR 438-07-015, the Board was required to consider whether a continuance was the appropriate response. Because the Board failed to do that, I would remand the case to the Board for further consideration.

I dissent.

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[1] Even though the Board stated that it would not consider the disputed evidence, it adopted the ALJ's conclusion that the attending physician's diagnosis of an occupational disease failed to account for claimant's earlier-compensated injury. The only evidence of that earlier injury was contained in the supposedly excluded claims file documents. Because I conclude that the Board must address the discovery issue, it is not necessary to decide whether the Board erred in accepting that conclusion.

Cite as 154 Or App 574 (1998) June 24, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Tina M. Victoria, Claimant.

SAFECO INSURANCE COMPANY, Petitioner,

v.

TINA M. VICTORIA, WILSON-HEIRGOOD ASSOC., and SAIF CORPORATION, Respondents.

(WCB Nos. 95-08855 and 95-08856; CA A96213)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 21, 1997.

Jerald P. Keene argued the cause and filed the brief for petitioner.

Charles R. Mundorff argued the cause and filed the brief for respondent Tina M. Victoria.

David L. Runner argued the cause and filed the brief for respondents Wilson-Heirgood Assoc. and SAIF Corporation.

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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154 Or App 576> Safeco Insurance (Safeco) seeks review of an order of the Workers' Compensation Board (Board) assigning it responsibility for claimant's bilateral arm condition. We review for errors of law, substantial evidence and abuse of discretion. ORS 656.298(7); ORS 183.482(7), (8). We reverse and remand for reconsideration.

In November 1994, claimant began suffering bilateral arm symptoms while working at Safeco doing repetitious computer input work. In February 1995, claimant left Safeco and took a job with a SAIF-insured employer (Wilson-Heirgood). Her duties there included typing, initially minimal in amount but increasing to a quarter of her time within two months and 40 percent by the time of the hearing.

When her symptoms "failed to improve following her job change," claimant sought treatment for the first time. On March 3, 1995, she filed a claim against Safeco. Physicians diagnosed bilateral overuse syndrome. Safeco and SAIF agreed that the claim was work related but disputed responsibility. Following the hearing, the administrative law judge (ALJ) found that claimant's attending physician, Dr. Layne, stated that claimant's symptoms first occurred during her Safeco employment but he "makes no conclusion regarding major causation." However, the ALJ found that Dr. Woolpert, an independent examiner, concluded the "major cause of claimant's condition is her work activity at Safeco." The ALJ added that Woolpert "acknowledged that claimant's arm complaints were caused in some part by her work at Wilson-Heirgood Insurance."

The ALJ found Woolpert's opinion persuasive and held that, because work at Safeco was the major contributing cause, Safeco was responsible for claimant's condition. Despite having found that the experts agreed that there was "contribution from the employment activities at both employers," the ALJ ruled that the last injurious exposure rule was not applicable because claimant proved that her prior employment was the "actual cause" of her condition. The Board affirmed without opinion.

154 Or App 577> On judicial review, Safeco contends that the Board erred in failing to apply the last injurious exposure rule (of responsibility). Specifically, Safeco argues that the Board erred in equating "major causation" with "actual causation." It contends that, unless "actual cause" is interpreted as meaning "sole cause," the purpose of the last injurious exposure rule would be thwarted. Claimant responds that the last injurious exposure rule should be restricted to cases where it is impossible to determine which employment was the major cause of a claimant's compensable injury.[1]

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[1] SAIF agrees with claimant's argument on application of the last injurious exposure rule but also argues that we need not reach the substance of Safeco's challenge because it did not issue a notice of intent to disclaim responsibility within 30 days of receipt of claimant's claim, as required here, because under *Norstadt v. Murphy Plywood*, 148 Or App 484, 490-93, 941 P2d 1030, *on recons* 150 Or App 245, 945 P2d 654 (1997), the 1990 version of ORS 656.308(2) applies. However, because SAIF did not preserve that challenge below, we decline to address it here.

The last injurious exposure rule is both a rule of proof and a rule of assignment of responsibility. *Roseburg Forest Products v. Long*, 325 Or 305, 309, 937 P2d 517 (1997). Here, only the latter aspect of the rule is relevant, as both Safeco and SAIF agree that the claim is work related and the only dispute is responsibility.

Claimant's assertion that the rule should be applied only to cases where it is impossible to determine which employment is the major contributing cause of a claimant's compensable injury is not apposite here, because it employs a principle of the last injurious exposure rule when it is used as a rule of proof. I*n Willamette Industries, Inc. v. Titus*, 151 Or App 76, 82, 950 P2d 318 (1997), we explained that

> "[p]roof that the subsequent employment independently contributed to the current disability is required before the [last injurious exposure] rule of responsibility can be invoked defensively by the targeted employer."

Once the rule is invoked, proof of sole causation by the previous employment, or proof of impossibility by the more recent employment, is required to avoid responsibility. *Id.* at 82 n 4. The Board found claimant's work at Safeco to be the major contributing cause of her condition, but it also found that the experts agreed there was "contribution from **<154 Or App 577/578>** the employment activities at both employers." Thus, SAIF's insured was the last employer that could have caused claimant's arm condition. That is sufficient to invoke the last injurious exposure rule as a rule of responsibility, and the Board erred in not doing so.

Reversed and remanded for reconsideration.

Cite as 155 Or App 21 (1998) July 15, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Anette D. Batey, Claimant.

SAIF CORPORATION and BLUE CROSS/BLUE SHIELD OF OREGON, Petitioners,
v.
ANETTE D. BATEY, Respondent.
(WCB No. 95-12921; CA A95030)

Judicial Review from Workers' Compensation Board.
On petitioners' petition for reconsideration filed May 13, 1998. Opinion filed April 29, 1998. 153 Or App 634, 957 P2d 195.
David L. Runner for petition.
Meagan A. Flynn *contra.*
Before Deits, Chief Judge, and De Muniz and Haselton, Judges.
DEITS, C. J.
Petition for reconsideration allowed; opinion adhered to.

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155 Or App 23> SAIF petitions for reconsideration of our opinion in *SAIF v. Batey*, 153 Or App 634, 957 P2d 195 (1998), in which we affirmed the Workers' Compensation Board's award of claimant's attorney fees under ORS 656.382(1) and ORS 656.386(1). SAIF argues that we failed to address one of its arguments, that we applied an incorrect standard of review on one of its assignments of error and that we incorrectly stated its position in that assignment of error.

SAIF first asserts that we did not address its contention, in support of its claim that the Board erred in awarding attorney fees under ORS 656.386(1), that the aggravation claim was a legal nullity and that, therefore, no attorney fees could attach to its "denial" of the claim. Although we impliedly rejected SAIF's argument on this point in our earlier opinion, SAIF is correct that we did not directly address that argument.

As on appeal, in its petition for reconsideration, SAIF points to ORS 656.277 and *Safeway Stores, Inc. v. Johnson*, 134 Or App 432, 895 P2d 811, *rev den* 322 Or 167 (1995), to support its argument. ORS 656.277 provides, in part:

> "Claims for nondisabling injuries shall be processed in the same manner as claims for disabling injuries, except that:
>
> "(1) If within one year after the injury, the worker claims a nondisabling injury originally was or has become disabling, the insurer or self-insured employer, upon receiving notice or knowledge of such a claim, shall report the claim to the Director of the Department of Consumer and Business Services for determination pursuant to ORS 656.268.
>
> "(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."

SAIF argues that the mandatory nature of the language in the statute means that it is legally impossible to file a valid claim for an aggravation until more than one year **<155 Or App 23/24>** after the date of disability. We agree that a claim for an aggravation filed before one year has passed is not a valid claim under ORS 656.277. However, it does not necessarily follow that the act of filing an aggravation claim within one year is a legal nullity for all purposes. Nothing in ORS 656.386(1) indicates that the claim must eventually be determined to be valid in order for penalties to attach. *Safeway Stores* does not require otherwise. In *Safeway Stores*, we held that where no *claim for compensation* had been filed, the denial issued by the employer was a legal nullity. We emphasized that the award of partial permanent disability, on which the employer based its denial, was not a claim for compensation. *Safeway Stores*, 134 Or App at 436. A claim for compensation includes a "written request for compensation." *Id.* Here, there *was* a written request for compensation. Accordingly, the Board did not err in awarding fees on the denial of the aggravation claim.

Next, SAIF argues that we misstated its assertion that the Board erred in concluding that SAIF had committed two separate acts of misconduct for purposes of awarding a penalty under ORS 656.262(11) as well as awarding attorney fees under ORS 656.382(1). SAIF points out that we stated that it "acknowledges that it made two mistakes." On reconsideration, we agree that that sentence is not a completely accurate statement of SAIF's position. It was SAIF's position that there was *one* act that constituted a mistake, but that all "actions flowing from the original mistake [were] components of that mistake[.]" However, for the reasons explained in the earlier opinion and here, we continue to reject SAIF's argument.

SAIF also argues that we articulated an incorrect standard of review in our discussion of its first assignment of error. It bases that assertion on our comment that "[t]he critical question here is whether substantial evidence supports the Board's conclusion that SAIF's actions amounted to two separate acts of misconduct." 153 Or App at 639. SAIF claims that our reference to "substantial evidence" in the first part of the sentence "reflects that the court viewed itself as reviewing a finding of fact," which it contends is incorrect. However, contrary to SAIF's assertions, the court properly understood the standard of review. As noted above, on appeal, SAIF **<155 Or App 24/25>** argued that it made one initial mistake and that all actions that flowed from that mistake were part and parcel of the "original" mistake, rather than two separate mistakes. In essence, its argument required the Board to decide, as a factual matter, whether there was only one act that could be determined to be an act of misconduct or whether there were two discrete acts, each of which could be determined to be an act of misconduct, as claimant claimed. The Board determined, as a finding of fact, that there were two separate acts. It then concluded, as a matter of law, that those two acts each represented a discrete act of misconduct upon which a penalty could attach. We reviewed the Board's findings of fact, that there were two separate acts, for substantial evidence in the record and we then reviewed the Board's conclusion of law, that the two acts were each acts of misconduct upon which penalties could attach, for error of law. We found no error on either point, and we adhere to our holding.

Petition for reconsideration allowed; opinion adhered to.

Cite as 155 Or App 120 (1998) July 15, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Gene H. Gosda, Claimant.

GENE H. GOSDA, Petitioner,

v.

J. B. HUNT TRANSPORTATION and LIBERTY MUTUAL INSURANCE, Respondents.

(94-03915; CA A96563)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 11, 1998.
David Morrison argued the cause for petitioner. With him on the brief was Aller & Morrison.
Jerald Keene argued the cause and filed the brief for respondents.
Before De Muniz, Presiding Judge, and Haselton and Linder, Judges.
DE MUNIZ, P. J.
Reversed and remanded for reconsideration.

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155 Or App 122> Claimant seeks review of an order of the Workers' Compensation Board (Board). The Board adopted and affirmed an order of the administrative law judge (ALJ) denying the compensability of claimant's claim. We review for errors of law and substantial evidence, ORS 656.298(7); 183.482(7) and (8), and reverse and remand.

Claimant began working as a long-haul truck driver in 1975. Most recently, he worked with employer, beginning in 1992 and ending in 1995. Throughout his years as a long-haul driver, claimant's work caused him to use his hands in ways that ultimately led to his medical condition--*e.g.*, holding a steering wheel that vibrated, switching gears, cinching chains and straps, and loading and unloading items. In 1992, claimant began to experience numbness in his hands, a sensation that gradually increased in intensity. In 1996, claimant went to a doctor for treatment and subsequently filed a claim for an occupational disease with employer. Shortly thereafter, claimant was diagnosed with severe bilateral carpal tunnel syndrome and was advised to obtain surgery.

Employer's insurer had a physician examine claimant. That physician reviewed claimant's history and medical records and reported that claimant's work as a truck driver was the major contributing cause of claimant's condition. Two weeks later, insurer denied the compensability of claimant's occupational disease, writing in a denial letter that "[i]nformation obtained during this investigation fails to establish your condition * * * is related to your work activity with [employer]." Employer did not dispute responsibility.

Claimant requested a hearing on the issue of compensability[1] and named only employer as the responsible party. Claimant did not assert the applicability of the last injurious exposure rule (LIER) at any time during the hearing. The ALJ determined that all of the medical evidence, including the report of insurer's physician, "establishe[d] **<155 Or App 122/123>** that claimant's work as a truck driver caused his carpal tunnel syndrome." However, the ALJ affirmed insurer's compensability denial, ruling that "the evidence d[id] not establish that claimant's work for *this employer* was the major contributing cause of his carpal tunnel syndrome." (Emphasis in original.) The ALJ also ruled that, without a request by claimant to rely on the LIER as a rule of proof, the ALJ could not invoke the rule on its own motion to establish the compensability of claimant's condition. The ALJ relied on *Manwell Garibay*, 48 Van Natta 1476 (1996), which involved similar facts and stated that the ALJ could not invoke the LIER as a rule of proof on its own motion. The Board adopted and affirmed the ALJ's decision.

Apart from the specific circumstances of this case, two additional facts are present here that were not before the Board in its determination of this case. First, after the Board issued its decision in this case, we reversed the Board in *Garibay v. Barrett Business Services*, 148 Or App 496, 941 P2d 1036 (1997). Second, in *Garibay*, we applied the 1990 version of ORS 656.308(2);[2] however, the 1995 version of that statute applies here.

Claimant assigns error to the Board's order affirming the compensability denial of claimant's occupational disease claim. Claimant contends that, because "the instant case is legally indistinguishable from *Garibay*[,]" *stare decisis* mandates a reversal here. Though we disagree with claimant that *Garibay* controls the outcome here, for the reasons that follow, we agree that the Board's order must be reversed and remanded for reconsideration.

Claimant is correct that the facts of this case are analogous to the facts of *Garibay*. There, over a 13-year period, the claimant had worked for three employers with working conditions capable of causing his medical condition. 148 Or App at 498. However, he filed an occupational disease **<155 Or App 123/124>** claim against only his most recent employer. The employer denied compensability, and the claimant requested a hearing on that issue. At the hearing, the medical evidence undisputably established that the claimant's medical "condition was caused by [his] work [as a tree harvester] over the 13 years[.]" *Id.* Without reaching the responsibility issue, the Board ultimately affirmed the ALJ's ruling that the claimant had failed to prove major contributing causation with respect to the named employer. *Id.* at 499-500. Additionally, because the claimant had failed to refer to the LIER as a rule of proof, the Board refused to invoke the rule on its own motion to establish the compensability of the claimant's condition. *Id.* at 500.

On judicial review, we viewed the case differently from the Board, framing it as a case "about responsibility[,]" rather than compensability. *Id.* at 501. We concluded that, "although [the employer] did not, in the technical sense, raise responsibility as a defense, that was the practical effect of its contention to the ALJ that [the] claimant had a preexisting condition for which [the employer] was not responsible." *Id.* at 501. Our analysis followed from that conclusion. We analyzed the effect of the employer's failure to comply with the responsibility disclaimer requirement of ORS 656.308(2) (1990), which provided, in part:

> "Any employer or insurer which intends to disclaim responsibility for a given injury or disease claim on the basis of an injury or exposure with another employer or insurer shall mail a written notice to the worker as to this position. * * * Any employer or

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[1] At the hearing, claimant also raised the issue of a penalty for an unreasonable denial; however, that issue is not before us in this judicial review.

[2] We applied the 1990 version of ORS 656.308(2) in Garibay because the 1995 amendments altered time limitations with respect to actions that had been taken on the claim before the effective date of those amendments. *Garibay v. Barrett Business Services*, 148 Or App 496, n 2, 941 P2d 1036 (1997) (citing *Norstadt v. Murphy Plywood*, 148 Or App 484, 941 P2d 1030, *mod* 150 Or App 245, 942 P2d 654 (1997)).

> insurer against whom a claim is filed may assert, as a defense, that the actual responsibility lies with another employer or insurer, regardless of whether or not the worker has filed a claim against that other employer or insurer, *if that notice was given as provided in this subsection.*" (Emphasis supplied.)

As the emphasized language shows, ORS 656.308(2) (1990) expressly conditioned an employer's ability to assert a responsibility defense on its earlier provision of a responsibility disclaimer to the claimant. We held that the employer's failure to comply with the disclaimer requirement "barred [the employer] from making [a responsibility] argument." *Id.* at 501. In holding so, we did not address the compensability question that the Board considered in *Garibay*.

155 Or App 125> Here, compensability is the issue. Employer's insurer sent claimant a letter denying compensability, claimant requested a hearing on that issue, insurer defended that issue on a failure of proof theory, and the ALJ ultimately agreed, ruling that claimant had "failed to prove causation with respect to this employer." The issue of responsibility was not reached. Thus, to resolve this case, we must now squarely address the issue raised by the Board's *Garibay* opinion: whether the ALJ or the Board must invoke the LIER as a rule of proof to determine the compensability of a claim in the absence of a specific reference to it by the claimant.

We hold that the Board must do so. The Board's decision not to apply the LIER rule as a rule of proof when the medical evidence would otherwise establish compensability under the rule is inconsistent with the objective of Oregon's Workers' Compensation Law (Law). That goal is to provide compensation benefits to Oregon workers who have legitimately been injured as a result of their employment, ORS 656.012 (2), a goal that also influenced the adoption of the LIER rule in Oregon. *See Inkley v. Forest Fiber Products Co.*, 288 Or 337, 343, 605 P2d 1175 (1980) (rule was adopted as a method to avoid the "inequity of denying a disabled worker his benefits under the statute because he mistakenly filed against the wrong employer").

Here, as in *Garibay*, the undisputed evidence showed that the major contributing cause of claimant's occupational disease was his work. Such evidence would have supported a finding of compensability under the LIER of proof.[3] *See Willamette Industries v. Titus*, 151 Or App 76, 80, 950 P2d 318 (1997) ("The rule of proof allows a claimant to prove compensability of an injury without having to prove the degree, if any, to which exposure to disability-causing conditions at a particular employment actually caused the claimant's condition."). Here, as in *Garibay*, the ALJ nevertheless declined to invoke the LIER as a rule of proof because claimant had not "properly pleaded or argued" the rule.

155 Or App 126> Yet, as a *rule of proof*, the LIER is a method of resolving the issue of compensability, one of several issues that may define the limits of a workers' compensation proceeding; it is not an issue itself. Accordingly, it need not be brought into a case by a claimant through a pleading[4] or argument, but rather, is applicable in any case in which the evidence supports its application. *See Bracke v. Baza'r*, 293 Or 239, 246, 646 P2d 1330 (1982) (if the injury is substantively within the reach of the Act, *i.e.* work-related, then the rule "fulfills a requirement of [a] claimant's burden of proof"). Consequently, if the ALJ makes the predicate factual findings necessary to establish compensability under the LIER of proof, then the rule must be applied, irrespective of whether the claimant has uttered its name. Otherwise, a compensable condition will be deemed noncompensable, a result out of line with the objective of the Law as well as the LIER itself.

Here, because the ALJ determined that "the medical evidence in this case establishe[d] that claimant's work as a truck driver caused his carpal tunnel syndrome[,]" a result we find to be supported by substantial evidence, the Board should have applied the LIER of proof to establish the compensability of claimant's occupational disease claim.

Reversed and remanded for reconsideration.

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[3] The LIER has two aspects, a rule of proof and a rule of assignment of responsibility. As a rule of assignment of responsibility, it assigns full responsibility to the last employer that could have caused the claimant's medical condition. *Willamette Industries v. Titus*, 151 Or App 76, 81, 950 P2d 318 (1997) (citing *Roseburg Forest Products v. Long*, 325 Or 305, 309, 937 P2d 517 (1997)).

[4] In a workers' compensation case, a claimant triggers a hearing by the submission of a "Request for Hearing" on which the claimant checks one or more of several boxes that identify the issues to be argued. Our reference to a "pleading" here is a reference to a "Request for Hearing."

Cite as 155 Or App 231 (1998) July 15, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Complying Status of R. M. Hardy & Co., alleged NCE.

EMPLOYERS INSURANCE OF WAUSAU, a Mutual Company, Petitioner,

v.

R. M. HARDY & CO. and DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, Respondents.

In the Matter of the Complying Status of Al Walker, alleged NCE.

EMPLOYERS INSURANCE OF WAUSAU, a Mutual Company, Petitioner,

v.

AL WALKER and DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, Respondents.

(93-12288 and 93-12287; CA A93850 (Control) and CA A94244)

(Cases Consolidated)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 12, 1997.

David O. Horne argued the cause and filed the brief for petitioner.

Alan J. Schmeits argued the cause for respondent R. M. Hardy & Co. With him on the brief was Silven, Schmeits & Vaughn.

Stephanie L. Striffler, Assistant Attorney General, argued the cause for respondent Department of Consumer and Business Services. With her on the brief were Hardy Myers, Attorney General, and Virginia L. Linder, Solicitor General.

No appearance for respondent Al Walker.

Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.

ARMSTRONG, J.

Affirmed.

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155 Or App 234> Wausau Insurance (Wausau) seeks judicial review of an order finding that R. M. Hardy and Company (Hardy) was not a noncomplying employer from April 14, 1993, to August 25, 1993, because it was insured by Wausau.[1] We affirm.

In July 1993, Hardy agreed to perform timber felling for an unknown party. Hardy engaged workers and, on July 21, 1993, it began performance on the contract. In August 1993, one of Hardy's subject employees was injured while working. The employee filed a workers' compensation claim, which the Department of Consumer and Business Services (DCBS) investigated.

On September 22, 1993, DCBS issued a proposed order in which it found that Hardy had employed one or more subject workers in Oregon from April 14, 1993, to August 25, 1993, but that, during that period, it had neither qualified as a self-insured employer nor caused a guaranty contract to be filed with DCBS. Accordingly, DCBS recommended that Hardy be declared a noncomplying employer from April 14, 1993, to August 25, 1993, and that the company be fined $1,000.

Hardy requested a hearing to review that order, see ORS 656.740(1),[2] arguing that it had not

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[1] Wausau also sought review of a determination that Al Walker was not a noncomplying employer. Our disposition of the claim involving Hardy makes it unnecessary to address the claim involving Walker.

[2] ORS 656.740(1) provides:

"A person may contest a proposed order of the Director of the Department of Consumer and Business Services declaring that person to be a noncomplying employer, or a proposed assessment of civil penalty, by filing with the Department of Consumer and Business Services, within 20 days of receipt of notice thereof, a written request for a hearing. Such a request need not be in any particular form, but shall specify the grounds upon which the person contests the proposed order or assessment. An order by the director under this subsection is prima facie correct and the burden is upon the employer to prove that the order is incorrect."

been a noncomplying employer because Wausau had provided it with workers' compensation coverage during that time. Pursuant to ORS 656.740(2), Wausau was joined as a party to the proceeding.[3]

155 Or App 235> Following the hearing, an ALJ found that a guaranty contract between Hardy and Wausau had been filed with DCBS on July 16, 1992. By definition, the ALJ concluded, the existence of that guaranty contract meant that Wausau had provided worker's compensation insurance to Hardy until Wausau properly canceled the contract. *See* ORS 656.419(1), (5). In order to cancel the contract properly, Wausau had to provide written notice of the cancellation to both Hardy and the Director of DCBS. See ORS 656.427(1).[4] The ALJ found that, while Wausau had notified Hardy that it had canceled the contract, there was no evidence that Wausau had notified the Director of DCBS of the cancellation until, at the earliest, October 19, 1993. Therefore, the ALJ concluded, the guaranty contract filed with DCBS had remained in effect through the relevant period and Hardy had not been a noncomplying employer during that time. The ALJ reversed the proposed order of DCBS. In accordance with ORS 656.740(4)(a), the ALJ's order became an order of the Director of DCBS. Wausau seeks review of that order.

An order declaring an employer to be a noncomplying employer is "prima facie correct and the employer has the burden of proving that the order is incorrect." ORS 656.740(1). On review, Wausau argues that the ALJ improperly ignored both the fact that the proposed order was prima facie correct and that Hardy had the burden of proving that the order was incorrect. We disagree.

155 Or App 236> The proposed order found that, from April 14, 1993, to August 25, 1993, Hardy had been a noncomplying employer because it had not caused a guaranty contract to be filed with DCBS during a time in which it had been employing one or more subject workers in Oregon. At the hearing, Hardy presented evidence that a guaranty contract between it and Wausau had been filed with DCBS and that Wausau had not canceled that contract. Wausau responded with evidence that it had canceled the contract. In making their arguments, both parties focused on whether Wausau had properly notified Hardy of the cancellation, not on whether Wausau had properly notified the Director.

The evidence that Hardy presented directly contradicted the proposed order's conclusion that Hardy was a noncomplying employer because it had not caused a guaranty contract to be filed. Consequently, Hardy did rebut the prima facie case that it was a noncomplying employer. As a result, the ALJ could not simply affirm the proposed order. Rather, the ALJ was required to determine, considering all of the evidence in the record, whether Hardy had, in fact, been a noncomplying employer during the relevant time period. Because Hardy had the burden of proof, the ALJ would have been required to affirm the proposed order if the ALJ had concluded that the evidence was in equipoise. If, however, the evidence was not in equipoise, then the burden would play no role in the ALJ's conclusion.

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[3] ORS 656.740(2) provides:

> "Where any insurance carrier, including the State Accident Insurance Fund Corporation, is alleged by an employer to have contracted to provide the employer with workers' compensation coverage for the period in question, the Workers' Compensation Board shall join such insurance carrier as a necessary party to any hearing relating to such employer's alleged noncompliance and shall serve the carrier, at least 30 days prior to such hearing, with notice thereof."

ORS 656.427(1) provides:

> "An insurer that issues a guaranty contract or a surety bond to an employer under this chapter may terminate liability on its contract or bond, as the case may be, by giving the employer and the Director of the Department of Consumber and Business Services written notice of termination. A notice of termination shall state the effective date and hour of termination."

[4] The cancellation would have been "effective at 12 midnight not less than 30 days after the date the notice [was] received by the director." *See* ORS 656.427(2)(a).

The ALJ found that the evidence was not in equipoise. He found that 1) on July 16, 1992, a guaranty contract between Hardy and Wausau was filed with DCBS; 2) under that contract, Wausau was required to provide workers' compensation insurance for Hardy until it canceled the contract; and 3) there was no evidence that Wausau had provided the Director with written notice that it was canceling its contract with Hardy. Wausau does not dispute those findings. Because Wausau could not cancel the contract without providing written notice of the cancellation to the Director, see ORS 656.427(1), the ALJ concluded that the guaranty contract had not been canceled. Accordingly, Hardy had been insured by Wausau during the relevant period, so it had not been a noncomplying employer. Those facts and conclusions led the ALJ to reverse the proposed order. Because the *prima* **<155 Or App 236/237>** *facie* case had been rebutted and the burden of proof was appropriately applied, we conclude that the ALJ did not ignore ORS 656.740(1) in reaching his decision.

Nonetheless, Wausau argues that the ALJ's decision must be reversed because, by basing it on a fact that neither party contested, *i.e.*, whether the Director had been properly notified of the cancellation, the ALJ committed a material error affecting the fundamental fairness of the proceeding. *See* ORS 183.484(7). We disagree. The issue at the hearing was whether Hardy had been a noncomplying employer. Wausau was joined in the proceeding precisely because Hardy took the position that it had not been a noncomplying employer due to the fact that Wausau had provided it with coverage during the relevant time period. Wausau took the position that, although it had once insured Hardy, it had canceled that coverage. In short, the critical issue at the hearing was whether Wausau had canceled the guaranty contract. Both parties were aware of that. ORS 656.419(5) provides that "[c]overage of an employer under a guaranty contract continues until canceled or terminated as provided by ORS 656.423 or ORS 656.427." ORS 656.427 provides that a guaranty contract may be canceled "by giving the employer and the Director of [DCBS] written notice of termination." In the light of those clear statutory provisions, we cannot say that it was fundamentally unfair for the ALJ to consider whether the Director had received notification of the termination when the ALJ was determining whether Wausau had terminated the guaranty contract.

Because of our resolution of Wausau's first assignment of error, we need not address its other assignments of error.

Affirmed.

Cite as 155 Or App 270 (1998) July 22, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Barbara J. Lloyd, Claimant.

KMART CORPORATION, Petitioner,
v.
BARBARA J. LLOYD, Respondent.
(94-00752; CA A97660)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 8, 1998.

Karen O'Kasey argued the cause for petitioner. With her on the brief was Schwabe, Williamson & Wyatt.

Meagan Flynn argued the cause for respondent. With her on the brief was Pozzi Wilson Atchison, LLP.

Before Edmonds, Presiding Judge, and Armstrong, Judge, and Warden, Senior Judge.

EDMONDS, P. J.

Reversed and remanded.

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155 Or App 272> In this review from a Workers' Compensation Board's order on remand, employer urges application of ORS 656.262(10)[1] as amended in July 1997, to reverse the Board's ruling that employer is barred from denying claimant's right knee condition. Claimant raises a constitutional challenge to the amendment under the Equal Privileges and Immunities Clause, Article I, section 20, of the Oregon Constitution. We reject the challenge and reverse and remand based on the retroactive application of ORS 656.262(10).[2]

In April 1986, claimant stepped in a hole in employer's parking lot and injured a toe on her left foot. Claimant filed a claim for the injury, and employer accepted the claim. Claimant began experiencing right knee pain in November 1986 and eventually was diagnosed with, a "permanent impairment of her right knee due to medial compartment degenerative change and chondromalacia." The chondromalacia occurred because of an abnormal walking gait caused by claimant's left foot injury. According to the medical records, the medial compartment degenerative process began before 1986. In June 1987, the cartilage in claimant's right knee was shaved. The claim was closed in November 1987 followed by a determination order for, "5 PERCENT LOSS OF YOUR RIGHT LEG (KNEE)." Neither party appealed the determination order.

155 Or App 273> Claimant sought treatment again in November 1992. At that time, claimant was diagnosed with having a loose fragment in the right knee, advanced arthritis and a possible degenerative medial meniscus tear. In March 1993, a total knee replacement was recommended by her physician due to claimant's degenerative arthritis. By then, claimant's aggravation rights under her 1986 claim had expired, and the Board considered the recommendation on its own motion. Employer contested the compensability of the knee replacement, and claimant requested a hearing.

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[1] ORS 656.262(10), as amended, 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 supplied to indicate the 1997 amendment made by House Bill 2971.)

[2] Oregon Laws 1997, chapter 605, section 2, provides:

"Notwithstanding any other provision of law to the contrary, the amendments to ORS 656.262 by section 1 of this Act apply to all claims or causes of action existing or arising on or after the effective date of this Act regardless of the date of injury or the date a claim is presented, and this Act is intended to be fully retroactive."

After the hearing, the Administrative Law Judge (ALJ) set aside employer's denial. The Board reversed, holding that claimant's medical evidence did not demonstrate that the compensable foot injury was a major contributing cause of the existing knee condition and that under the 1995 amendments to ORS 656.262, employer's denial was not barred simply because it had failed to appeal the determination order. After the Board's decision, we interpreted ORS 656.262(10) (1995) to mean that the failure to appeal a determination order still barred a subsequent denial of a condition for which permanent disability had been paid. *Deluxe Cabinet Works v. Messmer*, 140 Or App 548, 915 P2d 1053, rev denied, 324 Or 305 (1996), (*Messmer II*). Claimant sought review from the Board's decision, arguing that the denial was barred under *Messmer II*.[3]

We remanded the case back to the Board for reconsideration under *Messmer II*. *Lloyd v. K-Mart Corp.*, 146 Or App 383, 933 P2d 379 (1997). On remand, the Board held that employer was barred from denying the claim for the total knee replacement and degenerative arthritis under *Messmer II* because it had not appealed the 5 percent award granted to the claimant in 1987. After employer sought review, the legislature again amended ORS 656.262(10) and made the changes applicable to any claim existing on July 25, 1997.

Claimant concedes that the 1997 amendment to ORS 656.262(10) applies to her claim and that it requires **<155 Or App 273/274>** reversal of the Board's order unless the statute is unconstitutional under Article I, section 20, of the Oregon Constitution. Section 20 provides: "No law shall be passed granting to any citizen or class of citizens privileges, or immunities, which, upon the same terms, shall not equally belong to all citizens." In order to prevail on an Article I, section 20, challenge, claimant must show

> "(1) that another group has been granted a 'privilege' or 'immunity' which [her] group has not been granted, (2) that [the statute at issue] discriminates against a 'true class' on the basis of characteristics which [the class has] apart from that statute * * *, and (3) that the distinction between the classes is either impermissibly based on persons' immutable characteristics, which reflect 'invidious' social or political premises, or has no rational foundation in light of the state's purpose." *Jungen v. State*, 94 Or App 101, 105, 764 P2d 938 (1988), *rev den* 307 Or 658, 772 P2d 1341 (1989) (citations omitted).

The first issue is whether ORS 656.262(10) grants insurers and self-insured employers a privilege or immunity within the meaning of section 20. The statute creates an exception to the doctrine of claim preclusion for employers. The doctrine of claim preclusion applies in workers' compensation cases when there is an opportunity to litigate an issue before a final determination and the party against whom the doctrine could be applied fails to litigate the issue. *Drews v. EBI Companies*, 310 Or 134, 140, 142, 795 P2d 531 (1990). As a court-made doctrine, claim preclusion works to achieve finality in disputes by preventing parties from raising a claim after a final determination has been made and the judicial review rights concerning that determination have expired or been exhausted. *Id.* at 141. Claim preclusion has been applied to insurers, employers and workers in workers' compensation proceedings.[4] However, the legislature has the **<155 Or App 274/275>** authority to create exceptions to the doctrine by enacting statutory provisions or valid rules that a determination will not preclude another action or proceeding on the same claim. *Id.* at 141-42. Such an exception for employers exists under the 1997 amendment to ORS 656.262(10).

Whether the statute grants employers a privilege or immunity within the meaning of section 20 is discernible by comparing it to other "privileges or immunities," as well as by analyzing its legal effect.

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[3] Claimant did not challenge the Board's holding that the medical evidence failed to establish that the major contributing cause of claimant's knee condition was the accepted injury.

[4] *See, e.g., Deluxe Cabinet Works v. Messmer*, 140 Or App 548, 915 P2d 1053, *rev denied* 324 Or 305 (1996), (*Messmer II*) (employer precluded from challenging compensability of conditions after compensation has been awarded when employer failed to request a hearing to contest compensability); *Hammon Stage Line v. Stinson*, 123 Or App 418, 859 P2d 1180 (1993) (worker precluded from challenging calculation of award when worker failed to request a hearing on the determination order); *Popoff v. J.J. Newberrys*, 117 Or App 242, 843 P2d 1003 (1992) (worker barred by claim preclusion from asserting claims from medical services when worker failed to request a hearing after employer's denial).

We have held an exemption from administrative regulations to be an "immunity" within the meaning of section 20, *Northwest Advancement v. Bureau of Labor*, 96 Or App 133, 142, 772 P2d 934, *rev denied* 308 Or 315, 779 P2d 618 (1989), and the Supreme Court has broadly defined the word "privilege" in section 20 to include the ability to recover tort damages from a governmental body. *Hale v. Port of Portland*, 308 Or 508, 524, 783 P2d 506 (1989). *See also State v. Day*, 84 Or App 291, 294-95, 733 P2d 937, *rev denied* 303 Or 535, 738 P2d 977 (1987) (holding that eligibility to apply for a driver's license is a privilege); *Mid-County Future Alt. v. Port. Metro. Area LGBC*, 82 Or App 193, 728 P2d 63, *modified on other grounds*, 83 Or App 552, 733 P2d 451 (1987) (holding that the advantage of using special annexation procedures conferred a privilege under section 20). It is a tenable conclusion that the statutory authority to deny subsequently the compensability of a condition that is part of an unappealed determination order or notice of closure puts employers in a privileged position and that ORS 656.262(10) confers a privilege to employers that workers do not enjoy within the meaning of section 20.

The second issue is whether ORS 656.262(10) discriminates against a "true class." A "true class" for purposes of section 20 is a group of persons whose characteristics or status are not created by the challenged law but exist as a result of antecedent characteristics or status. *Hale*, 308 Or at 525. Classes created by the challenged law itself "are entitled to no special protection and, in fact, are not even considered to be classes for the purposes of Article I, section 20." *Sealey v. Hicks*, 309 Or 387, 397, 788 P2d 435 (1990). In *Sealey*, the court held that a "true class" distinction existed, for purpose of a section 20 challenge to a statute of repose, consisting of persons injured by products and those injured by other **<155 Or App 275/276>** causes. 309 Or at 397. The distinction was not created by the challenged law itself but by antecedent characteristics of the injured parties. It can reasonably be argued that the reasoning in *Sealey* is applicable to the facts here.[5] Although "subject worker" is specifically defined in ORS 656.027, workers were a class before the enactment of the worker's compensation law. Common law has long recognized the distinction between masters and servants. *See, e.g., Peeples v. Kawasaki Heavy Indust., Ltd.*, 288 Or 143, 146-47, 603 P2d 765 (1979). Claimant is part of a class of persons who are set apart by the fact that they work for another, a characteristic that they bring to the workplace and one not created by the challenged statute.

Assuming without deciding that claimant has satisfied the first two requirements of section 20, the third and final issue is whether the distinction that the legislature has made in ORS 656.262(10) between employers and workers has any rational foundation. Claimant argues that a provision granting employers a privilege not granted on comparable terms to workers is not rationally related to the policies undergirding the workers' compensation system and that it is inconsistent with the goal of creating an impartial and balanced compensation process. See ORS 656.012.[6]

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[5] *See also, Eckles v. State of Oregon*, 306 Or 380, 387, 760 P2d 846 (1988) (private claimants are not a true class when compared with SAIF claimants); *State ex rel Huddleston v. Sawyer*, 324 Or 597, 609-10, 932 P2d 1145 (1997) (offenders whose Measure 11 mandatory minimum sentence is either less or greater than maximum guideline sentences are not a true class).

[6] ORS 656.012 provides, in part:

"(1) The Legislative Assembly finds that:

"* * * * *

"(b) The method provided by the common law for compensating injured workers involves long and costly litigation, without commensurate benefit to either the injured workers or the employers, and often requires the taxpayer to provide expensive care and support for the injured workers and their dependents; and

"* * * * *

"(2) In consequence of these findings, the objectives of the Workers' Compensation Law are declared to be as follows:

"(a) To provide, regardless of fault, sure, prompt and complete medical treatment for injured workers and fair, adequate and reasonable income benefits to injured workers and their dependents;

"(b) To provide a fair and just administrative system for delivery of medical and financial benefits to injured workers that reduces litigation and eliminates the adversary nature of the compensation proceedings, to the greatest extent practicable;

"* * * * *

"(3) In recognition that the goals and objectives of this Workers' Compensation Law are intended to benefit all citizens, it is declared that the provisions of this law shall be interpreted in an impartial and balanced manner."

155 Or App 277> Under section 20, the legislature has the authority to decide what changes and procedures best address the problem of compensating injured workers so long as its decision is not irrational or "based on immutable personal characteristics, such as race or gender." *Jungen*, 94 Or App at 105. An inconsistency within or among legislative statutes is not enough to hold a statute invalid under section 20. Rather, the distinctions created between classes under the legislation must fail to have any rational basis. As we have said before, "We will not hold [a statute] invalid 'if any state of facts reasonably may be conceived to justify it.'" *Day*, 84 Or App at 294 (quoting from *Brown v. Portland School Dist. #1*, 48 Or App 571, 567, 617 P2d 665 (1980), *rev'd on other grounds* 291 Or 77, 628 P2d 1183 (1981)). We look both to the language of ORS 656.262 (10) and to its legislative history to determine whether there is a rational basis for the amendment.

ORS 656.262(10) pertains to the legal effect of the payment of permanent disability benefits on subsequent conditions. Consistent with the statutory objectives in ORS 656.012, the legislature could have rationally decided that the 1997 amendment would result in decreased litigation and prompter compensation for permanent disability. The following testimony before the House Labor Committee on the proposed amendment makes the point:

> "[C]urrent interpretation of the law increases litigation by forcing employers to appeal orders they normally would not. This increased litigation has negative effects for both employers and workers.
>
> "This bill restores balance and fairness by allowing the issue of compensability for conditions not accepted to be based on medical evidence, when and if a need for treatment arises. It removes the presumption of compensability based on the fact that an employer chooses not to litigate every determination order that may have included an unrelated item in the rating of permanent disability.
>
> **155 Or App 278>** "* * * * *
>
> "This bill restores stability to the system by reducing litigation to only those claims that in the future require treatment for an unaccepted condition. These claims for services will be judged, as they should be, on their merit and not on some incidental payment pursuant to a determination order." Testimony, House Labor Committee, HB 2971, April 22, 1997, Ex A.

We conclude that the text of the 1997 amendment to ORS 656.262(10) and its underlying legislative history demonstrates a rational basis for the distinction under the Equal Privileges and Immunities Clause of the Oregon Constitution. Accordingly, we reverse the Board's order on remand that concludes that employer is precluded from denying compensability, and we remand to the Board for reconsideration.

Reversed and remanded.

Cite as 155 Or App 318 (1998) August 5, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Gerald A. Glenn, Claimant.

ROSEBURG FOREST PRODUCTS, Petitioner,
v.
GERALD A. GLENN, Respondent.
(WCB 96-01649; CA A98734)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 15, 1998.
Charles E. Bolen argued the cause for petitioner. On the brief were Cynthia A. Wiens and Cowling, Heysell, Plouse & Ingalls.
Scott McNutt, Sr., argued the cause and filed the brief for respondent.
Before Riggs, Presiding Judge, and Landau and Wollheim, Judges.
RIGGS, P. J.
Reversed and remanded for reconsideration.

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155 Or App 320> Employer seeks review of an Order on Reconsideration of the Workers' Compensation Board affirming an order of an administrative law judge (ALJ) holding that claimant established the compensability of a low back strain and disc herniation. Employer asserts on review that the Board erred in its treatment of two pieces of documentary evidence and that the order is not supported by substantial evidence. Because we agree with employer that the Board committed legal errors in its weighing of the evidence, we reverse the Board's order and remand the case for reconsideration.

Claimant sought compensation for an alleged work-related injury to his back, contending that a November 1995 incident caused strain and herniation at L4-5. During employer's investigation of the claim, claimant was examined by Dr. Farris, a neurologist. On February 9, 1996, after receiving Farris' extensive report, employer denied the claim, stating:

> "We are unable to confirm the occurrence of your injury. If it did occur, we are unable to confirm that it contributes to the conditions or problems of which you have complained."

On February 26, 1996, employer's attorney spoke with Farris about her report. The next day, employer's attorney sent a letter to Farris documenting the conversation and stating, in part:

> "You indicated that this was a purely historical diagnosis and the attribution of the diagnosis to the work activity and/or injury claimed on 11/29/95 was based solely on [claimant's] history. *More specifically, there was no objective evidence of injury, at the time of your exam, and your review of the medical records generally failed to delineate any such objective indicia of injury.*" (Emphasis supplied.)

The letter asked for Farris to acknowledge in writing the medical opinions stated in it:

> "If the foregoing accurately summarizes our conversation and appropriately reflects the opinions you expressed therein, I would ask that you so signify, either by affixing your signature on the space provided below and by returning a copy of this letter, so notated, to this office, or, if you **<155 Or App 320/321>** are more comfortable doing so, by dictating a letter report, covering the matters which we discussed. As a third alternative, if you find that this is a generally accurate rendition of our conversation, but feel the need for additional or corrective commentary, I would invite you to provide such, either by interlineation or in the space provided below, before signing and returning this letter, as edited."

Farris signed the letter, unedited, under the pretyped line "I concur." Employer contends that the signature reflects Farris' concurrence in the letter's statement that there were no objective findings of injury and thereby supports employer's view that claimant did not experience a compensable injury.

The ALJ's order, affirmed by the Board without opinion, said in a footnote:

> "I attach little probative weight to the February 27, 1996 narrative report prepared by the employer's counsel, which Farris concurred with by way of her signature. The document was plainly prepared solely for the purposes of litigation."

Employer asserts that the ALJ's stated reason for discounting the letter was incorrect as a matter of law.

Assuming that the ALJ was correct that Farris' medical opinion was prepared in anticipation of litigation, it erred in rejecting the opinion on that basis. As we and the Board have said, the persuasiveness of a medical opinion depends not on the form in which the opinion is given, but on the completeness and thoroughness of its factual basis and the force of its reasoning. *See Somers v. SAIF*, 77 Or App 259, 263, 712 P2d 179 (1986); *Terry Myers*, 48 Van Natta 1039 (1996); *Marta I. Gomez*, 46 Van Natta 1654 (1993). Because of practical constraints of time and money, a medical opinion may be articulated or summarized by someone other than the doctor, with the doctor's adoption or concurrence. Such an opinion is to be evaluated on the same terms as a report prepared by the doctor. An opinion that lacks explanation or foundation may be discounted, but not for the reason that it is expressed as an adoption or concurrence. Although there is a possibility that employer's attorney prepared the letter summarizing the doctor's opinion in anticipation of litigation, that is not a **<155 Or App 321/322>** basis for giving "little weight" to the medical opinion contained therein. To the extent that that was the basis for the Board's discounting of Farris' opinion, it erred.

Employer also challenges the Board's seemingly inconsistent treatment of two medical reports supporting compensability. In April and May 1995, before the date of the injury giving rise to the claim at issue here, claimant saw Dr. Brazer, complaining about low back pain and slight numbness and tingling in the right leg that claimant attributed to a work incident in March 1995. Brazer's report of May 15, 1995, said that claimant

> "[r]eports that injury occurred approximately the 18th of March 1995. Reports at that time he was moving a piece of wood with sudden onset of discomfort."

Brazer diagnosed "mechanical low back strain" and prescribed medication and physical therapy. The symptoms resolved after physical therapy.

Later, the medical opinions of Drs. Keizer and Davis, relied on by claimant here, expressed the view that the November 1995 incident caused claimant to experience a strain and a herniation of the disc at L4-5. The Board discounted Keizer's opinion, saying that the report shows that Keizer was unaware of claimant's prior low back pain, "which detracts from the weight of his opinion." Employer argues that Davis' opinion is similarly flawed. In his report, Davis said that claimant had "no history of injury to the back, just some pulled muscles approximately one year ago, treated by [physical therapy]." Thus, although Davis was aware that claimant had had a back problem in April and May of 1995, his report shows that he was not aware of the March 1995 work-related incident to which claimant attributed it. Accordingly, employer is correct that Davis' opinion suffers the same defect as Keizer's. Both doctors were unaware of claimant's March 1995 injury as reported by Brazer. On remand, the Board should reconsider the medical record, giving appropriate attention to the matters addressed herein.

Reversed and remanded for reconsideration.

Cite as Or App 401 (1998) August 5, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Jose L. Hernandez, Claimant.

SAIF CORPORATION and EUREKA FISHERIES, INC., Petitioners,

v.

JOSE L. HERNANDEZ, Respondent.

(96-04633; A98805)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 5, 1998.
Michael O. Whitty argued the cause and filed the brief for petitioners.
Bruce D. Smith argued the cause and filed the brief for respondent.
Before Landau, Presiding Judge, and Deits, Chief Judge, and Wollheim, Judge.*
LANDAU, P. J.
Reversed and remanded for reconsideration.
* Wollheim, J., *vice* Leeson, J., resigned.

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155 Or App 403> Employer seeks review of an order of the Workers' Compensation Board (board) awarding claimant permanent disability. Employer contends that the board erred in failing to evaluate claimant's condition--specifically, claimant's weight loss as a symptom of an upper gastrointestinal disease--as of the date of the order on reconsideration. We agree and reverse and remand for reconsideration.

We begin with the applicable administrative rules to place the parties' dispute in proper context. Under the workers' compensation rules, impairment of the upper digestive tract is rated in terms of four classes. A Class 1 impairment, rated at 3 percent, is indicated when:

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

OAR 436-035-0420(2). A Class 2 impairment, rated at 15 percent, is indicated when:

> "(A) Symptoms and signs of organic upper digestive disease are present or there is anatomic loss or alteration; and
>
> "(B) Appropriate dietary restrictions and drugs are required for control of symptoms, signs and/or nutritional deficiency; and
>
> "(C) Loss of weight below the 'desirable weight' does not exceed 10%."

Id. A Class 3 impairment, rated at 35 percent, is indicated when:

> "(A) Symptoms and signs of organic upper digestive tract disease are present or there is anatomic loss or alteration; and
>
> **155 Or App 404>** "(B) Appropriate dietary restrictions and drugs do not completely control symptoms, signs, and/or nutritional state; or
>
> "(C) There is 10-20% loss of weight below the 'desirable weight' which is ascribable to a disorder of the upper digestive tract."

Id. Finally, a Class 4 impairment, rated at 63 percent, is indicated when:

> "(A) Symptoms and signs of organic upper digestive tract disease are present or there is anatomic loss or alteration; and

"(B) Symptoms are not controlled by treatment; or

"(C) There is greater than a 20% loss of weight below the 'desirable weight' which is ascribable to a disorder of the upper digestive tract."

Id. The "desirable weight" referred to in the rule is defined by a chart that lists desirable weights by sex, height and body build. *Id.* For example, the desirable weight for a male, 68 inches tall, is between 140 and 172 pounds, depending on whether the individual is of small, medium or large frame. *Id.*

With that framework in mind, we turn to the relevant facts, which are not in dispute. Claimant suffered a compensable injury to his left arm in 1991. In December 1993, as a result of the medications prescribed for the injured arm, claimant developed symptoms of a peptic duodenal ulcer. Claimant is 68 inches tall; the record does not disclose his body build. At the time the symptoms first developed, he weighed 145 pounds. By April 1995, claimant's weight fell to 137 pounds. By September 1995, claimant's weight rebounded to 142 pounds. On October 10, 1995, employer accepted a claim for the ulcer. Meanwhile, by November 1995, claimant's weight climbed to 151 pounds.

On December 1, 1995, employer closed the claim. Employer did not award permanent disability for the ulcer condition. Claimant requested reconsideration, and, on May 8, 1996, an order on reconsideration was issued rating claimant's condition a Class 1 gastrointestinal system impairment, at 3 percent. Claimant requested a hearing, contending that **<155 Or App 404/405>** he should have been rated a Class 2 impairment, at 15 percent. Employer opposed the request on the ground that claimant could not show the necessary weight loss required for a Class 2 rating. Claimant argued that weight loss is not a requirement of a Class 2 rating. The administrative law judge (ALJ) agreed and rated claimant's condition a Class 2 impairment, at 15 percent.

Employer requested review, arguing that the ALJ erred in concluding that weight loss is not a requirement of a Class 2 rating. The board agreed, holding that, under the plain terms of the rule, loss of weight not in excess of 10 percent below the desirable level is required for rating a condition a Class 2 impairment. The board went on to conclude, however, that, because claimant's weight fell from 145 pounds to 137 pounds between December 1993 and April 1995, he in fact did meet that requirement and thus was entitled to a Class 2 impairment rating, at 15 percent. One board member dissented, arguing that claimant's weight loss during the period from 1993 to 1995 is irrelevant, because, under ORS 656.283(7), claimant's weight as of the date of the order on reconsideration is controlling. As of that date, claimant actually had sustained a weight gain in relation to his weight before the onset of the ulcer. Employer moved for reconsideration on that ground. The board denied reconsideration without explanation.

On review, employer challenges the board's conclusion that claimant is entitled to a Class 2 impairment rating. Employer argues that the dissenting board member was correct in asserting that claimant failed to establish the required loss of weight as of the time of the order on reconsideration. Claimant argues that the applicable administrative rules do not require proof of loss of weight as of the date of the order on reconsideration. According to claimant, the rules require only that "dietary restrictions and drugs are required for control of symptoms." One symptom of a duodenal peptic ulcer, claimant notes, is weight loss. He argues that, if there is evidence that dietary restrictions and drugs are necessary to control his weight loss, and if the weight loss--without such treatment--would not exceed 10 percent, then he is entitled to a Class 2 impairment rating.

155 Or App 406> ORS 656.283(7) provides that "[e]valuation of the worker's disability * * * shall be as of the date of issuance of the reconsideration order[.]" As we held in *Safeway Stores, Inc. v. Smith*, 122 Or App 160, 163, 857 P2d 187 (1993), there is no ambiguity in that directive, no room for interpretation. In this case, the board failed to evaluate claimant's condition as of the date of reconsideration. In so doing, the board erred.

Claimant's argument that proof of weight loss is not required at all cannot be reconciled with the language of the applicable rule, which requires that claimant demonstrate that dietary restrictions and drugs are required for control of symptoms "and" that actual weight loss below the desirable level not exceed 10 percent. Claimant's proposed interpretation effectively reads out of the rule the conjunction "and," as well as the phrase that follows it.

Reversed and remanded for reconsideration.

Cite as 155 Or App 447 (1998) August 5, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Catherine G. Renfro, Claimant,

INTEL CORPORATION and AIG CLAIM SERVICES, Petitioners,
v.
CATHERINE G. RENFRO, Respondent.
(96-02773, 95-11919; CA A98921)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 5, 1998.
Ronald W. Atwood argued the cause and filed the brief for petitioners.
Robert Sola argued the cause for the respondent. On the brief was Hank McCurdy.
Before De Muniz, Presiding Judge, and Haselton and Linder, Judges.
HASELTON, J.
Reversed and remanded for reconsideration.

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155 Or App 449> Employer seeks review of an order of the Workers' Compensation Board, which set aside the denial of an aggravation claim. Central to the Board's holding was its determination that, because of the 1995 amendment to ORS 656.273(1), claimant was not required to prove diminished wage-earning capacity in order to establish a compensable aggravation of an unscheduled condition. We conclude that the Board erred in that regard and, consequently, reverse and remand.

Claimant suffered a grievous head injury when she fell down a flight of steps while working for employer in July 1982. She consequently experienced a variety of sequelae, including vertigo, hearing loss, chronic headaches, chronic tinnitus, perilymph fistula, and cognitive disfunction. Claimant attempted, unsuccessfully, to return to work in 1983 and 1985 and was finally able to return to modified part-time work in 1988 and modified full-time work in August 1989. In July 1990, her claim was closed by a determination order. Ultimately, in July 1991, she was awarded 80 percent unscheduled permanent partial disability and 13.5 percent scheduled permanent partial disability for right ear hearing loss.

In the summer of 1991, as claimant continued to work for employer, her condition worsened, with increased hearing loss and vomiting. She sought treatment and, ultimately, in July 1995, Dr. Black, a surgeon who had previously twice repaired claimant's fistula, rendered an opinion that claimant's fistula had reopened. In July 1995, claimant filed her aggravation claim, ORS 656.273, which employer denied.

The administrative law judge (ALJ) considered conflicting expert medical evidence, determined that claimant's condition had actually worsened since July 1991, and, consequently, set aside the denial. The ALJ's opinion and order did not expressly consider and determine whether claimant had demonstrated diminished wage earning capacity; rather, it merely noted, "In Dr. Black's opinion, claimant is * * * definitely less able to work than she was in July 1991."

155 Or App 450> On review, the Board affirmed. The Board rejected employer's argument that Black's opinion was inadequate to establish an "actual worsening" (*i.e.*, a pathological, rather than symptomatic, worsening) of claimant's unscheduled condition.[1] *SAIF v. Walker*, 145 Or App 294, 305, 930 P2d 230 (1996), *rev allowed* 325 Or 367 (1997). The Board then considered, and rejected, employer's argument that, under *Smith v. SAIF*, 302 Or 396, 730 P2d 30 (1986), claimant was required to prove that the worsening of her unscheduled condition had resulted in diminished wage-earning capacity and that she had failed to do so:

---

[1] Before the Board, employer apparently did not contest the sufficiency of Black's opinion as to worsening of claimant's scheduled condition (hearing loss).

> "[A]lthough [employer] argues that there is no evidence of a diminished earning capacity in this case, we have previously held that the amended version of ORS 656.273(1) now defines a 'worsened condition' as an 'actual worsening of the compensable condition supported by objective findings.' * * * * In [*Jason S. Palmer*, 48 Van Natta 2394 (1996)], we found that the legislature intended to focus on a worker's physical condition, rather than on a loss of earning capacity or loss of use or function in a legal sense. Therefore, it is no longer necessary for a claimant to prove diminished earning capacity in order to establish a worsened condition involving an unscheduled body part." (Footnote omitted.)

On review, employer argues that the Board erred in two respects: (1) The Board erred in holding that diminished wage-earning capacity is not a required element of a claim for aggravation of an unscheduled condition. (2) The Board erroneously "ignored" employer's argument that claimant's evidence showed only a "waxing and waning" of claimant's symptoms. ORS 656.273(8).

We reject the second argument without further discussion but reverse and remand on the first ground. We conclude, particularly, that the 1995 amendment to ORS 656.273(1) did not "legislatively overrule" *Smith's* holding that, to establish a compensable aggravation of an unscheduled condition, a claimant must prove that the worsening of the condition resulted in diminished earning capacity.

155 Or App 451> In *Smith*, the court considered the requirements for establishing a compensable aggravation of an unscheduled disability under ORS 656.273(1) (1985). That statute provided:

> "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury."

The court concluded:

> "A worker may be able to continue to work at a present job but still suffer a loss of earning capacity to carry on other work in the broad field of general occupations, see ORS 656.214(5), because of a worsened condition. That is, in a claim for increased compensation for unscheduled disability under ORS 656.273, the worker need not show that he is less able to work in his present employment, but must prove that *his symptoms have increased or otherwise demonstrate that his underlying condition has worsened so that he is less able to work in the broad field of general occupations resulting in a loss of earning capacity.*" *Smith*, 302 Or at 401.

That construction of ORS 656.273(1) (1985), and particularly the interpretation of "worsened condition," "became part of that statute." *S-W Floor Cover Shop v. Natl. Council on Comp. Ins.*, 318 Or 614, 622, 872 P2d 1 (1994). *See, e.g., Fred Meyer, Inc. v. Farrow*, 122 Or App 164, 166, 857 P2d 189 (1993) ("A claimant who alleges a worsening of an unscheduled disability must prove a loss of earning capacity.").

In 1990, the legislature amended ORS 656.273(1), Or Laws 1990, ch 2, section 18, leaving the text construed in Smith intact but adding, inter alia, the following language:

> "A worsened condition resulting from the original injury is established by medical evidence supported by objective findings."

In 1995, the legislature again amended ORS 656.273(1) so that the pertinent text now reads:

> "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 **<155 Or App 451/452>** worsened condition resulting from the original injury is established by medical evidence of *an actual worsening of the compensable condition* supported by objective findings." (1995 amended language emphasized.)

In *Walker*, we addressed the significance of the phrase added by the 1995 amendments and concluded that "actual worsening" required proof of pathological worsening of a claimant's condition:

> "[T]he legislature's use of the terms 'actual worsening' was not intended to include a symptomatic worsening. Under the amended statute, in order for a symptomatic worsening to constitute an 'actual worsening,' a medical expert must conclude that the symptoms have increased to the point that it can be said that the *condition* has worsened. In other words, ORS 656.273(1), as amended, requires that there be direct medical evidence that a condition has worsened. It is no longer permissible for the Board to infer from evidence of increased symptoms that those symptoms constitute a worsened condition for purposes of proving an aggravation claim." *Walker*, 145 Or App at 305 (emphasis in original).

Our analysis, thus, focused solely on "symptomatic" versus "pathological" worsening. Nothing in *Walker* suggests that the legislature, in adding the phrase "actual worsening of a compensable condition," intended to repudiate *Smith's* fundamental proposition that, to establish the compensability of an unscheduled condition, the claimant must prove diminished earning capacity. As employer asserts:

> "A 'worsened condition' under pre-1995 law was defined as loss of earning capacity. The effect of the amendment to the statute was to narrow the means to prove a 'worsened condition' to an *actual worsening* of the compensable condition. It was the second sentence of ORS 656.273(1) which amended and modified the manner in which a 'worsened condition' was proved. However, the first sentence of ORS 656.273 was not changed and the link between the terms 'worsened condition' and 'loss of earning capacity' was not disturbed."

We thus conclude that, to prove a compensable aggravation of an unscheduled condition, a claimant must prove (1) an "actual worsening" of that condition, *Walker*, 145 **<155 Or App 452/453>** Or App at 305, that (2) results in diminished earning capacity. The Board erred in failing to consider the second element.[2]

Claimant argues, nevertheless, that we should affirm because "substantial evidence [supports] the ALJ's finding of diminished earning capacity." We discern no such "finding" in the ALJ's opinion and order. In all events, the Board, because of its assumption that diminished earning capacity was immaterial, did not consider, much less determine, that matter. We remand for it to do so with respect to claimant's unscheduled condition.

Reversed and remanded for reconsideration.

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[2] Claimant asserts that ORS 656.273(1) does not require proof of diminished earning capacity with respect to her *scheduled* disability (hearing loss). Employer does not dispute that principle. *See Fred Meyer, Inc. v. Farrow*, 122 Or App at 167 ("We conclude that aggravations are measured by the same standard that made the condition originally compensable. An aggravation of an unscheduled injury is measured by increased loss of earning capacity. An aggravation of a scheduled injury is measured by increased loss of use.").

Cite as 155 Or App 559 (1998) September 2, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Rose E. Venetucci, Claimant.

ROSE E. VENETUCCI, Petitioner,
v.
METRO and SAIF CORPORATION, Respondents.
(WCB 96-04416; CA A97153)

Judicial Review from Worker's Compensation Board.
Argued and submitted February 12, 1998.
Andrew H. Josephson argued the cause and filed the brief for petitioner.
David Runner argued the cause and filed the brief for respondents.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
WARREN, P. J.
Reversed and remanded.
Edmonds, J., dissenting.

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155 Or App 561> Claimant seeks review of an order of the Workers' Compensation Board affirming the Administrative Law Judge's (ALJ) dismissal of her request for hearing. The issue is whether the ALJ erred by dismissing claimant's claim because she failed to seek reconsideration of a notice of closure. Because we conclude that claimant was not required to seek reconsideration of the notice of closure, we reverse.

Claimant suffered a compensable heel injury while working for Metropolitan Service District (Metro). Metro's insurer, SAIF, originally calculated claimant's average weekly wage at $515 and compensated her based on that amount from August 25, 1993 through December 15, 1993. On May 18, 1994, SAIF sent her a notice of closure. That notice provided that "[d]eduction of overpaid temporary disability, if any, from unpaid permanent disability is approved." Claimant was not awarded permanent disability in that notice of closure.

On June 16, 1994, an audit by SAIF alleged that claimant's modified weekly wage rate was $371.13 and that SAIF had made an overpayment of $2,392.05.[1] SAIF mailed claimant notice of this alleged overpayment the following day, indicating that it would set off the overpayment against any future awards of permanent disability.

On claimant's motion for reconsideration, the Department of Consumer & Business Services (DCBS) rescinded the May 18 closure as premature.[2] SAIF issued a second notice of closure on October 30, 1995, that provided an award of $2,237.02 for permanent partial disability. That notice contained the same general language as the first regarding overpayment and setoff. Nothing in the second notice, however, referred specifically to an actual overpayment.

155 Or App 562> On November 28, 1995, SAIF advised claimant by letter that the overpayment was being deducted from her award for permanent partial disability. Claimant did not request reconsideration of the second notice of closure but instead sought a hearing before the Board, contesting SAIF's amended calculation of her weekly income and alleged overpayment.

SAIF moved to dismiss the request for hearing based on ORS 656.268, which provides, in part:

> "(4)(e) If a worker objects to the notice of closure, the worker first must request reconsideration by the department under this section. The request for reconsideration must be made within 60 days of the date of the notice of closure."

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[1] The auditor recalculated claimant's average weekly wage. The manner of calculating claimant's weekly wage is the issue in the underlying appeal but was never reached below due to the Board holding that it did not have jurisdiction.

[2] The Department found that claimant was not medically stationary at the time of claim closure.

SAIF argues that claimant's objection was to the second notice of closure and that, having failed to seek reconsideration of that notice, she was prohibited from proceeding directly to hearing. The ALJ agreed, relying on the Board's decision in *William T. Masters*, 48 Van Natta 1788 (1997).[3]

Claimant argues that she was not required to seek reconsideration because her objection was not to the second notice of closure, but, rather, it arose from the subsequent letter informing her that her award of permanent disability was being withheld due to the alleged overpayment. That issue, she argues, is controlled by ORS 656.283(1), which provides, in part:

> "Subject to ORS 656.319, any party or the Director of the Department of Consumer and Business Services 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 supplied.)

ORS 656.704(3) provides that "matters concerning a claim under this chapter are those matters in which a worker's **<155 Or App 562/563>** right to receive compensation, or the amount thereof, are directly in issue." Claimant contends that the letter informing her that her permanent disability was being withheld placed her right to receive compensation directly in issue and she permissibly proceeded by requesting a hearing. We agree.

The underlying issue in this case is whether SAIF correctly calculated claimant's wage rate for purposes of paying temporary partial disability. That calculation forms the basis for SAIF's assertion that claimant was overpaid for the period of August 25, 1993 through December 15, 1993. However, that issue was never reached below because the ALJ and the Board held that claimant's failure to seek reconsideration of the October 30, 1995, notice of closure precluded her from raising that issue at hearing. ORS 656.268(4)(e) requires that a claimant who objects to a notice of closure must first seek reconsideration of that notice. ORS 656.283(7) prohibits a claimant from raising issues at a hearing that were not raised at reconsideration. Taken together, those statutes preclude a claimant from raising an issue at hearing if that issue stems from an objection to a notice of closure that was not preserved by mandatory reconsideration. The issue here is whether claimant's claim is an objection to a notice of closure so that it falls within the requirements of mandatory reconsideration.

The deciding question in this case is what is claimant objecting to? For her claim to be barred, she must be objecting to the October 30, 1995 notice of closure. In that notice, SAIF concluded that claimant is "entitled to compensation for Temporary Partial Disability for the period from Aug 23, 1993 through Dec 16, 1993." Those benefits had already been paid. The notice also provided that claimant was awarded permanent partial disability in the amount of $2,237.02. That money had not yet been paid. The notice contained a provision that, "Deduction of overpaid temporary disability, if any, from unpaid current or future permanent or temporary disability awards or payments is allowed." On its face, that notice of closure does not reveal SAIF's intent to withhold claimant's award of permanent partial disability to recover its alleged overpayment of temporary benefits.

155 Or App 564> However, SAIF and the dissent argue that SAIF's earlier letter informing claimant of the overpayment put claimant on notice of its intent to withhold payment. While that might be true, the fact that claimant was on notice of SAIF's intent should not be construed to mean that claimant must seek reconsideration of a notice of closure with which she does not object. Claimant had no objection to any award provided in the notice of closure. She did not object to either the time period established for partial disability or the award of permanent disability. In fact, claimant had no objection until 28 days later, when SAIF manifested its intent to withhold payment of her permanent disability. At that point, claimant's right to receive compensation was placed directly in issue and she subsequently requested a hearing on that issue. Her objection was not to the notice of closure but, rather, to SAIF's letter informing her that she would not receive her permanent disability payment. That issue can be raised at anytime at hearing pursuant to ORS 656.283(1).

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[3] In *Masters*, relying on facts similar to those found here, the Board noted that an issue arises from the notice of closure when a subsequent audit reveals an overpayment. The Board retreated from that position in *Blaine P. Hosey*, 50 Van Natta 360 (1998). In *Hosey*, the Board held that an issue arises from the notice of closure when that issue is manifest in the notice.

The dissent places great stock in SAIF's earlier correspondence, which notified claimant of its intent to deduct future payments in satisfaction of the alleged overpayment and in the notice of closure provision that allowed for setoff of overpayments, "if any," from future awards. However, nothing in the notice of closure indicated SAIF's present intention to withhold claimant's permanent disability to recover the overpayment. Lacking that manifestation of intent, we cannot insert an inference into the notice of closure. ORS 656.268(4)(e) requires claimants seek reconsideration if they object to the "notice of closure," not if they object to anything associated with a notice of closure. In short, for mandatory reconsideration pursuant to ORS 656.268(4)(e) to preclude further review, a claimant must have an objection that is manifest in the notice of closure. Here, claimant's objection arose upon receipt of SAIF's letter informing her of its intent to withhold payment of her permanent disability. That intent was not manifest in the notice of closure.

Reversed and remanded.

EDMONDS, J., dissenting.

The evidence is uncontested that on June 17, 1994, SAIF sent claimant a letter that expressed the calculation of **<155 Or App 564/565>** how an overpayment for time loss occurred in 1993 for the period of August 25, 1993 through December 15, 1993, because of incorrect wage information. The letter calculated the overpayment in the amount of $2,392.05 and said, in part:

> "Your claim has been closed with no permanent partial disability award granted. This overpayment may be recovered from future claim compensation.
>
> "If you disagree with this statement, please contact me within 30 days. If I do not hear from you within this time, I will assume you agree this is an accurate accounting."

On October 30, 1995, SAIF issued the notice of closure, the language of which is the basis for the issue that the majority frames. The notice informed claimant that she was entitled to time loss for the period of August 23, 1993 through December 16, 1993, and to an award for permanent partial disability in the amount of $2,237.02. It also said, "*Deduction of overpaid temporary disability*, if any, from unpaid current or future permanent or temporary disability awards or payments *is allowed*." (Emphasis supplied). Finally, it stated, "IF YOU DISAGREE WITH THIS NOTICE OF CLOSURE, YOU HAVE THE RIGHT TO ASK FOR RECONSIDERATION. THIS MUST BE DONE WITHIN 60 DAYS FROM THE DATE OF THIS NOTICE OF CLOSURE." Claimant did not request reconsideration of the notice of closure, even though she had earlier requested reconsideration of a prematurely issued notice of closure received before the June 1994 letter. On November 28, 1995, SAIF offset payment of claimant's permanent partial disability award because of the overpayment pursuant to its October 30 notice. Claimant first requested a hearing on that action on May 7, 1996. The Board dismissed for lack of jurisdiction under ORS 656.283(7) because claimant had not requested reconsideration of the notice of closure authorizing the offset, and claimant seeks review of that ruling.

On review of the Board's decision, claimant argues:

> "Claimant should not be required to first request an order on reconsideration in order for the Hearings Division to retain jurisdiction regarding the issue of rate of temporary disability benefits. The reconsideration process is **<155 Or App 565/566>** reserved for issues regarding claim closure. ORS 656.283(7). The rate of temporary disability benefits is not created or arise [*sic*] at the time of claim closure. It is an issue that may arise at any time. The issue of rate of temporary disability benefits can be brought directly into hearing without going through the reconsideration process because it is a matter concerning a claim."

Regardless of the argument raised by claimant, the majority opines that the "notice of closure does not reveal SAIF's intent to withhold claimant's award of permanent partial disability to recover its alleged overpayment of temporary benefits." 155 Or App at 563. Therefore, it concludes that ORS 657.283(7) did not require claimant to request reconsideration of the notice by the department before she requested a hearing before the Board. 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 be not raised at hearing unless the issue arises out of the reconsideration order itself."

ORS 656.283(7) is clear on its face. Issues resolved by a notice of closures cannot be raised to the Board unless they were first raised to the department on reconsideration of the notice of closure. Here, the offset was expressly mentioned in the notice of closure. The notice says, "Deduction of overpaid temporary disability benefits, if any, from unpaid current or future permanent or temporary disability awards or payments *is allowed*." (Emphasis supplied.) The notice of closure could not be more express with the use of its "is allowed" language. The language tells claimant that if overpaid benefits exist, SAIF is going to offset the overpayment against payments on the award of permanent disability. The notice was not news to claimant. She knew from the June 17, 1994, letter that there had been an overpayment of time loss. The majority's reading of the language of the closure notice is untenable.

Even claimant does not argue that she was not aware of SAIF's intention to affect an offset by its notice of closure. Rather she contends that the statute does not control **<155 Or App 566/567>** because the issue she now contests is the *rate* that SAIF used to arrive at the conclusion in June 1994 that there was an overpayment. In other words, she appears to be asserting that there really was not an overpayment. SAIF is correct when it argues that claimant's contention is defeated by the language of ORS 656.268(4)(b), which provides that a notice of closure must inform the worker of the "amount and duration of temporary total or temporary partial disability compensation" and "of the right of the worker to request reconsideration." Here, the notice of closure told claimant all that the statute required regarding the amount of permanent disability including the fact that claimant's award would be offset by the overpayment of time loss, "if any" and that if she disagreed with the contents of the notice of the closure, she was required to seek reconsideration. Even though SAIF offset claimant's permanent disability award within the 60-day period for reconsideration, claimant still did not seek reconsideration but waited months later before she requested a hearing.

For these reasons, I dissent.

Cite as 155 Or App 568 (1998) September 2, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Boyd Belden, Claimant.

SAIF CORPORATION and DANEGON PLASTICS, INC., Petitioners,
v.
BOYD K. BELDEN, Respondent.
(Agency No. 95-08382; CA A96457)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 4, 1998.
David L. Runner argued the cause and filed the brief for petitioners.
Donald M. Hooton argued the cause and filed the brief for respondent.
Before Warren, Presiding Judge, and Edmonds and Armstrong,* Judges.
ARMSTRONG, J.
Affirmed.
Warren, P.J., dissenting.
* Armstrong, J., *vice* Deits, C.J.

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155 Or App 570> SAIF seeks review of an order of the Workers' Compensation Board that held that ORS 656.262(7)(b), which was enacted in 1995, applied retroactively, thereby entitling claimant to seven percent permanent partial disability (PPD). We review for errors of law, ORS 183.462(8), and affirm.

We accept the facts as found by the Board. In 1986, claimant seriously fractured his left distal femur in an accident that was not related to work. In 1992, he twisted his left knee while walking at work. SAIF denied a claim for left knee strain on the ground that his noncompensable preexisting condition was the major cause of his current condition.

In 1993, an Administrative Law Judge (ALJ) set aside SAIF's denial, finding that the 1992 work-related injury was the major contributing cause of claimant's combined condition. SAIF then accepted claimant's combined condition. Claimant's treating doctor declared claimant's knee condition medically stationary in September 1994. SAIF submitted the claim to the Department of Consumer and Business Services (DCBS) for closure, and the DCBS issued a determination order awarding claimant six percent PPD for his left knee. SAIF did not issue claimant a written denial before claim closure stating that his accepted injury was no longer the major cause of his combined condition.

Claimant sought reconsideration of the determination order by a medical arbiter. The medical arbiter found that claimant had limitations with respect to his knee's range of motion and repetitive use, which he attributed to claimant's preexisting left knee condition. Based on the medical arbiter's report, the DCBS reduced claimant's PPD award to zero on reconsideration.

Claimant requested a hearing at which he argued that the reduction of his PPD award could not be sustained under ORS 656.262(7)(b), which provides that, if an insurer intends to deny an accepted compensable condition, it must issue a written denial to the claimant before it acts to close the claim. Although the statute did not exist at the time of claim closure in November 1994, claimant asserted that it **<155 Or App 570/571>** applied retroactively to his claim. He argued that, under that statute, SAIF's failure to issue a written denial of claimant's current condition before his claim was closed rendered the closure premature, or, in the alternative, precluded SAIF from arguing that claimant's impairment was not related to the compensable injury.

The ALJ agreed that ORS 656.262(7)(b) applied retroactively and held that the statute required that the claim closure be set aside as premature. SAIF sought Board review and the Board concluded that, although the statute applied retroactively, it did not require that the closure be set aside. Instead, the Board held that, because SAIF had failed to issue claimant a current condition denial, all of

claimant's impairment had to be attributed to the compensable injury. Accordingly, the Board awarded claimant seven percent scheduled PPD.[1]

On review, SAIF argues that the Board erred when it applied ORS 656.262(7)(b) retroactively. We disagree. The legislature enacted ORS 656.262(7)(b) in 1995 as a part of Senate Bill 369, which substantially revised the Workers' Compensation Law. Or Laws 1995, ch 332. Section 66(1) of Senate Bill 369 provides, in part:

> "Notwithstanding any other provision of law, this Act applies to all claims or causes of action existing or arising on or after the effective date of this Act, regardless of the date of injury or the date a claim is presented, and *this Act is intended to be fully retroactive unless a specific exception is stated in this Act.*"

Or Laws 1995, ch 332, section 66(1) (emphasis added). We have interpreted that provision to mean that, unless an express exception exists, the revised law is to be applied to cases pending on review. *Volk v. America West Airlines*, 135 Or App 565, 569, 899 P2d 746 (1995).

155 Or App 572> SAIF suggests that section 66(6) of the 1995 law could be understood to exclude ORS 656.262(7)(b) from the retroactivity provision. That section 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."

(Emphasis added.) Under that exception, provisions enacted as part of Senate Bill 369 that eliminate or alter statutory time limits do not apply retroactively. *Norstadt v. Murphy Plywood*, 148 Or App 484, 941 P2d 1030, *adhered to as modified* 150 Or App 245, 945 P2d 654 (1997). In other words, if, before the effective date of Senate Bill 369, a statute required a party to take action on a claim within a certain period of time, a provision enacted as a part of Senate Bill 369 that alters that period does not apply retroactively.

To determine whether ORS 656.262(7)(b) applies retroactively, then, we must determine whether its retroactive application would alter the period of time in which a party has to act. To do that, we must compare how the system operated before and after the legislature enacted that statute. If the amended statute does not alter any procedural time limitations, we must apply it retroactively.

In 1990, the legislature enacted ORS 656.005(7)(a)(B), which, at the time of the closure of claimant's claim, provided:

> "If a compensable condition combines with a preexisting disease or condition to cause or prolong disability or a need for treatment, the resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment."[2]

ORS 656.005(7)(a)(B) governs the circumstances under which a claimant is substantively entitled to compensation for a combined condition. *United Airlines, Inc. v. Brown*, 127 Or App 253, 257, 873 P2d 326, *rev den* 319 Or 572 (1994). **<155 Or App 572/573>** Once an insurer accepts a combined condition pursuant to ORS 656.005(7)(a)(B), it is obliged to treat that condition as compensable until it properly denies it.

Before 1995, there was no mechanism by which an insurer could deny an accepted combined condition. *Id.* (holding that ORS 656.005(7)(a)(B) did not provide a mechanism through which an insurer could deny an accepted combined condition). Thus, even if, under ORS 656.005(7)(a)(B), a claimant was

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[1] Although the initial determination order assessed claimant's PPD at six percent, the Board concluded that the medical arbiter's assessment of claimant's condition indicated that he should be awarded seven percent PPD. Neither party challenges that figure on review.

[2] In 1995, ORS 656.005(7)(a)(B) was amended and the text modified. Those textual modifications do not effect the outcome of this case.

no longer substantively entitled to compensation for a combined condition, the claimant was still entitled to compensation for the condition through claim closure. Moreover, under ORS 656.268, an insurer could close a claim only when the conditions accepted under it had become medically stationary or the claimant had enrolled and become "actively engaged in training." ORS 656.268(1) (amended Or Laws 1995, ch 2, section 3). That time did not necessarily have to coincide with the time at which a claimant's compensable injury had ceased to be the major contributing cause of the combined condition. In short, under the system as it existed before 1995, once an insurer had accepted a combined condition, it could not avoid paying compensation for that condition, even if it were no longer compensable.

In 1995, the legislature enacted ORS 656.262(6)(c) and ORS 656.262(7)(b) and amended ORS 656.268 to change the way in which combined conditions are treated. In order to determine the meaning of those statutes, we examine the text of them in context, turning to legislative history only if we cannot discern the meaning of the statutes from that review. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-11, 859 P2d 1143 (1993).

Under ORS 656.262(6)(c), an insurer may now deny an accepted combined condition at any point if the "compensable injury ceases to be the major contributing cause of the combined * * * condition."[3] Under ORS 656.268,[4] an insurer **<155 Or App 573/574>** still must promptly close a claim when the claimant's condition becomes medically stationary, but now it may also move to close a claim when the compensable injury is no longer the major contributing cause of the combined condition. As a substantive matter, those statutes effectively reverse the old system. Now, an insurer can accept a combined condition pursuant to ORS 656.005(7)(a)(B) without being concerned that it will be obliged to continue to pay compensation for that condition if it stops being compensable.

While those two statutes effectively protect an insurer from paying for noncompensable claims, they do not prescribe the procedure that the insurer must follow in order to take advantage of its ability to deny an accepted combined condition. For that, the legislature enacted ORS 656.262(7)(b), which 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) is a notice statute.[5] Its purpose is to ensure that, if an insurer is going to take advantage of its newly acquired right to deny an accepted combined condition, it does so in a manner

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[3] 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."

[4] ORS 656.268 provides, in part:

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

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

[5] The other subsections of ORS 656.262(7) provide additional support for our conclusion that ORS 656.262(7)(b) was intended to be a notice statute, because each of the subsections identifies circumstances in which the insurer must give notice. ORS 656.262(7)(a) describes when, after claim acceptance, an insurer must give written notice of acceptance or denial of aggravation or new medical condition claims. ORS 656.262(7)(c), in turn, requires an insurer to give a claimant a written updated notice of acceptance at claim closure.

that provides the claimant with a reasonable opportunity to object to that denial. ORS <155 Or App 574/575> 656.262(7)(b) achieves that purpose by providing that an insurer that takes the position that a claimant's accepted combined condition is no longer compensable must issue a written denial pursuant to ORS 656.262(6)(c) before it may close the claim pursuant to ORS 656.268.

If an insurer concludes that a claimant's combined condition is no longer compensable, it must issue a written denial regardless of the reason that it seeks to close the claim. That is, if a claimant's combined condition ceases to be compensable at the same time that the conditions accepted under the claim become medically stationary, the insurer must issue a written denial of the combined condition even if it seeks to close the claim on the ground that the conditions are medically stationary. However, if the insurer believes that the combined condition remains compensable at the time that the claimant's conditions become medically stationary, it may close the claim on the ground that the conditions are medically stationary without issuing a denial of the combined condition. If an insurer does that, the combined condition remains accepted and the insurer is precluded from arguing at claim closure that the condition is no longer compensable.

In summary, before 1995, once an insurer had accepted a claim for a combined condition, it could not deny the claim, in writing or otherwise, on the ground that the compensable injury had ceased to be the major contributing cause of the worker's condition. *United Airlines*, 127 Or App at 257. In 1995, the legislature changed that, and an insurer may now deny an accepted condition when it is no longer compensable. However, to be effective under ORS 656.262(7)(b), the denial must be issued to the claimant, in writing, before claim closure.

After comparing the system as it operated before 1995 with how it operates after 1995, we conclude that the new statutory provisions do not extend or shorten the time period within which a party must act to preserve its rights. ORS 656.262(6)(c) and ORS 656.268 simply authorize activities that had been prohibited in the past and ORS 656.262(7)(c) simply places a procedural constraint on an insurer's ability to take advantage of those new provisions. <155 Or App 575/576> Accordingly, section 66(6) does not preclude the retroactive application of those provisions. Because no other exception to retroactivity expressly applies, we conclude that the Board did not err when it applied ORS 656.262(7)(b) retroactively.[6]

Applying the statutes retroactively, we affirm the decision of the Board. The Board found that SAIF had accepted claimant's combined condition. That condition became medically stationary and SAIF sought to have the claim closed. It did not issue a written denial of the accepted combined condition. Therefore, when it closed the claim, it accepted that the condition remained compensable. The DCBS initially awarded claimant six percent PPD. On reconsideration, a medical arbiter reassessed claimant's impairment. Based on that assessment, the Board awarded claimant seven percent PPD.

SAIF does not dispute that, if the combined condition is compensable, claimant is entitled to seven percent PPD. Instead, it argues that because the medical arbiter found that the claimant's compensable injury was not the major contributing cause of his resulting impairment, it should not have to pay compensation for that impairment. Essentially, SAIF is attempting to deny, at claim closure, claimant's accepted combined condition on the basis that it is no longer compensable. As we have already explained, for such a denial to be effective under ORS 656.262(7)(b), it has to be issued in writing before claim closure. Because that was not done, claimant's combined condition remained accepted <155 Or App 576/577> through claim closure, and we affirm the Board's decision to award him seven percent PPD.

Affirmed.

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[6] SAIF also argues that our decisions in *AMFAC, Inc. v. Garcia-Maciel*, 98 Or App 88, 92, 778 P2d 967 (1989), and *Gooderham v. AFSD*, 64 Or App 104, 667 P2d 551 (1983), require us to conclude that the statute cannot be applied retroactively. In each of those cases, we concluded that it was unreasonable, under the circumstances, to apply a rule promulgated by an agency retroactively. Likewise, SAIF argues, in this case it is unreasonable to apply ORS 656.262(7)(b) retroactively because to do so would penalize SAIF for failing to issue a written denial before it moved to close claimant's claim, even though the law prohibited insurer from issuing such a denial at the time it closed claimant's claim. However well-reasoned SAIF's argument may be, its reliance on our decisions in *AMFAC* and *Gooderham* is misplaced. In this case, we are not interpreting a rule promulgated by an agency but a statute enacted by the legislature. That statute, Oregon Laws 1995, chapter 332, section 66, expressly provides that certain other statutes are to be applied retroactively. ORS 656.262(7)(b) is one of those statutes. In the light of that statutory mandate, our task is not to determine whether it is reasonable to apply ORS 656.262(7)(b) retroactively but, simply, to apply the statute retroactively.

WARREN, P. J., dissenting.

Because the majority opinion holds that the insurer should have complied with a procedural requirement that did not exist at the time of closure and that was, in fact, inconsistent with the law as it then existed, I dissent.

As the majority notes, before the legislature's 1995 enactment of ORS 656.262(7)(b), an insurer was prohibited from issuing a current condition denial before closure of the claim. *United Airlines, Inc. v. Brown*, 127 Or App 253, 873 P2d 326, *rev den* 319 Or 572 (1994). Thus, in this case, had SAIF denied claimant's current condition and ceased paying benefits before it closed the claim, it would have been subject to a penalty for unreasonable claim denial and termination of benefits.

The 1995 enactment of ORS 656.262(7) changed the law to permit an insurer to deny the compensability of a combined condition before claim closure, at the same time requiring the issuance of a written denial when the insurer becomes aware that the accepted injury is no longer the major contributing cause of the combined condition. As the majority correctly points out, we have held that the 1995 legislation is generally to be applied retroactively to cases pending on appeal, unless an express statutory exception exists. *Volk v. America West Airlines*, 135 Or App 565, 899 P2d 746 (1995). There is no statutory exception that would excuse SAIF's compliance with the written denial requirement that did not exist at the time of closure.

Unlike the majority, I conclude that the analysis does not end there. The Supreme Court has held that courts will not apply a statutory provision if an application of the literal meaning would produce an unintended, absurd result or if the literal import of the words is so at variance with the apparent policy of the legislation as a whole as to bring about an unreasonable result. *Johnson v. Star Machinery Co.*, 270 Or 694, 704, 530 P2d 53 (1974). We have held, further, that where retroactive application of an administrative rule is <155 Or App 577/578> "unreasonable in its prejudice," the rule should not be applied retroactively. *Amfac, Inc. v. Garcia-Maciel*, 98 Or App 88, 778 P2d 967 (1989).

In several of its decisions since the enactment of the 1995 legislation, the Workers' Compensation Board has held that where retroactive application of the new law will defeat the general legislative intent by producing an absurd or unjust result that is clearly inconsistent with the purposes and policies of the workers' compensation law, the statute will not be applied retroactively. *See, e.g., Rick A. Webb*, 47 Van Natta 1550 (1995); *Ida M. Walker*, 43 Van Natta 1402 (1991). The Board has recognized the unfairness of retroactively altering the rights and obligations of parties who have acted properly in reliance on the law in effect at the time of their actions, *Webb*, 47 Van Natta at 1551, and has held that substantial justice would not be served by requiring retroactive compliance with procedural requirements of the statute. *Id.*

In my view, the same rule applies in the context of ORS 656.262(7)(b). Retroactive application of the written denial requirement to SAIF in this case means imposition of an obligation that not only was not required but that was prohibited at the time of closure. I would hold that the legislature manifestly could not have intended that absurd and unjust result. Accordingly, I would reverse the Board's decision and remand the case for reconsideration.

I dissent.

Cite as 155 Or App 586 (1998) September 2, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Hillard J. Fortson, Claimant.

SAIF CORPORATION and POPE & TALBOT, INC., Petitioners,
v.
HILLARD J. FORTSON, Respondent.
(96-01843; CA A99413)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 8, 1998.
Michael O. Whitty argued the cause and filed the brief for petitioners.
James Edmunson argued the cause for respondent. With him on the brief was Cole, Cary & Wing.
Before Edmonds, Presiding Judge, and Armstrong, Judge, and Warden, Senior Judge.
ARMSTRONG, J.
Affirmed.
Warden, S.J., dissenting.

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155 Or App 589> SAIF seeks review of an order of the Workers' Compensation Board in which the Board found that claimant's injury arose out of and in the course of claimant's employment and, therefore, was compensable. We review for errors of law, ORS 183.482(8)(a), and affirm.

The relevant facts are undisputed. Claimant is a long-term production and maintenance worker at employer's paper production facility. At the time of his injury, claimant's working title was power and recovery lead operator and his principal duty was to keep equipment running properly in the recovery boiler area. In addition to his regular duties, claimant was occasionally given extra work assignments. It was unusually cold on February 1, 1996, and claimant was called in to help maintain free-standing, diesel-fueled heaters that were being used to prevent pipes at various locations at the plant from freezing. Claimant's job was to keep the heaters fueled and running. Heater work involved making the rounds of the plant facility, going to each location, fueling the heaters, checking their operation and correcting any problems with them. The task required two rounds, each of which would take approximately two hours. Claimant's shift began at 6:30 p.m. and was to run until some time between 4:00 and 6:00 a.m. Claimant was not expected to perform any tasks other than heater maintenance.

Although claimant arrived for work at 6:30 p.m., the fuel truck for the heaters was in use, and claimant and his co-worker were not expected to have any task to perform until the truck became available at 8:00 p.m. Claimant initially decided to stay in the plant control room area, but, after a while, he decided to check on a beechwood crate that he had seen lying in the plant's main yard the day before. Claimant had salvaged similar crates before and wanted to take this one so that he could use the wood at home. Employer had a policy that allowed employees to take waste materials for their own use, provided that they first obtained permission from employer and a pass to remove the salvaged material from the plant grounds. Although employer expected personal salvage work to be done when employees were off the **<155 Or App 588/589>** clock, there was no written policy as to when and how that work should be done. Additionally, employer allowed employees to identify and locate salvageable materials while on the clock, as long as they did not leave an area to which they had been assigned or interrupt their work activities to do it. Claimant had submitted a salvage request and, after checking with his supervisor to make sure that the request had been granted and the pass issued, he set out to locate the crate. It was no longer in the yard where claimant had first seen it, so claimant went to check the dumpster, which was a significant distance from the control room where he originally had gone to await the arrival of the fuel truck, to see if the crate had been discarded. He climbed the ladder attached to the dumpster and, after reaching the top rung, slipped and fell, fracturing both of his arms.

As insurer for employer, SAIF denied claimant's claim for compensation on the ground that he "was not in the course and scope of [his] employment at the time of the alleged injury." Claimant

requested a hearing, after which the administrative law judge (ALJ) upheld SAIF's denial, concluding that "claimant's February 1, 1996, injuries did not occur within the course and scope of his employment." On review, the Board reversed, concluding that

> "[i]n this case, claimant was on paid time when he was injured. The injury occurred on the employer's premises. Because claimant had no work responsibility (other than to be available in the event of heater malfunction) at the [time] of the injury, he did not 'depart' from work duty to investigate the contents of the dumpster. Instead, because the dumpster was in sight of the heater area, claimant was available to perform his work duties while he looked for the crate * * * .
>
> "In addition we find that claimant and employer generally contemplated that employees would look for salvage materials while working, so long as such activity did not interfere with work. We also find that employer knew claimant was doing that on February 1, 1996, because claimant informed his supervisor that he was going to look for the crate before he climbed the dumpster ladder. We further note the employer's course of conduct in allowing employees to identify discarded materials on paid time. **<155 Or App 589/590>** Finally, because employer-discarded materials would reasonably be expected to reach a trash receptacle before leaving the premises, we conclude that the employer actively acquiesced in, if not outwardly condoned, claimant's investigation of the dumpster for the purpose of locating the previously identified discarded crate."

The Board went on to note that the fact that claimant's activity conferred no benefit on employer did not change its conclusion that his injuries were work related.

SAIF does not dispute that claimant's injuries occurred in the course of his employment but contends that the Board erred in concluding that those injuries were compensable, because claimant was injured while on a purely personal errand that was of no benefit to employer and that presented no risk that could be related to his work. Hence, SAIF argues, the injuries did not arise out of claimant's employment. We disagree.

The Oregon Supreme Court recently has clarified the test to be applied when seeking to determine whether an injury is sufficiently work related to be compensable:

> "For an injury to be compensable under the workers' compensation law, it must 'aris[e] out of' and occur 'in the course of employment.' ORS 656.005(7)(a). The 'arise out of' prong of the compensability test requires that a causal link exist between the worker's injury and his or her employment. *Krushwitz v. McDonald's Restaurants*, 323 Or 520, 525-26, 919 P2d 465 (1996); *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 366, 867 P2d 1373 (1994). The requirement that the injury occur 'in the course of' the employment concerns the time, place, and circumstances of the injury. *Krushwitz*, 323 Or at 526; *Norpac*, 318 Or at 366.
>
> "This court views the two prongs as two parts of a single 'work-connection' inquiry, that is, whether the relationship between the injury and the employment is sufficient that the injury should be compensable. *Krushwitz*, 323 Or at 526; *Norpac*, 318 Or at 366. *See* ORS 656.012(1)(c) (Legislative Assembly finds that 'those injuries that bear a sufficient relationship to employment * * * merit incorporation of their costs into the stream of commerce.'). Both prongs of the work-connection test must be satisfied to some degree; neither is dispositive. *Krushwitz*, 323 Or at 531; *Norpac*, **<155 Or App 590/591>** 318 Or at 366. The work-connection test may be satisfied if the factors supporting one prong of the statutory test are minimal while the factors supporting the other prong are many. *Krushwitz*, 323 [325 Or 597] Or at 531 (citing *Phil A. Livesley Co. v. Russ*, 296 Or 25, 28, 672 P2d 337 (1983)). Both prongs serve as analytical tools for determining whether, in the light of the policy for which that determination is to be made, the causal connection between the injury and the employment is sufficient to warrant compensation. *Andrews v. Tektronix, Inc.*, 323 Or 154, 161-62, 915 P2d 972 (1996)."

Fred Meyer, Inc. v. Hayes, 325 Or 592, 596-97 (1997) (footnotes omitted). The determination about whether an injury is work related is to be made in light of the policy embodied in the workers' compensation system to protect workers from financial hardship due to injuries incurred in production, regardless of fault. *Andrews*, 323 Or at 162 n 2. Thus, the ultimate test is:

> "Considering all the pertinent circumstances, are the temporal, spatial, circumstantial and causal connections between the claimant's injury and employment sufficient to justify compensation, when sufficiency is evaluated in the light of the Act's policy of providing financial protection to workers who are injured in the course of employment, regardless of fault?"

Id. at 162.

SAIF argues that the test also must include an evaluation of the risk of injury to claimant and contends that, because claimant's work did not involve the dumpster and because the dumpster itself posed, at best, a neutral risk, the risk of injury did not result from the nature of claimant's work or originate from some risk to which the work environment exposed claimant. SAIF overemphasizes the importance of the risk analysis. While it is true that past decisions of this court and the Supreme Court have included such a risk analysis, that analysis is not dispositive. *See, e.g., Phil A. Livesley Co. v. Russ*, 296 Or 25, 31, 672 P2d 337 (1983) ("while risk and causation are important factors in a work-connection analysis, they are but two of many factors, and even when risk and causation are weak, compensation is not **<155 Or App 591/592>** automatically foreclosed") Rather, it is the totality of the circumstances surrounding the injury that determines compensability.

In this case, there is no dispute that claimant's injuries occurred in the course of his employment. Thus, the first prong of the unitary test is satisfied. As for the second prong, there is no dispute that employer's policy was to allow employees to locate and identify salvageable materials while working, as long as the employee did not depart from his or her duties to do so.[1] Furthermore, there is no dispute that, at the time of his injuries, claimant was not departing from any duty -- he had some free time while he waited for the fuel truck to arrive, and he decided to spend it looking for the crate rather than sitting in the control room. In light of employer's policy, we conclude that the activity was contemplated by both employer and claimant and that the activity was acquiesced to by employer. The fact that claimant's activity conferred no benefit on employer is not determinative. We have in the past considered the benefit to the employer of the conduct that injured the claimant when evaluating whether the injury was connected with work. *See, e.g., Mellis v. McEwen, Hanna, Gisvold*, 74 Or App 571, 574, 703 P2d 255 (1985). However, in *First Interstate Bank v. Clark*, 133 Or App 712, 717, 894 P2d 499 (1995), we specifically rejected a mechanical application of factors such as that, on the ground that such an application does not permit meaningful consideration of the circumstances of the injury in their totality, as required by *Norpac* and its progeny. Although it is true that some of the factors identified in *Mellis* remain helpful under *Norpac* in evaluating the connection between work and an injury, *see id.*, the benefit to the employer of a claimant's activity at the time of injury has not been a dispositive factor in any recent case. Indeed, recent decisions by the Supreme Court have rarely dealt with that factor at all. One need look no farther than the decisions involving "horseplay" to see **<155 Or App 592/593>** that injuries that result from activities that are of little or no benefit to an employer can be compensable under the totality of the circumstances. *Cf. Kammerer v. United Parcel Service*, 136 Or App 200, 204, 901 P2d 860 (1995) (discussing principles underlying compensation for certain injuries received as result of horseplay).[2]

Affirmed.

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[1] SAIF argues that the Board's conclusion that employer allowed employees to locate and identify salvageable materials while working is inconsistent with its finding that employer expected employees to remove those materials on their own time. We disagree. The act of locating or identifying materials is separate from the act of removing those materials. The Board clearly distinguished between those activities and, therefore, its findings and conclusion are not inconsistent.

[2] One might posit that "horseplay" benefits an employer by boosting employee morale, in which case the same could be said for the activity at issue in this case. By allowing employees to salvage materials, employer boosts morale and receives the benefit of worker loyalty.

WARDEN, S. J., dissenting.

The majority affirms the order of the Workers' Compensation Board which found that claimant's injury arose out of and in the course of his employment and concluded that it was, therefore, compensable. In doing so, the Board reversed the finding and conclusion of the Administrative Law Judge. Because the decision of the Administrative Law Judge was the correct one, I dissent.

The facts are sufficiently set forth in the majority opinion; I differ with the majority as to whether those facts establish that claimant's injury was one "arising out of and in the course of employment." ORS 656.005(7)(a). I would conclude that they do.

To establish compensability, the claimant had to establish that the injury resulted form his job. As the Supreme Court said in *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 366, 867 P2d 1373 (1994):

> "A claimant must also establish a causal connection between the injury and the employment, which is the second element of our unitary work-connection inquiry, namely, whether the injury 'arose out of' the employment. It is well-established that an 'employer * * * is not liable for any and all injuries to its employe[es] irrespective of their cause, and the fact that an employe[e] is injured on the premises during working hours does not of itself establish a compensable injury. The employe[e] must show a causal **<155 Or App 593/594>** link between the occurrence of the injury and a risk connected with his or her [318 Or. 369] employment.' *Phil A. Livesley Co. v. Russ*, 296 Or. 25, 29, 672 P.2d 337 (1983)."

More recently, the Supreme Court has articulated the proper test for determining whether an injury is one "arising out of" employment, *i.e.*, whether there is a causal connection between the employment and the injury, as: "whether the risk of claimant's injury either resulted from the nature of his work or whether the work environment exposed him to the risk of his injury." *Redman Industries, Inc. v. Lang*, 326 Or 32, 36, 943 P2d 208 (1997). Here, there is no causal connection between claimant's's injury and the nature of his work and nothing in his work environment that exposed him to the risk of his injury. At the time of his injury, claimant was engaged in pursuing his personal woodworking hobby, not his work or anything connected with his work.

The majority appears to rely on the facts that claimant's activity at the time of his injury was contemplated by and acquiesced in by the employer. That reliance would be "make weight," if that could be said for it. Neither fact goes to causation, but to employer's willingness to make available to employes material for which employer had no use and no wish to retain ("freebies," if you wish) and to protect employes from any charge of theft in taking such materials. That they establish any risk from the nature of claimant's work or his work environment resulting in his injury is a quantum leap of sophistry that even lawyers should reject.

The administrative law judge was correct in his finding and conclusion, and I would reverse the Board and reinstate the order of the Administrative Law Judge. Therefore, I dissent.

Cite as 155 Or App 595 (1998) September 2, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Jim R. Reed, Claimant.

JIM R. REED, Petitioner,
v.
LABOR FORCE OF OREGON and LIBERTY NORTHWEST INSURANCE CORPORATION,
Respondents.
(96-06663; CA A98353)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 8, 1998.
James S. Coon argued the cause for petitioner. With him on the brief was Swanson, Thomas & Coon.
Alexander D. Libmann argued the cause and filed the brief for respondent.
Before Edmonds, Presiding Judge, and Armstrong, Judge, and Warden, Senior Judge.
ARMSTRONG, J.
Affirmed.

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155 Or App 597> Claimant seeks review of an order of the Workers' Compensation Board in which the Board held that claimant was not entitled to temporary disability compensation for the period from November 1, 1995, to March 12, 1996. We affirm.

The relevant facts are undisputed. In 1994, claimant suffered a compensable lower back injury. The claim was closed in March 1995 with an award of permanent disability. On November 1, 1995, claimant's treating physician, Dr. Gray, filed a notice of an aggravation claim with Liberty Northwest Insurance Corp. (Liberty), employer's workers' compensation insurer. The notice of claim form, which was provided by the Workers' Compensation Division, included a check-the-box section in which the attending physician was asked to state "yes" or "no" about whether time-loss compensation was authorized. Gray did not check either box. Liberty accepted the claim, which remained open at the time of the Board's decision, but did not pay claimant any temporary disability benefits until March 13, 1996. Liberty did not contact Gray at any time to determine whether he would have authorized such benefits earlier.

On April 10, 1996, claimant requested a hearing before an administrative law judge (ALJ), claiming entitlement to temporary disability benefits for the period from November 1, 1995, to March 12, 1996. On April 22, 1996, Gray submitted a medical report in which he stated that he was "authorizing time loss from November 1, 1995 to present, and for another eight weeks, for [claimant] because of his lumbar disc herniation." On December 9, 1996, the ALJ entered an opinion and order in which she concluded that claimant was not entitled to temporary disability benefits for the period from November 1, 1995, to March 12, 1996, because there had been no contemporaneous authorization of those benefits by claimant's treating physician and because any retroactive effect of the April 22, 1996, authorization was limited by statute to the 14-day period before it was issued. The ALJ rejected claimant's argument that Liberty was under a statutory obligation to contact Gray in order to verify claimant's entitlement to time loss. On review, the Board **<155 Or App 597/598>** affirmed the ALJ's order, concluding that there was no statutory requirement that Liberty verify claimant's entitlement to temporary disability. The Board further concluded that an administrative rule that required insurers to verify and document a claimant's entitlement to temporary disability within five days of a notice of claim was invalid. Finally, the Board reasoned that, even if the regulation *were* valid, so that Liberty had violated it when it failed to contact Gray within five days of receiving the notice of claim, claimant still would not be entitled to temporary disability benefits, because the Board would not assume that Gray would have authorized those benefits *at that time.*

Claimant assigns error to the Board's conclusion that Liberty did not have an affirmative obligation to contact Gray within five days of the notice of claim in order to verify claimant's entitlement to temporary disability. Claimant bases his argument on OAR 436-060-0020(6), which provides in relevant part:

> "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 * * * may infer authorization from such medical records as a 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 at the time of, and indicating, the worker's inability to work."

(Emphasis added.) Claimant contends that, had Liberty contacted Gray within five days of the notice of claim, as required by the rule, he would have authorized the disability payments. Accordingly, claimant contends that the proper remedy for Liberty's failure to act is to award him those benefits as of the date of the notice of claim.

Although claimant's legal arguments may have merit, we cannot, on this record, say that he is entitled to the benefits that he seeks. Even if we were to conclude that the rule was valid and had been violated, and further concluded that Liberty's arguments against retroactive application **<155 Or App 598/599>** were unavailing, claimant is entitled only to those benefits for which there is contemporaneous evidence of entitlement. *See, e.g., SAIF v. Christensen*, 130 Or App 346, 351, 882 P2d 125 (1994), *rev allowed* 320 Or 567 (1995) (even though SAIF acted unreasonably in failing to verify claimant's inability to work, SAIF had no duty to begin paying benefits because there was no medical verification of inability to work). The Board concluded that there was no evidence in the record, apart from Gray's letter, to support claimant's contention that he was disabled in November 1995.[1] In reaching that conclusion, the Board stated:

> "Finally, we disagree with claimant that, if the rule requires verification, it necessarily results in finding that claimant is entitled to temporary disability for the disputed period. In making this argument, claimant relies on Dr. Gray's April 22, 1996 time loss authorization from November 1, 1995. Prior to March 13, 1996 (when insurer began paying temporary disability), the record contains no indication that claimant was less disabled than at claim closure.[2] * * * *Based on the absence of evidence showing disability, we will not assume that Dr. Gray's authorization of time loss in April 1996 necessarily means that he would have provided the same authorization in November 1995.*"

(Emphasis supplied.) Our review of the Board's factual findings is for substantial evidence, ORS 183.482(8)(c), and we cannot say, on this record, that the Board's conclusion was untenable. Claimant presented no evidence, other than Gray's letter, from which the Board could have inferred authorization. Claimant's argument that the Board was required to find authorization because there was no contrary evidence is unavailing. The Board was within its authority to reject claimant's interpretation of Gray's letter. To conclude otherwise would be to say that, *as a matter of law*, Gray's letter established claimant's entitlement to temporary disability, and we decline to take that position. Accordingly, we conclude that claimant is not entitled to temporary disability **<155 Or App 599/600>** benefits for the disputed period. *Christensen*, 130 Or App at 351. We do not reach the merits of claimant's other arguments.

Affirmed.

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[1] Claimant confirmed at oral argument that Gray's letter was the only evidence in the record to establish entitlement to temporary disability benefits as of November 1, 1995.

[2] It is not clear whether the Board intended to say "more disabled than at claim closure," which, in this context, would make more sense.

Cite as 155 Or App 601 (1998) September 2, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Petition of

WAYNE E. COGHILL, dba Allstate Siding Supply Co., Petitioner,
v.
The filings of the **NATIONAL COUNCIL ON COMPENSATION INSURANCE**, Respondent below, and SAIF CORPORATION, Respondent.
(INS 93-09-026; CA A96550)

Judicial Review from Department of Consumer and Business Services.
Argued and submitted May 15, 1998.
Charles M. Fryer argued the cause and filed the brief for petitioner.
Denise G. Fjordbeck, Assistant Attorney General, argued the cause for respondent. With her on the brief were Hardy Myers, Attorney General, and Michael D. Reynolds, Solicitor General.
Before Edmonds, Presiding Judge, Armstrong, Judge, and Warden, Senior Judge.
ARMSTRONG, J.
Affirmed.

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155 Or App 603> Petitioner seeks review of a final order of the Insurance Division of the Department of Consumer and Business Services (DCBS) upholding premium audit billings by SAIF for the period between April 1, 1992, and March 31, 1993.[1] We review for errors of law, ORS 183.482(8)(a), and affirm.

The following relevant facts were found by an Administrative Law Judge (ALJ) and adopted by DCBS.[2] Petitioner contracts to sell and install vinyl, steel, aluminum and wood siding, usually to builders of new buildings. After petitioner has contracted with a customer to sell and install siding, petitioner assigns a siding installer to the job. Petitioner either assigns the job to an employee or enters into a contract with a person whom petitioner considers to be an independent contractor.

During the audit period, petitioner relied on seven installers for various jobs.[3] Petitioner would describe the job to the installers, including the siding, size and other relevant factors. The installers usually accepted the jobs. The installers and petitioner would then prepare a contract for the job, signed by petitioner. The contract had petitioner's name on it and told the installer the customer's address and telephone number, the customer's color preference, and the materials to be used on the job.

Petitioner sometimes assigned employees to install less technical jobs. He also hired some of the outside installers as employees if he wanted to exercise more control over a particular job. He made the decision about whether to use employees or installers on a job based on the circumstances of each job, sometimes after the job had begun. Both employees **<155 Or App 603/604>** and installers were paid by the square foot. Employees were paid 55 cents per square foot and installers were paid 75 cents per square foot. The installers were paid more to cover their expenses.

The installers were responsible for picking up the siding provided by petitioner and taking it to the job site. They were responsible for providing their own tools, ladders and transportation for any job, although petitioner sometimes would provide special equipment for the installers to use.

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[1] In a companion case, *Coghill v. Natl. Council on Comp. Ins.*, 155 Or App 638 , ___ P2d ____ (1998), petitioner challenges audit billings for the period from April 1, 1993, to March 31, 1994.

[2] In his summary of argument, petitioner states that the conclusion by DCBS that he was required to pay workers' compensation premiums was not supported by substantial evidence. He does not identify any DCBS findings that he considers to be erroneous but, rather, devotes the body of his argument to points of law. In that light, we conclude that petitioner has not challenged DCBS's findings.

[3] For purposes of this opinion, we will use the term "installers" to refer to those individuals considered by petitioner not to be employees.

Petitioner occasionally inspected job sites, especially if he had assigned employees to the site. On some jobs, he assigned more than one contract installer. A sales representative of petitioner, Paul Phillips, would also visit work sites to promote customer relations and to report any sloppy work to petitioner. Sloppy work occurred in about one percent of the jobs. Petitioner was responsible to the customer for one year for any poor workmanship or products. Installers were liable to petitioner for one year for poor workmanship.

Installers were free to install the siding in any manner, although standard jobs were usually done in the same manner and did not require a high degree of skill. Installers set their own work hours. Petitioner mainly hired installers who were skilled and who could do the work promptly.

All the installers were bonded and registered with the state Construction Contractors Board (CCB) and filed business tax forms for their businesses. If an installer refused to correct poor workmanship, petitioner had the right to seek remedial action through the CCB against the installer's bond and registration. Both petitioner and installers could refuse to accept future jobs.

Petitioner required installers to sign a "Declaration of Independent Contractor Status." The declaration stated that the installer was an independent contractor who would work without the assistance of others unless the installer gave petitioner seven days' notice of the hiring of an assistant and provided workers' compensation coverage for the assistant. The declaration also stated that the parties understood **<155 Or App 604/605>** that installers would not be eligible to receive workers' compensation from employer.

At various times during the audit period, some installers told Occupational Safety and Health Administration (OSHA) inspectors that they were working for petitioner. On January 25, 1993, Gus Waltersdorf told an OSHA inspector that he was working as a foreman for petitioner, with a crew that included Rod Hall. Rod Hall told the inspector that he had been working for petitioner for five years. Petitioner did not report either Waltersdorf or Hall on its payroll reports to the Employment Department. On March 25, 1993, Doug Miller told an OSHA inspector that he worked for petitioner. Petitioner did not report Miller's payroll to the Employment Department. On September 2, 1992, the general contractor at a construction site told an OSHA inspector that Vern West was the foreman for petitioner for the siding work on that job. West told the inspector that he worked for petitioner and that petitioner was his supervisor. The inspector called petitioner and petitioner did not deny that West was his employee. Petitioner was assessed a fine because West was not using a safety belt while on a lift. Petitioner paid the fine and was not reimbursed by the installer. Petitioner required installers to comply with Oregon workers' safety laws. SAIF included all seven of petitioner's installers as workers in its premium audit of petitioner's workers' compensation coverage.

In order to determine whether an individual is a subject worker entitled to benefits under the Workers' Compensation Law, we first must determine whether that individual is a "worker." *S-W Floor Cover Shop v. Natl' Council on Comp. Ins.*, 318 Or 614, 622, 872 P2d 1 (1994).[4] "Worker" is defined by ORS 656.005(30),[5] which provides in pertinent part:

> "'Worker' means any person * * * who engages to furnish services for a remuneration, *subject to the direction and control of an employer*[.]"

(Emphasis supplied.) It is the right to control, not actual control, that is dispositive. *Oregon Drywall Systems v. Natl. Council on Comp. Ins.*, 153 Or App 662, 666, 958 P2d 195 (1998). Factors bearing on whether a person has the right to control another person include: (1) direct evidence of a right to control; (2) furnishing of tools and equipment; (3) method of payment; and (4) the right to discharge without liability. *Castle Homes, Inc. v. Whaite*, 95 Or App 269, 271, 769 P2d 215 (1989).

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[4] Neither party has argued, and therefore we do not address, whether the 1995 amendment to ORS 656.027(7) that establishes conclusively that contractors registered with the CCB are not workers who are subject to the Workers' Compensation Law, Or Laws 1995, ch 216, section 3(7)(b), applies to this case.

[5] At the time this proceeding began, "worker" was defined by ORS 656.005(28). That subsection was renumbered in 1995, and is now ORS 656.005(30). Or Laws 1995, ch 332, section 1. The text was unaltered. We refer to the statute in its current form.

> "[F]or the most part, any single factor is not merely indicative of, but, in practice, virtually proof of, the employment relation; while, in the opposite direction, contrary evidence is as to any one factor at best only mildly persuasive evidence of contractorship, and sometimes is of almost no such force at all."

3 Larson, *Workmen's Compensation Law*, section 44.31, at 8-90 (1998). If the "right to control" factors are inconclusive, then it is appropriate to consider the relative nature of the work. Id. In this case, the ALJ determined, and DCBS affirmed, that the "right to control" test was inconclusive and that, under the "nature of the work" test, the installers were workers.

We agree with DCBS that the "right to control test" is indeterminative. Although petitioner clearly has attempted to establish a system by which independent installers are kept separate from employees, particularly in his use of contracts purporting to establish independent contractor status for certain installers on certain jobs, other aspects of petitioner's operation have blurred the line between employee and non-employee.[6] Petitioner claims to have exercised no control over the installers' work methods, but the facts indicate some attempt by him to control the quality of the work. In addition, petitioner occasionally **<155 Or App 606/607>** assigned employees to work along with installers. It is not clear that he could control employees' work in such cases without also directing the installers. More troubling is the fact that petitioner would sometimes determine whether an installer was an employee after a job had begun. That suggests a greater degree of control over a project than typically would occur in a pure subcontracting situation. Furthermore, there is the fact that some installers identified themselves as employees of petitioner when questioned by state inspectors. Because the direct evidence of control is mixed, we must consider this factor to be neutral.

Additionally, although the installers supplied most of their own tools, petitioner supplied specialized equipment when needed. Hence, this factor must be viewed as neutral. The method of payment also is neutral at best. Although installers were paid in accordance with the contract and their progress on the project, they were paid at a rate determined by petitioner. *Compare Oregon Drywall Systems*, 153 Or App at 668 (subcontractors submitted bids and billings based on square footage or hours, based on their own assessment of the job, its difficulty and the time involved). As for the right to terminate, DCBS found no facts as to the consequences of an attempt by petitioner to remove an installer from an ongoing project, so we must rate this factor as neutral as well.[7]

Because the "right to control" test is inconclusive, we look to the relative nature of the work. Under that test, we take into account

> "the character of the [contractor's] work or business, -- how skilled it is, how much a separate calling or enterprise it is, to what extent it may be expected to carry its own accident burden and so on -- and its relation to the employer's business, that is, how much it is a part of the employer's regular work, whether it is continuous or intermittent, and whether **<155 Or App 607/608>** the duration is sufficient to amount to the hiring of continuous services as distinguished from contracting for the completion of a particular job."

3 Larson, *Workmen's Compensation Law*, section 43.52, at 8-27 to 8-28 (1998). The purpose of the nature of the work test is to consider factors that are relevant to the workers' compensation system rather than to the common-law issues involved in the right to control test. *Trabosh v. Washington County*, 140 Or App 159, 166, 915 P2d 1011 (1996). Under the nature of the work test, a worker whose services are a regular and continuing part of the cost of a product, and whose method of operation is not so independent that it forms a separate route through which the costs of industrial accident can be channeled, is presumptively a subject worker. *Id.* DCBS concluded that, under the nature of the work test, the installers were workers and not independent contractors. We agree.

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[6] Because "worker" status is determined by statute, the fact that installers signed documents declaring themselves to be independent contractors, although evidence of the parties' intent, is not legally dispositive. *See Henn v. SAIF*, 60 Or App 587, 592, 654 P2d 1129 (1982).

[7] The ALJ concluded that the "right to fire" factor weighed in favor of worker status because petitioner could refuse to offer future jobs to installers and installers could stop accepting jobs from petitioner. That is an incorrect conclusion. The exercise of a right not to deal with a particular installer in the future is consistent with the idea that a satisfactory end result is all that is aimed for by the contract, and is not, therefore, evidence of an employer-employee relationship. *See Henn*, 60 Or App at 592-93.

The installers performed work that was identical to that performed by petitioner's employees and that was, indeed, an integral part of petitioner's business. The majority of the installers' work did not require any advanced skills or specialized knowledge. Because the installers were paid by petitioner and because petitioner set the rate of pay, the installers were not able to pass any increased cost of doing business on to the customer. Therefore, petitioner was in a better position to cover the cost of industrial accidents.

Furthermore, although each job was discrete and of limited duration, petitioner had an ongoing working relationship with the installers. The same installers worked for petitioner year after year. Some installers had been employees of petitioner in the past, and some had been hired on as employees by petitioner during the audit period. The record before us does not show that the installers worked with or for any other parties during the audit period. Again, the fact that petitioner could, at his discretion, decide at any time whether an installer would be an employee on a particular job blurs the distinction between employee and non-employee for all jobs.

Petitioner bears the burden of proving that the installers were not employees. *Premsingh v. Natl. Council on* <155 Or App 608/609> *Comp. Ins.*, 111 Or App 624, 627, 826 P2d 120 (1992). We conclude that, on this record, DCBS properly could conclude that petitioner did not meet that burden. Accordingly, DCBS did not err in upholding the premium audit billings.

Affirmed.

Cite as 155 Or App 633 (1998) September 2, 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.
(95-12710 and 95-040M; CA A96056 (Control) and CA A96299)
(Cases Consolidated)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 28, 1997.
On petitioners' petition for reconsideration filed March 11, 1998. Opinion filed February 25, 1998. 152 Or App 780, ___ P2d ____.
David L. Runner for petition.
Christine Jensen and Malagon, Moore & Jensen, *contra.*
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
ARMSTRONG, J.
Reconsideration allowed; previous opinion supplemented and adhered to as supplemented.

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155 Or App 635> Petitioners seek reconsideration of our decision in *SAIF v. Pendergast-Long*, 152 Or App 780, 954 P2d 1270 (1998), in which we concluded that the Workers' Compensation Board had jurisdiction over claimant's request for medical services because claimant had challenged SAIF's denial of the compensability of the underlying claim. Petitioners contend that, under the Supreme Court's subsequent decision in *SAIF v. Shipley*, 326 Or 557, 955 P2d 244 (1998), the hearings division lost jurisdiction of the claim when claimant stated at hearing that her claim was for medical services under ORS 656.245. We allow the petition and adhere to our opinion as supplemented herein.

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, which employer accepted as a back strain. 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 the 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 disc derangement at L5-S1. The examining physician recommended surgery to fuse the lumbar spine from L4 to S1 to treat that condition, which surgery was performed in September 1995.

In conjunction with the surgery, claimant filed a request for compensation and temporary total disability (TTD) benefits. Because claimant's aggravation rights had expired in March 1991, SAIF submitted the request for TTD benefits to the Board's own motion division.[1] On November 7, **<155 Or App 635/636>** 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):
>
> "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."

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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 April 4, 1996. After the hearing, the administrative law judge (ALJ) issued an 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 cause of the condition that required surgery. The Board reaffirmed its decision in a December 1996 order on reconsideration. In January 1997, the Board issued its own motion order granting claimant TTD benefits for the period beginning with her hospitalization for surgery and continuing until she was medically stationary.

In our original opinion, we concluded that the Board had jurisdiction over the claim because claimant had challenged SAIF's denial of the compensability of the condition for which she had sought treatment and TTD. We based our conclusion on our interpretation of SAIF's original denial, and we stated that "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."

Under ORS 656.245(6), the hearings division has jurisdiction over a medical services claim only if the claim was disapproved because of a formal denial of compensability of the underlying claim. Otherwise, jurisdiction over medical services claims lies with the Director of the Department of Consumer and Business Services. In *Shipley*, the claimant **<155 Or App 636/637>** had originally disputed SAIF's denial of his aggravation claim but, at hearing, he withdrew the aggravation claim and conceded that he had suffered no new compensable injury. *Shipley*, 326 Or at 560. Instead, the claimant contended that his medical treatment was materially related to the original compensable condition and that he was, therefore, entitled to benefits for those medical services, based on the accepted claim. *Id.* The Supreme Court held that once the issue had thus been reframed, the ALJ and the Board had no authority to decide it under ORS 656.245(6) and, therefore, the claim should have been dismissed. *Id.* at 565.

Our case is different from *Shipley*. *Shipley* involved a dispute over medical treatment for an accepted condition. Here, the parties disputed whether the condition for which claimant sought treatment, the disc derangement at L5-S1, was compensable. Because the compensability of the underlying condition was at issue, the Board had jurisdiction over the claim. ORS 656.245(6).[2]

Reconsideration allowed; previous opinion supplemented and adhered to as supplemented.

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[2] Claimant stated in response to a motion by SAIF to dismiss her claim that her claim was "for medical treatment for the accepted injury." Standing alone, that statement could be understood to characterize the claim as one for medical services for the accepted 1986 back strain rather than as one that sought to establish the compensability of the L5-S1 disc derangement and the treatment of that condition. If that were the case, the dispute would be one over which the Director rather than the Board had jurisdiction. However, the parties' briefs and argument to the Board and the Board's decision make clear that the dispute was over the compensability of the disc derangement, which comes within the Board's jurisdiction.

Cite as 155 Or App 494 (1998) August 26, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Arlene J. Koitzsch, Claimant.

LIBERTY NORTHWEST INSURANCE CORPORATION and AGRIPAC, INC., Petitioners,
v.
ARLENE J. KOITZSCH, Respondent.
(WCB 96-01318; CA A98570)

En Banc
Judicial Review from Workers' Compensation Board.
Argued and submitted March 4, 1998; resubmitted in banc June 10, 1998.
Barbara Woodford argued the cause and filed the brief for petitioners.
Linda C. Love argued the cause for respondent. With her on the brief was Craine & Love.
DEITS, C. J.
Affirmed.
Edmonds, J., dissenting.

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155 Or App 496> Employer seeks review of a Workers' Compensation Board order that increased claimant's earlier permanent partial disability (PPD) award, based on the Board's conclusion that an intervening statutory change in the PPD rate applies retroactively to the award. We affirm.

In 1989, claimant filed a claim for an occupational disease. The Board issued an order awarding PPD to her. Claimant sought our review, contending that the Board erred in establishing the number of degrees of PPD. We reversed and remanded to the Board for reconsideration of that issue. *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, 866 P2d 514 (1994). Following our remand, the Board issued a second order in November 1994, which increased the number of degrees of PPD, awarded an out-of-compensation attorney fee and awarded an attorney fee to be paid by the carrier directly to claimant's attorney. Employer's insurer paid the PPD award at the rate of $145 per degree, the statutory rate in effect when claimant filed the claim. *See former* ORS 656.214(2) (1987) (establishing the rate).

Employer petitioned for judicial review of the 1994 order. Its contentions to us were directed only at the carrier-paid attorney fee award, and neither claimant nor employer raised any issue regarding the award of PPD. We reversed and remanded to the Board regarding the attorney fee issue in July 1995. *Liberty Northwest Ins. Corp. v. Koitzsch*, 135 Or App 524, 899 P2d 724 (1995). Some time after our second remand, claimant requested that the Board increase the PPD award, because the 1995 legislature had changed the PPD rate to $347.51 per degree, ORS 656.214(2), and had provided that the amended statute was to be applied retroactively. Or Laws 1995, ch 332, sections 17, 66(1).[1] The Board concluded that a ruling regarding the applicable rate was "premature" at that time and that

> "[s]hould claimant disagree with the insurer's actions in paying the permanent disability awarded in this case, she may seek a hearing concerning that matter. *See* ORS **<155 Or App 496/497>** 656.283(1). *The issue would be ripe at that time.*" (Emphasis supplied.)

In February 1996, claimant sought a hearing regarding the applicable rate. Both the ALJ and the Board agreed that the higher statutory rate applies retroactively because judicial review of the 1994 order was pending when the new law went into effect in June 1995. The Board explained:

> "Although the insurer's appeal [in the Court of Appeals] was limited to the attorney fee issue, the * * * 1994 order nevertheless was not 'final' within the meaning of ORS 656.295(8) and section 66 of the 1995 Act. A Board order is not 'final' so long as 'one of the parties' timely appeals to the court for judicial review. Thus, the fact that the insurer's appeal was limited to the attorney fee issue is immaterial to the finality of the Board's order. Due to the insurer's appeal of the Board's order, the order did not become final until after the effective date of the Act."

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[1] In the remainder of this opinion, we will generally refer to the 1995 Act as "chapter 332."

Employer seeks review of the Board's order and assigns error to its ruling that the increased PPD rate applies. The issue is whether the provision in chapter 332 that increased the rate applies retroactively to this claim. Section 66(1) of chapter 332 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."

However, section 66(5)(a) creates the following exception to the act's retroactive operation:

> "The amendments to statutes by this Act and new sections added to ORS chapter 656 by this Act do not apply to any matter for which an order or decision has become final on or before the effective date of this Act."

Also relevant is ORS 656.295(8), which provides:

> "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. The order shall **<155 Or App 497/498>** contain a statement explaining the rights of the parties under this subsection and ORS 656.298."

In *Volk v. America West Airlines*, 135 Or App 565, 899 P2d 746 (1995), *rev den* 322 Or 645 (1996), we interpreted sections 66(1) and (5)(a), in context with ORS 656.295(8), and concluded that the

> "legislature intended the changes in the law to apply to Board orders for which the time to appeal had not yet expired on the effective date of the Act or, if the case had been appealed, to any case that was still pending before the court on the effective date of the legislation." *Id* at 569.

We noted further in *Volk* that, to whatever extent the text and context might not be conclusive, "the legislative history supports the same interpretation." *Id*. We emphasized the following comments by the sponsor of chapter 332 that we quoted from the legislative history:

> "There's only one part of the implementation dates, I think, probably needs a real flat statement on the record and that is that the retroactivity also applies to cases in which a final order has not yet issued in litigation. There's a bunch of cases in the system right now that have been decided by different factfinders under two or three different versions of the law depending on whether the Board interpretation or the Court of Appeal's interpretation or the Supreme Court interpretation was in effect at that time and this says 'this law applies to everything no matter where it is unless you have already been to court, had it decided and there's a decision been rendered and the decision is not subject to being appealed anymore.' Otherwise, except with the exceptions here, this is the law for everybody and we'll go out and apply it whether it's pro-worker or pro-employer.
>
> "* * * * *
>
> "[T]he amendment, sub-5 will be 'the amendments to this chapter do not apply to any matter for which an order or decision has become final as of the date of passage of this Act;--the old concept of *res judicata*; you litigate it, it's over, we're not going back and reopening litigation." *Id*. at 570-72.

Based on the foregoing, we concluded in *Volk* that the chapter 332 provisions that related to the issue in the case applied **<155 Or App 498/499>** retroactively to it, "because review of the Board's order was sought, but was not finally resolved by the courts at the time of the effective date of the Act[.]" *Id*. at 573.

Employer contends that this case differs from *Volk* in a critical respect; namely, that although the Board's 1994 *order* was on appeal to this court at the time of the act's effective date, the parties presented no question in the appeal about the resolution of the PPD *issue* in that order. Employer reasons that the PPD award was therefore a "matter" as to which the 1994 order had become final, notwithstanding the fact that the order itself had been appealed, and that the PPD award accordingly comes within the exception to retroactivity set forth in section 66(5)(a). Hence, according to employer, the increase in the PPD rate under chapter 332 cannot be applied retroactively to the 1994 award.

Claimant responds that the proper inquiry is whether the 1994 order had become final, and that, under *Volk*, the fact that the appeal from it was pending on the effective date means that it had not. According to claimant, particular issues that are addressed in a Board order do not become "final," within the meaning of section 66(5)(a), independently of the order itself. Therefore, if the order was on appeal when chapter 332 took effect, the order as a whole was not final at that time, and it is immaterial to the retroactivity question under chapter 332 that no specific challenge was made in the appeal to any particular ruling or issue addressed in the order.

We agree with claimant. Employer's argument hinges on its understanding that the word "matter" in section 66(5)(a) refers to a component part of the Board's disposition of a claim and signifies that that part can achieve "finality" independently of the order that contains it. That understanding is contrary to the language of section 66(5)(a) itself. The section does not refer to *matters* that have become final, but to any matter *for which an order or decision has become final."*[2] (Emphasis supplied.) The emphasized phrase would **<155 Or App 499/500>** have been superfluous if the legislature had meant that "matters" within orders can become final separately and independently of the orders that contain or rule on them.

The statutory context is also contrary to employer's understanding. ORS 656.295(8) provides that a Board order is final unless an appeal from it is taken to this court within the statutorily specified period. Thus, if an order is appealed, the order itself does not become final until there is a final decision on appeal. ORS 656.295(8) supports the view that "finality" is a property of the *order*, not *parts* of the order. Further, ORS 656.295(8) makes it clear that the order is the thing that is appealable to this court. As in other appellate contexts, *e.g.*, appeals from circuit court judgments, this court obtains jurisdiction over the entire case when an appeal is taken from the judgment or order. As a general proposition, as long as an appeal is pending, finality does not attach piecemeal to the parts of a judgment or order that are not placed in direct controversy by the parties' assignments or arguments in the appeal; it attaches to the case as a whole after the appellate process is complete.[3]

That that general proposition holds true in workers' compensation cases is demonstrated by the Supreme Court's statement in *Drews v. EBI Companies*, 310 Or 134, 149, 795 P2d 531 (1990), that, for purposes of issue or claim preclusion:

> "A claim determination is not final until hearing and judicial review rights are barred or exhausted. The statutory scheme indicates that the finality requisite for claim or issue preclusion, against the worker, occurs only when a worker fails to timely request a hearing after a claim denial, a determination order, or a notice of claim closure, ORS 656.319, or by failure to file a timely appeal to the Board, ORS 656.289(3), or the courts. ORS 656.295(8)."

Hence, under *Drews*, the PPD award in the 1994 Board order, which employer argues became a final "matter" under section 66(5)(a) independently of the order itself, could **<155 Or App 500/501>** not even have been final for purposes of issue preclusion once employer appealed from the order and as long as the appeal was pending. For the reasons discussed earlier, however, section 66(5)(a) does not create that anomaly: It makes the finality of the "order" essential to the finality of the "matters" it contains and is therefore fully consistent with *Drews* and the other related statutory and judicial authority we have discussed.[4]

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[2] Employer's argument makes no point about the word "decision" in the quoted statutory language. However, the legislative history that we quoted in *Volk* and have reiterated here indicates that the word refers to a final judicial decision in an appeal from an order.

[3] In the workers' compensation setting, as in others, the underlying proceedings can have certain effects that continue during or are not affected by the taking of an appeal, *e.g.*, interim compensation. However, that is not the same issue as the one this case presents.

[4] Our mention of issue and claim preclusion is intended to serve only the illustrative purpose set out in the text. Unlike the dissent, we do not regard either form of preclusion to be a decisive issue in this case. Indeed, employer does not raise the preclusion doctrines at all, much less seek reversal on the basis of them. In any event, the dissent's discussion of preclusion does not seem to us to advance its position. Insofar as it relies on the 1994 order and/or claimant's not challenging the PPD award in it, the dissent appears to be transposing the "finality" requirement of the preclusion doctrines and the "finality" exception to

Ultimately, this case turns on a precise understanding of terms that entail somewhat subtle shades of meaning and that are often used colloquially in ways that differ from their precise meaning. For example, employer states that

> "the permanent disability award matter was finally resolved and not on appeal. Only the attorney fee matter was on appeal."

However, *issues (or matters)* are not appealed; *orders* are appealed, and issues are simply a matter for assignments and arguments within the appeal after it has been brought. The appellate courts directly consider only the issues that the parties raise, but their decision nonetheless entails a disposition of the entire order from which the appeal is taken. *See, e.g.*, ORS 183.482(8); ORS 656.298(1),(7).

Similarly, the term "finality," as used in connection with issues, orders and their disposition on appeal, also has a precise meaning that differs from the one posited in employer's argument. Employer uses the term in a sense that is synonymous with "conclusive" or even "preserved." That would be a correct understanding of the term if the question here **<155 Or App 501/502>** were whether claimant could have relitigated the original 1994 PPD award before the Board, upon our remand of the order; further, the answer to that question would probably be "no," because the PPD issue was not raised in the appeal to us from that order, and our remand to the Board did not encompass the issue. However, that is not the question presented here. Rather, the question is whether the Board's ruling on the issue became *dispositionally* final before the appeal from the entire order was decided. The answer to that question is also "no."

Employer also relies on *Price v. SAIF*, 296 Or 311, 675 P2d 479 (1984), in support of its thesis that an order can be final as to one issue but not another. In that case, the claimant sought compensation for a back condition and for a putatively related heart condition. SAIF issued a partial denial for the heart condition. The Board affirmed that denial but, in the same order, it remanded the issue of the extent of disability for the accepted back condition to the hearings officer. The Supreme Court held that the Board's disposition of the heart condition issue was final and appealable to the Court of Appeals, even though the other ruling in the order was not.

Claimant argues, and the Board concluded, that *Price* is inapposite, because it dealt with whether part of an order can be final for purposes of *appealability*, not with the different question involved here, of whether an order can be *dispositionally* final in part and non-final in part when a proper appeal has been taken from it. We agree that the questions are different. In addition, however, this case differs from *Price* in that there is no partial denial issue here. In *Dean v. SAIF*, 72 Or App 16, 695 P2d 90, *rev den* 298 Or 822 (1985), and *Lindamood v. SAIF*, 78 Or App 15, 18, 714 P2d 1057 (1986), we concluded that "Price was limited to the partial denial situation and did not otherwise change existing law regarding what is a final order."[5] *Price* is not relevant to the issue presented in this case.

155 Or App 503> We conclude, based on the text and context of the relevant provisions, that an issue or "matter" does not become "final," within the meaning of section 66(5)(a) of chapter 332, until the Board order dealing with the matter or the appellate review of the order becomes final. It follows that the PPD award in the 1994 order was not final when chapter 332 took affect and that the Board was correct in increasing the award pursuant to that act.

Affirmed.

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retroactivity under chapter 332. At best, the dissent's preclusion discussion in connection with the 1994 order begs the real question, *i.e.*, the meaning of the statute. Further, insofar as the dissent relies on the Board's November 15, 1995, order on remand as having a preclusive effect, it does not explain how an order that refuses to rule on an issue on grounds of prematurity can have any preclusive effect on a subsequent adjudication of the issue.

[5] We summarized the "existing law" in *Mendenhall v. SAIF*, 16 Or App 136, 138, 517 P2d 706, *rev den* (1974), where we said that, to be final for purposes of appealability, a Board order "must be one which determines the rights of the parties so that no further questions can arise before the tribunal hearing the matter."

EDMONDS, J., dissenting.

At the heart of the disagreement between the majority and myself is the issue of whether claimant subsequently can recover permanent partial disability (PPD) at a rate that was not in effect at the time that the order on the extent of PPD became final. Because I believe that the majority's analysis is contrary to the principles of issue preclusion and what the legislature intended when it amended the Workers' Compensation Law in 1995, I dissent.

The Board awarded 78 degrees for 52 percent PPD to claimant in 1994 in WCB case No. 90-13984, after we remanded for reconsideration of the extent of her disability. *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, 866 P2d 514 (1994). Claimant did not seek review of the Board's ruling. Accordingly, employer's insurer paid the PPD award in a lump sum at the rate of $145 per degree of impairment, the statutory rate in effect at the time, on November 18, 1994. *See* ORS 656.202(2) (providing that awards be paid "in the amounts provided for, by the law in force at the time the injury giving rise to the right to compensation occurred"); ORS 656.214(2) (1987) (establishing the rate of compensation at that time).

In addition to awarding PPD to claimant in 1994, the Board also awarded an to-be-paid out-of-compensation attorney fee to claimant's attorney and for the first time, an attorney fee to be paid directly by the insurer to claimant's attorney. Employer sought review only as to the order that it pay an attorney fee directly to claimant's attorney. On review, we held that the Board had exceeded its authority and remanded to the Board for reconsideration in July 1995. **<155 Or App 503/504>** *Liberty Northwest Ins. Corp. v. Koitzsch*, 135 Or App 524, 899 P2d 724 (1995). On remand, claimant sought an award for the first time from the Board of an additional amount of money for her PPD at the rate of $347 per degree for the impairment that had been adjudicated in 1994. She did not contend that her disability had increased; rather, she argued that she was entitled to additional compensation for the prior award because the 1995 legislature had increased the rate of PPD while review was pending on employer's appeal. The Board rejected claimant's request, reasoning that any ruling on an increased rate of PPD would be premature.[1] The Board issued its order on remand on November 15, 1995. That order does not make an award of PPD or mention the 1994 order. It vacates the portion of the previous order that granted a carrier-paid attorney fee and declines to rule on claimant's request that the prior award of PPD be paid at the higher rate. Neither party sought review of the November 15, 1995, order.

In February 1996, claimant filed a new request for hearing with the Hearings Division, claiming that the previously awarded PPD had not been paid at the proper rate. That request was designated as WCB case No. 96-01318, which is the case presently before us. Before the administrative law judge (ALJ), claimant stipulated that the November 15, 1995, order in WCB case No. 90-13984 was final. However, she asserted that she was entitled to additional monies for her impairment as a result of the retroactivity provisions of the 1995 amendments that had increased the rate of compensation for PPD. Employer pointed out that it had paid the PPD awarded in 1994 at the rate then in effect and before the **<155 Or App 504/505>** effective date of the amendments. Nevertheless, ALJ reasoned that because

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[1] The Board said:

"Consequently, we find that at this juncture, any ruling regarding the applicable rate for claimant's permanent disability benefits would be premature and advisory in nature. *See, e.g., David J. Aronson*, 47 Van Natta 1948 (1995); *see also James J. Sheets*, 44 Van Natta 400 (1992)."

In *Aronson*, the claimant also requested the higher rate of PPD in light of the 1995 amendments. The Board reasoned that because the insurer had yet to process its prior order withdrawing an order affirming the ALJ's order that increased the claimant's PPD award, any ruling regarding the applicable rate would be premature. It pointed out that if the claimant subsequently disagreed with the insurer's action, it could seek a hearing under ORS 656.283(1). This case differs in that the insurer had processed and paid claimant's PPD in 1994.

ORS 656.214[2] provided for the payment of PPD at the rate of $347 per degree at a time when WCB case No. 90-13984 was still pending, claimant was entitled to the increased rate. Employer appealed to the Board. The Board agreed with the ALJ's, reasoning:

> "Although the insurer's appeal was limited to the attorney fee issue, the November 10, 1994 order nevertheless was not 'final' within the meaning of ORS 656.295(8) and section 66 of the 1995 Act. A Board order is not 'final' so long as 'one of the parties' timely appeals to the court for judicial review. Thus, the fact that the insurer's appeal was limited to the attorney fee issue is immaterial to the finality of the Board's order. Due to the insurer's appeal of the Board's order, the order did not become final until after the effective date of the Act."

Employer seeks review of the Board's latest order. It argues that the PPD award was made and paid in 1994 at the rate in effect at the time and that the Board's order is final to that matter. Consequently, it asserts that claimant is precluded from requesting compensation at the higher rate. Claimant argues that she is entitled to the increased rate of PPD under the 1995 amendments because they were in effect at the time that the Board vacated its award for carrier-paid attorney fees in November 1995 and that there was no prior final order on the rate of PPD.

The fact that the unappealed November 1994 order is the last order that awards PPD and the fact that claimant did not seek review of that order or the subsequent November 15, 1995, order which held that her request was premature raises issues regarding issue preclusion. In general, the doctrine of claim and issue preclusion applies to workers' compensation cases. *Drews v. EBI Companies*, 310 Or 134, 142, 795 P2d 531 (1990). Issue preclusion precludes future litigation on issues when they have been actually litigated and determined in a setting where the determination is essential **<155 Or App 505/506>** to a final decision. It applies to issues of fact or law. *Id.* at 139-40. In workers' compensation cases, issue preclusion rules apply where they "facilitate prompt, orderly and fair problem resolution." *North Clackamas School Dist. v. White*, 305 Or 48, 52, 750 P2d 485, modified 305 Or 468, 752 P2d 1210 (1988). Also, issue preclusion may be rendered inapplicable by legislative enactments. Thus,

> "[t]he point at which finality attaches to a statutory administrative proceeding for preclusion purposes will usually be governed by statutory provisions. Indeed, a statutory scheme of remedies may expressly contemplate that successive proceedings may be brought, notwithstanding the finality of the first proceeding. But the statutory scheme will usually spell out the situations where a second proceeding is not precluded by finality of a first proceeding." Drews, 310 Or at 142-143.

The above-mentioned principles regarding issue preclusion frame our examination of the applicable statutes and inform our analysis in this case. Oregon Laws 1995, chapter 332, section 66(1), 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 [June 7, 1995], 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."

Subsection 5(a) of section 66 provides:

> "The amendments to statutes by this Act and new sections added to ORS chapter 656 by this Act do not apply to any matter for which an order or decision has become final on or before the effective date of this Act." Or Laws 1995, ch 332, section 66(5)(a).

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[2] ORS 656.214(2) provides, in part,

"When permanent partial disability results from an injury, the criteria for the rating of disability shall be the permanent loss of use or function of the injured member due to the industrial injury. The worker shall receive $347.51 for each degree stated against such disability * * *."

In this case, the Board entered its only order in WCB case No. 90-13984 regarding PPD in 1994, and employer paid that award. Neither party sought review of the 1994 order. Of course, claimant would have had no occasion to seek review of the rate paid because it was paid at the rate then in effect. No statute in effect in 1994 postponed the finality of that order, once the time for review expired under ORS 656.295(8). In the absence of any statute that would have **<155 Or App 506/507>** postponed the finality of the order on PPD, the doctrine of issue preclusion precludes any subsequent litigation of that issue. *North Clackamas School Dist.*, 305 Or at 52-53. Because the award of PPD and the rate at which it was to be paid were issues actually litigated and determined in a setting where its determination was essential to the final decision reached, claimant is precluded from raising those issues in her 1996 claim.

When claimant requested additional compensation for PPD from the Board on remand in 1995 in WCB case No. 90-13984, the Board denied her request, holding that her procedural remedy was under ORS 656.283(1). That statute provides in pertinent part that "any party * * * may at any time request a hearing on any matter concerning a *claim* * * *." (Emphasis supplied.)[3] In other words, the Board did not rule on the entitlement to compensation under the new rate. Rather, it held that as a procedural predicate, she was required to file a new claim for the increased compensation. The Board's ruling constituted an adjudication on the issue of whether claimant could recover the new rate in WCB case No. 90-13984. The Board's decision actually determined that issue, and its determination was essential to the final decision reached. Claimant did not seek review of the Board's order regarding the issue of whether she was required to file a new claim in order to recover the new rate, and it also became final under ORS 656.295(8). Again, the doctrine of issue preclusion precludes her from relitigating that issue in a new claim. *Id.*

The majority attempts to reason around the doctrine of issue preclusion by utilizing the 1995 amendments to the Workers' Compensation Law. According to the majority, the "matter" of the rate of payment of PPD in this case was never the subject of a final order or decision until after the new rate became effective in June 1995 under the amendments. Apparently, the majority believes that the Board's November **<155 Or App 507/508>** 15, 1995, order in WCB case No. 90-13984 has the legal effect of incorporating the 1994 PPD order so that the 1994 order did not become final until after the 1995 amendments became effective. Its analysis has several flaws.

First, the request for additional compensation before us is not under WCB case No. 90-13984. Claimant's request has the status of a new claim under ORS 656.283. She does not seek review from any order or decision in WCB case No. 90-13984 or the November 15, 1995 order, having stipulated to the ALJ that the latter became final. Therefore, it is legally impossible for us to enter an order in that case. Second, the majority does not deal with the legal significance of the failure of claimant to seek review from the 1995 order. Third, the 1995 order does not adjudicate the entitlement to PPD at the new rate except by implication. Rather, it determines that the issue was not legally cognizable in WCB case No. 90-13984, a determination not challenged by claimant. Finally, the majority fails to recognize that by enacting the 1995 amendments, the legislature has expressly provided for claim splitting for purposes of finality and issue preclusion. Rather than enacting a statutory scheme that avoids claim preclusion as discussed in *Drews*, the 1995 amendments on retroactivity express a legislative intention to statutorily adopt the doctrine of issue preclusion regarding matters in pending claims that have become final before the effective date of the amendments.

Subsection 5(a) provides a specific exception to the general retroactivity of the 1995 amendments to the Workers' Compensation law and requires careful scrutiny. Or Laws 1995, ch 332, ' 66(5)(a). The legislature did not use the phrase "claim or causes of action" in the exception provision as it did in the general retroactivity provision of the bill. Rather, the exception to retroactivity applies to "any *matter* for which an order or decision has become final * * *." (Emphasis supplied.) In context, a "matter" is an issue that arises within a claim. For instance, ORS 656.283(1) provides that a claimant may request a

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[3] A " 'claim' means 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). "'Compensation ' includes all benefits, including medical services, provided for a compensable injury to subject worker or the worker's beneficiaries by an insurer or self-insured employer pursuant to this chapter." ORS 656.005(8).

hearing "on any matter concerning a claim, except matters for which a procedure for resolving the dispute is provided in another statute * * *." The choice of the legislature to use the phrase "matter for <155 Or App 508/509> which an order or decision has become final" in the exception clause rather than the words a "claim" or a "cause of action" used in the general retroactivity clause cannot be ignored. The use of different language can only be indicative of the legislature's intent to permit the splitting of issues out of claims for purposes of finality of determinations of matters within the same claim.[4] Under the exception clause, a determination on a matter within a claim on which review was not sought and which became final before the effective date of the amendments is deemed not subject to the 1995 amendments, including the increased rate of PPD.

Also, the majority's decision embodies a policy that is contrary to the legislature's intent to afford finality to adjudications within the workers' compensation system when not appealed. The decision means that the finality of orders or decisions regarding matters does not occur until there is a final order on the claim. If the majority is correct, that means that the legislature must have contemplated that all aspects of a claim pending on June 7, 1995, are subject to reconsideration under the amended statutes, even if litigation on a matter within a claim was not pending. Accordingly, if that had been the intention of the legislature, it would have used the word "claims" in subsection 5(a) rather than the phrase "any matter for which an order or decision has become final."

Moreover, the policy ramifications of the majority's decision conflict with other workers' compensation statutes and upset the harmony between statutes like ORS 656.313 and ORS 656.298(3)(c). ORS 656.313 stays payment of ordered compensation when appealed. Under the statute, an insurer has a duty to pay the compensation within 30 days of the order, if it does not appeal. In this case, employer paid the PPD ordered in 1994, electing not to exercise its right to appeal. Unless the majority is also willing to hold that employer can now appeal the award of PPD decided in 1994, employer finds itself liable for the difference between $147 <155 Or App 509/510> per degree and $347 per degree four years later, having foregone its appeal rights. Also, ORS 656.298(3) requires a petitioner to specify the issues on review including "[a] brief statement of the relief requested and the reasons the relief should be granted." The obvious purpose of the statute is to inform the parties about which matters are to be litigated on appeal and by implication, which rulings can be considered final. When read with ORS 656.295(8),[5] the statutes express a legislative policy of finality that permits parties to rely on the hearing division's rulings as final determinations of matters unless an issue is raised at the next level of review. In light of the majority's analysis, the designation of issues for review no longer has any bearing on the issue of finality.[6]

Finally, our decision in *Volk v. America West Airlines*, 135 Or App 565, 899 P2d 746 (1995), *rev den* 322 Or 645 (1996) does not dictate a contrary result. In that case, the claimant sought review of an order of the Board in which the Board concluded that it lacked authority to order the insurer to pay an attorney fee directly to the claimant's attorney. We first addressed ORS 656.386(2), which had been amended by chapter 332. We framed the issue as "whether the legislature intended the new law to apply in a case such as this where the Board has taken its final action and the matter has been appealed

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[4] As the Supreme Court has recognized in a different context, "[A Board] order which addresses two separate aspects of the same claim * * * may finally determine one issue but not the other." *Price v. SAIF*, 296 Or 311, 316, 675 P2d 479 (1984). Subsection 5(a) is a reflection of the legislature's intent to create a similar concept for purposes of the retroactivity of the 1995 amendments.

[5] 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."

[6] The need for a policy of finality is illustrated by the facts in this case involving a claim commenced in 1990, PPD compensation ordered and paid in 1994 and a request for increased compensation pending in 1998 (because of the fortuity of the 1995 amendments). On these facts, it is difficult to believe that the legislature would not have intended the 1994 PPD award to be final in light of the language of subsection 5(a).

to, but not finally resolved by, the court." *Volk*, 135 Or App at 569. In light of the provisions of ORS 656.295(8), we concluded that "the legislature's intent in subsection (5)(a) of section 66 was to make the new law applicable to matters for which the time to appeal the Board's decision had not expired or, if appealed, had not been finally resolved by the courts." *Id.* at 572-73. We did not decide whether the legislature contemplated that a claim could be split so that a **<155 Or App 510/511>** matter in a claim could become final while review was pending on a different matter in the claim.

In summary, the law of issue preclusion controls the outcome of this case. The decision of the matter of the rate of PPD became final when claimant did not seek review of the Board's rejection of her request that she be awarded PPD at the higher rate in November 1995. Claimant is now precluded from raising that issue through a new claim made in 1996. Moreover, the payment of PPD in 1994 ended employer's obligation under ORS 656.214(2) when claimant did not seek review of the order on that matter. Subsection 5(a) is an expression by the legislature regarding the splitting of claims so that matters finally decided within a case are accorded the status of final orders. When applied to this case, it makes the 1994 order awarding PPD at the rate of $147 per degree not subject to the retroactivity provisions of the 1995 amendments. For several reasons, we should reverse the Board's decision requiring employer to pay additional PPD at the new rate.

I dissent.

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